

Application Packet for Oregon Trauma Center Accreditation



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Emergency Medical Services and Trauma Systems

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INFORMATION

Purpose

The purpose of this document is to provide instruction to Oregon hospitals for completion of their trauma center accreditation or designation application, and to provide guidance for the trauma site survey process.

A systematic approach to trauma care provides the best means to protect the public from premature death and prolonged disability. A trauma care system reduces death and disability by identifying the causes of injury and promoting activities to prevent injury from occurring, by assuring that the required emergency medical resources are available, and that the necessary infrastructure is in place to deliver the "right" patient to the "right" hospital.

History

In 1985 the Oregon Legislature enacted a trauma system statute which directed the Oregon Department of Human Services (DHS) to develop a comprehensive emergency medical services and trauma system. DHS is authorized to categorize or designate trauma hospitals, in accordance with area trauma system plans, which meet the objectives and standards of the Oregon Administrative Rules.

DHS, in conjunction with the Oregon State Trauma Advisory Board (STAB) and the seven Area Trauma Advisory Boards (ATABs), developed statewide objectives and standards for the comprehensive care of severely injured patients. These objectives and standards were adapted from the American College of Surgeons Committee on Trauma to meet Oregon's diverse demographic and geographic needs and were adopted into rule by the Oregon Secretary of State in 1987. Each ATAB has implemented an area-wide trauma system plan which meets the statewide objectives and standards.

Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR)

The Oregon Legislature passed Senate Bill 147 which provided the authority for the creation of a statewide trauma system. Oregon became one of the earliest states in the nation to approach trauma care in a systematic manner. The original legislation has been amended over the years, and is presently codified as Oregon Revised Statutes (ORS) 431.607 to 431.619. The implementing regulations, first promulgated by the Department of Human Services on September 20, 1985 are set forth as Oregon Administrative Rules (OAR) Chapter 333, Division 200 and 205.

Accreditation / Designation

For area trauma system plans prescribing categorization of hospitals, DHS accredits all hospitals meeting the area trauma system plan standards. For area trauma system plans prescribing designation of hospitals, DHS accredits selected hospitals which meet the state requirements and the standards of the area trauma system plan. DHS selects hospitals based on an assessment that the best interests of the area's patients are served by the particular applicant, and upon expected patient volume. Competing applicants are judged based on an assessment and determination of which hospital provides the highest degree of compliance with the standards in Exhibit 4 of the OARs, and the quality of care the hospital delivers.

Levels of Care

Trauma hospitals are distinguished from other facilities in that they guarantee the immediate availability of surgeons, anesthesiologists, physician specialists, nurses, ancillary services, and resuscitation/life-support equipment on a 24-hour-a-day basis, dedicated to the care of trauma patients. Trauma facilities are designated or categorized as Level I, II, III, or IV, with Level I and II centers offering the highest level of care. Oregon has adopted, with a few modifications, the American College of Surgeons' "Optimal Standards of Care of the Trauma Patient" as the minimal acceptable standards.

Level I Trauma Center

The role of the Level I trauma center is to provide the highest level of definitive, comprehensive care for the severely injured adult and pediatric patient with complex, multi-system trauma. A Level I facility is the regional resource trauma center in the system and has the capability of providing total patient care for every aspect of injury from prevention through rehabilitation. Highly specialized care for pediatric trauma, burns, spinal cord injury, eye injury, limb reimplantation, and other clinical problems is available at the Level I center. An emergency physician, general surgeon, anesthesiologist, and nursing and ancillary personnel who can initiate immediate surgery are in-house and available to the patient upon arrival to the emergency department. A neurosurgeon is on-call and promptly available to the patient. A broad range of sub-specialists are on-call and promptly available to provide consultation or care. In addition to direct patient care, Level I trauma centers are responsible for resident training, research, regional quality improvement, community education, outreach, and injury prevention.

Level II Trauma Center

The role of the Level II trauma center is to provide definitive care for severely injured adult and pediatric patients with complex trauma. The services available at a Level II trauma facility and the resource requirements are similar to those at a Level I trauma center. Physicians who are ATLS trained and experienced in caring for traumatically injured patients, nurses, and ancillary staff are in-house and immediately available to initiate resuscitative measures. A board certified general surgeon and anesthesiologist are on-call and available to the patient. A neurosurgeon is on-call and promptly available. There is a broad range of specialists available for consultation or care, and comprehensive diagnostic capabilities and supportive equipment are available. Level II trauma centers serve as regional resource centers for definitive care, quality assurance, community education, outreach, and injury prevention.

Level III Trauma Center

The role of the Level III trauma center is to provide initial evaluation and stabilization, including surgical intervention, of the severely injured adult or pediatric patient. A Level III trauma center provides comprehensive inpatient services to those patients who can be maintained in a stable or improving condition without specialized care. Critically injured patients who require specialty care are transferred to a higher level trauma system hospital in accordance with criteria established in the area trauma plan. An in-house multidisciplinary trauma resuscitation team is immediately available upon arrival of the patient to the emergency department. A board certified general surgeon trained in ATLS is on-call and available to the patient. Level III trauma centers also provide community education, outreach, and injury prevention programs.

Level IV Trauma Center

The role of the Level IV trauma center is to provide resuscitation and stabilization of the severely injured adult or pediatric patient prior to transferring the patient to a higher level trauma system hospital. Resuscitation and stabilization may involve surgical intervention. Trauma trained nursing personnel are immediately available to initiate life-saving maneuvers. Physicians trained in ATLS are promptly available to provide patient resuscitation, and in most cases are present upon patient arrival to the emergency department. Ancillary personnel are also in-house or promptly available at all hours of the day. Level IV trauma centers have all of the appropriate equipment and diagnostic capabilities to resuscitate the severely injured patient. Most Level IV trauma facilities provide community education, outreach, and injury prevention resources.

APPLICATION PROCESS

Obtaining an Application Packet

The current application packet for trauma hospital accreditation is available to the public and may be obtained by contacting DHS, EMS & Trauma Systems Section by mail at 800 NE Oregon Street, Suite 465, Portland, OR 97232. By phone, the Trauma Section staff is available from 8am to 5pm, Monday through Friday, at 971-673-0520. The application may also be printed from the web site at <http://egov.oregon.gov/DHS/ems/trauma>.

Application Presentation and Format

A complete application must be submitted for review. The submission of an incomplete or outdated application, or amendments without an application, will not be accepted. The application is evaluated on substance, not length.

The application must be submitted on standard 8 ½ by 11", 3-hole punched paper, with labeled (not numbered) tabs for each section, and a cover page on top. All pages should be numbered consecutively. Secure document for mailing with clip, loose rings, or rubber bands. DHS will reuse your previous application binder already on file. **Do not place pages in plastic slip covers and/or 3-ring binder.**

The following tab format should be used in the binder:

- Table of Contents
- Verification and Affirmation
- Profile and Statistics
- Executive Summary
- Trauma Service
- Trauma Team
- Clinical Capabilities
- Clinical Specialties
- Emergency Department
- Operating Room
- PACU
- Critical Care
- Radiology, Lab and Transfusion
- Pediatric Services
- Other Services
- Rehabilitation
- Inter-Hospital Transfer
- Trauma Registry
- Quality Improvement
- Educational Requirements
- Public Education and Prevention

Amendments to the Application

Institutional changes affecting the trauma program occurring after the application is submitted must be sent to DHS in writing within 60 days of submission of the application.

Withdrawal of Application

Facilities have the right to withdraw their application at any time prior to dispositive action by DHS.

Proprietary Information/Public Disclosure

The submitted hospital application becomes the property of DHS, and becomes public record at the end of the accreditation process, subject to the laws and rules applicable to public records.

Application Evaluation

Applications are evaluated by DHS staff for completeness and compliance with requirements specified in this application. Applications are evaluated by clinical providers who are expert in trauma care for appropriateness and quality of trauma care.

Application Deadline

Level I and II trauma centers will submit the four (4) copies of their application, while Level III and IV trauma centers must submit three (3) copies of their application **no later than three (3) weeks prior to the scheduled survey visit.** The application is sent to:

Trauma Program Manager
Emergency Medical Services & Trauma Systems Section
Department of Human Services
800 NE Oregon St, Suite 465
Portland, Oregon 97232

PREPARATION FOR THE ACCREDITATION VISIT

Appointment of Accreditation Team

DHS will appoint individuals as reviewers to conduct the site surveys. Hospitals may object to the appointment of any accreditation team member, but must do so in writing within ten (10) working days of receipt of the list of team members. DHS will consider an objection only if it can be clearly shown that there exists a substantial conflict of interest on the part of an accreditation team member, such as potential financial or personal gain, past or potential employment, or gain from the use of confidential information.

Contact with Accreditation Team Members

The administration, faculty, medical staff, employees and representatives of a hospital are prohibited from having any contact with an accreditation team member prior to the date of the survey, except as directed by DHS. A violation of this provision may be grounds for dismissing the accreditation team member and may disqualify the hospital from further consideration under this application. Contact is permitted only if necessary in an unrelated line of business and if DHS is informed.

Medical Records Review

Representative medical records chosen from patients receiving care since the last accreditation visit will be selected by DHS staff from the Oregon Trauma Registry (OTR) data. Examples of types of records requested include adult and pediatric patients who sustained head, chest, abdominal, spinal cord, orthopedic or multi-system injury. A list of records requested for review during the survey visit will be sent to the hospital at least the two weeks prior to the survey. These medical records are to be placed in the survey team conference room prior to the team's arrival. Trauma centers currently using electronic medical records systems must call the EMS & Trauma Systems Section at 971-673-0520 to request further clarification regarding the presentation of the electronic medical record during the survey visit. **NOTE: All quality improvement documents (review sheets, letters, meeting minutes, etc.) pertinent to the hospital's review of the patient's care should be copied and placed directly on or in the patient's medical record that is selected for review.**

The Accreditation Team Visit

The accreditation visit consists of a survey of the hospital by an on-site team composed of persons selected by DHS. The team evaluates compliance with the standards listed in Exhibit 4 by reviewing medical records, evaluating staff rosters and schedules, reviewing quality improvement committee minutes and other documents relevant to trauma care, evaluating equipment and the hospital physical plant, and conducting formal and informal interviews with hospital personnel. The team formally reports its findings and interpretations to DHS.

Materials and Conference Room

A private conference room with sufficient space for the survey team and the hospital staff who will attend the opening and closing sessions should be made available. The following materials should be placed in the conference room prior to the arrival of the survey team:

- A list of key hospital personnel with name, title, and phone/pager number to contact them during the survey.
- The requested medical records with individual QI documentation (see Medical Records Review, previous page).
- Trauma Program budget; Departmental and overall Hospital annual budget.
- Hospital Diversion/Bypass Report for the 12 months prior to survey, by month: Number of times on divert and total number of hours on divert, reason(s) for divert, and number of patients diverted.
- Evidence of ATLS certification, such as a copy of the ATLS card, for each emergency physician and trauma surgeon participating on the trauma call roster. While this certification is not required to be current, it must have been completed at least once by each physician caring for trauma patients. For each emergency physician, and trauma surgeon participating on the trauma call roster who does not hold a current ATLS certification, trauma related CME course listings are required. Each physician's educational course attendance file or CME list containing the name of the program or course attended that demonstrates the required 16-hours (over 4 years) of **trauma related** Category I CME should be available in the conference room.
- Medical staff credentialing committee delineation of trauma care privileges.
- Trauma-specific policies and protocols for each clinical area (ED, ICU, OR, PACU, Medical-Surgical) for adult and pediatric patients. Include trauma-specific policies and protocols for ancillary services, such as nutrition, physical therapy, occupational therapy, respiratory services, and social services as available.
- Emergency Department patient logs for the previous three (3) months.
- Evidence of TNCC or TEAM certification, such as a copy of the card or a certificate of attendance, for each ED and ICU nurse. While this certification is not required to be current, it must have been completed at least once by each ED and ICU nurse caring for trauma patients. For each ED and ICU nurse who does not hold a current TNCC or TEAM certification, their educational file containing the name of the program or course attended that demonstrates the required 16-hours (over 4 years) of **trauma** education should be available in the conference room.
- Report of the average daily census and/or utilization for the OR for the six (6) months preceding the accreditation visit.
- Call schedules for OR personnel and PACU nurses responding to care for trauma patients for the previous three (3) months.
- If no blood bank on site, copy of the written blood bank service agreement.
- Staffing pattern and schedule for CT technicians.
- Where teleradiology is used, presentation of QI data on turn-around-time for reporting film reads.

- Data on trauma patients serving as organ donors.
- Minutes from trauma committee meetings and peer review meetings (if peer review is done separate from multidisciplinary committee) for the past two (2) years.
- Examples of two patient issues, system, or educational issues that have completed the QI loop.
- Documentation of trauma QI, including ED, Surgery, or other committee peer review minutes, trauma committee meeting minutes, trauma case screens and program audits, and/or regional QI activities for the past two years.
- Demonstration of participation in ATAB and/or STAB QI reviews.
- Educational activities conducted with or for nurses, prehospital providers, referring physicians, and other hospitals.
- Injury prevention resource materials used by the trauma program.

Trauma Service and Hospital Staff Participation

The following personnel should be available for the opening session of the survey visit. The hospital representatives noted with an asterisk (*) will be assigned to tour the facility or meet individually with a survey team member:

- (*) Trauma Medical Director
- (*) Trauma Coordinator
- (*) Emergency Department Medical Director
- (*) QI coordinator
- (*) Trauma Registrar
- Hospital Administrator or designee
- Nurse Executive or Director of Nursing
- Managers of ED, ICU, PACU, OR, and Med/Surg unit(s)
- Medical Director of Surgery, Neurosurgery, Orthopedics, Anesthesiology, and Pediatrics as requested.
- Directors of Medical Records, Social Services, Clinical Laboratory, Blood Bank, and Radiology

Accreditation Visit Schedule - Tentative (*Subject to change*)

Opening Remarks and Introductions: Introduction of the survey team and opening remarks. Trauma Service and Hospital personnel are introduced to the survey team. Plan to present a brief 5-10 minute executive overview of the hospital's trauma program, including actions taken to address previously identified weaknesses, current strengths, and improvements since the last survey. Five minutes should focus on the trauma CQI program. Five minutes should focus on the trauma CQI program.

Hospital Tour: The survey team members will individually tour the facility and/or meet with an assigned hospital representative (*). The surveyors may wish to independently interview hospital staff.

Medical Record and Document Review: The Trauma Nurse Coordinator should be available during the medical record review. The survey team may have questions for members of the hospital staff, such as the QI coordinator, trauma registrar, or the Trauma Director. Individuals should be available by phone or pager to respond to questions as needed.

Exit conference: A confidential exit interview is conducted at the conclusion of the survey visit. To facilitate a roundtable discussion, it is recommended that invited attendees be the Hospital Administrator or designee, Trauma Medical Director, Trauma Nurse Coordinator, and Emergency Department Medical Director.

EVALUATION

Final Report

Each applicant hospital receives a written report of the accreditation results within approximately eight (8) weeks of the survey. This report is confidential and will be made available only to the applicant hospital. The results of the trauma system hospital accreditation visit is made by certified letter. The applicant has thirty (30) days from the receipt of an announcement of non-accreditation to file a request with DHS for reconsideration.

Maintaining Compliance

The hospital's commitment of resources and personnel made in the application are expected to remain in effect during the period of accreditation. DHS may inspect, review, evaluate and/or audit trauma patient discharge summaries, trauma patient care logs, medical records, trauma QI committee minutes, and other documents relevant to trauma care at any time during the accreditation period to verify compliance with trauma system standards. If, during the period of accreditation, the hospital is unable to maintain services according to their accredited trauma center level, the hospital shall notify DHS immediately. Confidentiality of these records shall be maintained in accordance with state law.

Probation / Suspension / Termination

DHS may formally re-survey a trauma system hospital for substantial failure to comply with trauma system standards and policies, or incomplete or incorrect reports to DHS. The re-survey findings may result in no further action; placing a hospital on probation; revocation; or suspension of the trauma accreditation. A trauma system hospital may without cause terminate its trauma system hospital status upon ninety (90) days written notice to DHS and the ATAB's list of interested parties.

APPLICATION INSTRUCTIONS

A complete application must be submitted for review. The submission of an incomplete or outdated application, or amendments without an application, will not be accepted. The application is evaluated on substance, not length.

The application must be submitted on standard 8.5 x 11, 3-hole punched paper, with labeled (not numbered) tabs for each section, and a cover page on top. All pages should be numbered consecutively. Secure document for mailing with clip, loose rings, or rubber bands. DHS will reuse your previous application binder already on file.

PLEASE DO NOT INSERT PAGES INTO PLASTIC SLIP COVERS OR PLACE IN 3-RING BINDER.

The following **tab format** should be used in the binder:

Table of Contents

Verification and Affirmation

Review page 11, and obtain appropriate signatures. One of the submitted application binders should contain this page with original signatures.

Profile and Statistics

Facility Profile and Trauma Service Statistics: Complete the facility profile on page 13. Statistical information should be retrieved from your hospital using a recent 12-month period. Be sure to identify the time period used. Use complete 12-month trauma registry data from the 18 month period preceding the survey date to complete the chart on page 15.

To complete the remaining tabbed sections, please refer to the Standards and Documentation instructions starting on page 17.

Executive Summary

Trauma Service

Trauma Team

Clinical Capabilities

Clinical Specialties

Emergency Department

Operating Room

PACU

Critical Care

Radiology, Lab and Transfusion

Pediatric Services

Other Services

Rehabilitation

Inter-Hospital Transfer

Trauma Registry

Quality Improvement

Educational Requirements

Public Education and Prevention

VERIFICATION AND AFFIRMATION

We, the undersigned, verify the truthfulness of the attached application for trauma service accreditation or designation, and affirm the continuing compliance with these requirements for the provision of trauma care.

- The attached application for trauma service accreditation/designation is true and accurate for a period of at least 60 days following receipt by DHS. If for any reason a part of this application should change within the 60 days, we will contact DHS in writing with the change(s).
- In preparing this application, we have not been assisted by any accreditation team member prior to the date of the survey, except as directed by DHS. A violation of this provision may disqualify the hospital from further consideration under this application.
- We will provide care to trauma system patients which is consistent with the standards advocated by the Advanced Trauma Life Support course, American College of Surgeons, Committee on Trauma.
- We will comply in all material respect with the Oregon Administrative Rules and all current State and ATAB system standards by providing the resources, personnel, equipment, and response required by these rules.
- As an accredited trauma center, we will report to the Oregon Trauma Registry all required data for each defined trauma patient within 90 days of death or discharge of that patient.
- We understand that the trauma hospital is responsible for all expenses incurred in planning, developing, and participating in the trauma system, and for expenses incurred if a re-survey of the facility is needed.
- We understand that accreditation will be renewed if the hospital submits an application for re-accreditation and if the DHS review finds that the hospital continues to meet the prescribed standards in Exhibit 4 and the ATAB plan.
- We endorse and fully support this application for and maintenance of an accredited/designated trauma service, and support this facility's participation in the regional and statewide Oregon trauma system.

Chairman/President of Governing Body Date

Administrator Date

Trauma Service (Medical) Director Date

Trauma Coordinator Date

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FACILITY PROFILE

Facility Information

Name of Facility:
(name to appear on designation certificate)

Phone:

FAX:

Physical Address:
(street & number)

City:

Zip:

Mailing Address:
(if different than above)

City:

Zip:

Personnel Information

Administrator:

Phone:

E-mail:

Application Contact:
(if not Trauma Coordinator)

Phone:

E-mail:

Trauma Service Director:

Phone:

E-mail:

Trauma Coordinator:

Phone:

E-mail:

Emergency Department Medical Director:

Phone:

E-mail:

Trauma Registry Contact:

Phone:

E-mail:

Critical Care Medical Director:

Phone:

E-mail:

LEVEL OF ACCREDITATION REQUESTED:

___ Level I

___ Level III

___ Level II

___ Level IV

General Hospital Information (use recent 12 month period): From ____/____/____ to ____/____/____

Number licensed hospital beds

Number of operating rooms

Number of hospital beds staffed and operational

Number of operating rooms specifically designated for trauma

Number Emergency Department beds

Number of staffed beds in Peds ICU

Number ED beds designated for trauma

Number of staffed beds avail for Peds

Annual Emergency Department visits

Average daily hospital census

Number staffed beds in adult ICU(s)

Total hospital inpatient days

Number ICU beds available for trauma

Average hospital inpatient LOS

Number of physicians with medical staff privileges

Average percent hospital occupancy

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Trauma Service Statistics (Use 12 months of data from the preceding 18 months)		
From / to /		
Report #1	Total number of trauma registry patients	
	Total number adult trauma patients 18 years and older	
	Total number pediatric trauma patients 0-17 years	
Report #2	Number (#) and Percent (%) of patients:	# / %
	Trauma System Entry: Field	/
	Emergency Dept.	/
	Retrospective	/
	Transferred in	/
	Hospital Response: Full Team Activation	/
	Modified Team Activation	/
	No Activation	/
	Report #3	Disposition from the ED to: Home
OR		/
ICU		/
Acute Care Ward & Other		/
Transfer out		/
Death		/
Admitted to ICU/ OR/ ward bypassing ED (Direct)		/
Report #4	Total Number (#) of patients and % mortality (by ISS group) for:	# / %
	ISS 0-9	/
	ISS 10-15	/
	ISS 16-25	/
	ISS 26-45	/
	ISS 46-75	/
Report #5	Number of patients with ISS > 15 who went from ED to ICU	
	Number of patients with ISS >15 who went from ED to OR	
	Number of patients with ISS > 15 transferred from ED to another facility	
FTE or hours per week allotted to Trauma Coordinator duties		
FTE or hours per week allotted to Trauma Registry duties		
Avg. hours/month dedicated to Trauma Medical Director duties		

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STANDARDS AND DOCUMENTATION

For the Standards and Documentation portion of the application, information is organized by trauma service components. For the remaining sections, please refer to the information below.

Standards - Outlines the minimum required state standards for each component of care for trauma service accreditation. Remember to review your regional Area Trauma Advisory Board (ATAB) trauma system plan for additional and/or more specific standards. Documentation of compliance with ATAB-specific standards is required.

Documentation to Submit with Application - The documentation submitted in the application should demonstrate the facility's compliance with the standards. All documents should be labeled and numbered. These documents should be in order and inserted directly following the appropriate trauma service component.

Documentation to be Available at Survey - These items are not submitted in the application binder, but are available in the conference room at the site survey for DHS staff and survey team members to review. Occasionally, additional documents may be requested while the survey visit team is onsite.

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1. Executive Summary - Submit with Application

Provide a brief (1 to 1 ½ page) history of the trauma program at your facility, including significant changes and accomplishments since the last survey, and actions taken to correct issues identified at last survey.

2. Trauma Service - Standards
<ul style="list-style-type: none"> > Demonstrated institutional commitment by the hospital's board of directors and/or administration to maintain adequate resources to care for all trauma patients presenting to the hospital, including commitment of financial, human and physical resources to optimize trauma patient care.
<ul style="list-style-type: none"> > The Trauma Director is responsible for coordinating the care of injured patients, the continuing medical education of personnel, and oversight of the trauma QI process; clinically involved with trauma patient management; responsible for credentialing trauma team members; AND is a <ul style="list-style-type: none"> > Level I, II, III: Board Certified Surgeon > Level IV: General Surgeon or Emergency Medicine Physician > Level I: ATLS Instructor
<ul style="list-style-type: none"> > Trauma Coordinator - an RN involved in clinical activities, education, research, QI, data collection, liaison to the medical staff, pre-hospital community and the patient's family. There must be dedicated hours for this position.
<ul style="list-style-type: none"> > Regular multidisciplinary trauma conferences that includes all members of the trauma team for the purpose of quality improvement through critiques of individual cases.
Trauma Service - Documentation to Submit with Application
<ul style="list-style-type: none"> <input type="checkbox"/> A letter from the facility's Board of Directors or Administration supporting the facility's application and commitment to maintain adequate financial, human and physical resources for the care of trauma patients; <input type="checkbox"/> Job description and CV for the Trauma Medical Director; <input type="checkbox"/> Job description and CV for the Trauma Coordinator; <input type="checkbox"/> Organizational chart for the Trauma Service; <input type="checkbox"/> Organizational chart showing the relationship of the trauma service to emergency medicine and surgery departments (may be a Medical Staff organizational chart); <input type="checkbox"/> Policy or description explaining the responsibility, authority, and function of the multidisciplinary trauma committee, including its relationship to other hospital QI committees and/or QI Executive Committee;
Trauma Service - Documentation to be Available at Survey
<ul style="list-style-type: none"> <input type="checkbox"/> Budget allocation for Trauma Service activities. <input type="checkbox"/> Overall departmental and hospital operating budgets.

3. Trauma Team and Activation - Standards

- > All adult and pediatric patients with multiple system or major injury or who meet trauma system triage criteria must be initially evaluated by the trauma team.
- > **Levels I, II, III:** The trauma team is organized and directed by a general surgeon who assumes responsibility for overall provision and standards of care for the multiply injured patient from resuscitation through discharge.
- > **Level IV:** The trauma team is organized and directed by an emergency medicine physician who assumes responsibility for overall care of a patient identified from resuscitation through discharge.
- > The trauma team leader is verified in ATLS; AND is a
Level I: General surgeon in-house and present to direct the patient's resuscitation in the ED, with a back-up surgeon promptly available.
Level II, III: General surgeon on-call and available to direct the patient's resuscitation.
Level IV: Emergency medicine physician on-call and available to direct the patient's resuscitation.

Trauma Team and Activation - Documentation to Submit with Application

- Policy or protocol listing roles and responsibilities of staff responding to a trauma activation;
- A description of the criteria and communication process used to activate the trauma team, including definition of full vs. modified trauma response (if used);
- A copy of the trauma scoring sheet or activation tool (if used);
- Policy/protocol delineating expected response time for physicians. Include methods used to document physician response times to trauma activation, and to monitor response time compliance;
- Average response time for the previous year for each general/trauma surgeon, ED physician, neurosurgeon, orthopedist, and anesthesia responding to trauma patients;
- Trauma Divert protocol, including the communication process for notifying pre-hospital providers of the facility's changes in trauma care capabilities;
- Policy/protocol regarding acceptance of trauma patients in transfer;
- Policy/protocol regarding transferring trauma patients to another facility for definitive care;
- Hospital Disaster/Mass Casualty Plan - submit an electronic version to DHS (do not include in application binder);
- Describe trauma team response to mass casualty scenario: i.e. notification that three critical and three seriously injured patients are en route to the facility.

Trauma Team and Activation - Documentation to be Available at Survey

- Diversion report - For the 12 months prior to survey: By month - number of times on divert, total number of hours on divert, reason(s) for divert, and number of patients diverted;

4. Clinical Capabilities & Availability - Standards

> Medical Staff structure includes:

Level I: Surgery; Emergency Medicine; Anesthesia; Neurological Surgery; Orthopedic Surgery; Neurosurgical Trauma Liaison.

Level II: Surgery; Emergency Medicine; Anesthesia; Neurological Surgery; Orthopedic Surgery.

Level III: Surgery; Emergency Medicine; Anesthesia.

Level IV: Emergency Department

> Published On-Call Schedule is available for:

Level I, II: General Surgery, Anesthesia, and Emergency Medicine; Published back-up general surgery schedule available.

Level III: General Surgery, Anesthesia, and Emergency Medicine.

Level IV: Emergency Department.

> General/Trauma Surgeons have completed ATLS and ATLS re-verification every four years or 16 hours of trauma related category I CME over four years. Two of the hours must address acute pediatric trauma management; AND for

Level I, II, III: Are board certified with full, unrestricted general surgery privileges; and are represented at 75% of multidisciplinary and peer review committee meetings.

Level IV: If general surgical services are available, must meet educational requirements for ATLS and CME.

> Emergency Medicine Physicians have completed ATLS and ATLS re-verification every four years or 16 hours of trauma related category I CME over four years. Two of the hours must address acute pediatric trauma management; are represented at 75% of multidisciplinary and peer review committee meetings; AND for

Level I: Are board certified/board eligible full-time emergency medicine practitioners with special competence in care of the critically injured adult and pediatric patient; Are in-house and immediately available to the patient upon arrival in the ED.

Level II, III: Are in-house and immediately available to the patient upon arrival in the ED; Are qualified and experienced in caring for patients with traumatic injuries and can initiate resuscitative measures.

Level IV: Are qualified and experienced in caring for patients with traumatic injuries and can initiate resuscitative measures.

Clinical Capabilities & Availability - Documentation to Submit with Application

- A copy of Medical Staff organizational chart/structure;
- Completed CME summary (Charts A & B) for all Emergency Medicine physicians and Trauma Surgeons responding to trauma for trauma related educational activities, including at least two hours on pediatric trauma, over the past four years.

- Published on-call schedules for General Surgery and Emergency Medicine for the four (4) months prior to the accreditation visit.

Clinical Capabilities & Availability - Documentation to be Available at Survey

- Copies of ATLS cards for all Emergency Medicine physicians and General Surgeons responding to trauma;
- Medical staff credentialing committee delineation of trauma care service privileges (where available).

5. Clinical Specialty Capabilities & Availability - Standards

> Anesthesiologists:

Level I: Are board certified/board eligible with full unrestricted anesthesiology privileges; represented at 75% of multidisciplinary and peer review committee meetings; in-house and immediately available to the patient with a back-up physician promptly available to the patient.

Level II: Are board certified/board eligible with full unrestricted anesthesiology privileges; Anesthesiologist or CRNA on-call and promptly available to the patient.

Level III, IV: With full unrestricted anesthesiology privileges OR a nationally CRNA; on-call and promptly available to the patient.

> Orthopedic Surgeons are:

Level I: Board certified/board eligible with full unrestricted orthopedic surgery privileges; on-call and promptly available to the patient; represented at 75% of multidisciplinary and peer review committee meetings; back-up orthopedic surgeon is promptly available to the patient.

Level II, III: With full unrestricted orthopedic surgery privileges; on-call and promptly available to the patient.

Level IV: If orthopedic services are available, have full unrestricted orthopedic surgery privileges; on-call and promptly available to the patient.

> Neurologic Surgeons are:

Level I: Board certified/board eligible with full unrestricted neurosurgery privileges; on-call and promptly available to the patient; or a general surgeon who has been credentialed in the initial management of neurotrauma, as determined by the director for neurotrauma, in-house or promptly available to the patient; represented at 75% of multidisciplinary and peer review committee meetings; back-up neurosurgeon is promptly available to the patient.

Level II: Board certified/board eligible with full unrestricted neurosurgery privileges; on-call and promptly available to the patient; OR a general surgeon who has been credentialed in the initial management of neurotrauma, as determined by the director for neurotrauma, in-house or promptly available to the patient.

Clinical Specialty Capabilities & Availability - Documentation to Submit with Application

- Anesthesia coverage - published call schedule for the month prior to the survey, including areas of responsibility;
- For hospitals with orthopedics or neurosurgeons responding to trauma care - published call schedules for the four (4) months prior to the survey;
- Policy, procedure or bylaws describing the on-call availability requirements for physician specialties;
- Protocol for notification of clinical physician specialties;
- List of clinical physician specialties (by specialty) who are on-call and promptly available to the patient within 30 minutes of notification;
- One month call schedule for Radiologists or documentation of variance for use of teleradiology;
- Level I:** Back-up call schedules for anesthesia, orthopedics, and neurosurgery, and the policy, protocol or bylaws describing process for back-up response.

6. Emergency Department - Standards

- > Designated Physician Director;
- > ED staffing ensures immediate care of the trauma patient;
- > RN provides continual monitoring of the trauma patient from hospital arrival until disposition from the ED.

- > Initial 16 hour Health Division approved trauma life support course for nurses; followed by;
- > Recertification or 16 hours of trauma related CEUs over a period of four years.

- > RN availability:
Level I, II: At least two RNs in the ED and immediately available to the patient upon arrival
Level III: At least two RNs in-house and promptly available to the patient
Level IV: At least two RNs in-house or on-call and promptly available to the patient

- > ED Equipment:
 - Airway control and ventilation equipment including laryngoscope and endotracheal tubes of all sizes, bag-mask resuscitator, sources of oxygen, pulse oximeter, CO₂ monitoring and mechanical ventilator;
 - Suction devices;
 - Electrocardiograph-oscilloscope-defibrillator with infant and pediatric paddles;
 - Apparatus to establish central venous pressure monitoring;
 - All standard intravenous fluids and administration devices, including intravenous catheters and intraosseous needles;
 - Thermal warmers for fluids and blood, including rapid volume infuser system (not required for Level IV);
 - Sterile surgical sets for standard emergency procedures;
 - Gastric decompression equipment;
 - Drugs and supplies necessary for emergency care of adult and pediatric patients;
 - Two-way radio communications with prehospital care providers;
 - Skeletal traction device for cervical injuries (hard collar cervical immobilization may be used as an alternative);
 - Special color coding of equipment based on age and size;

Emergency Department - Documentation to Submit with Application

- Completed educational chart (Chart C) for all ED RNs, including registry and traveler personnel working in the facility \geq 6 months;
- Registered nurse staffing matrix/staffing plan reflecting availability for trauma response;
- Emergency physician staffing plan;
- Emergency Department organizational chart;
- Copy of the ED Trauma flowsheet.

Emergency Department - Documentation to be Available at Survey

- ED patient logs for the three (3)months prior to the survey visit;
- Copies of TNCC or TEAM cards for all Emergency Department RNs caring for trauma patients;
- Trauma-specific ED polices and procedures.

7. Operating Room - Standards	
>	Attending Surgeon is present at operative procedures;
>	Level I: An operating room with in-house staff immediately available to the patient 24 hour per day where the primary function of the staff must be to the operating room.
>	Level II, III, IV: An operating room must be promptly available and adequately staffed 24 hours per day.
>	<p>OR equipment (required at all levels):</p> <ul style="list-style-type: none"> • Thermal control equipment - for patients and for blood and fluids; • X-ray capability, including c-arm image intensifier; • Monitoring equipment; AND for • Level I: Cardiopulmonary bypass capability; operating microscope, craniotomy instruments; endoscopes; bronchoscopes; rapid volume infuser • Level II: craniotomy instruments; endoscopes; bronchoscopes; rapid volume infuser • Level III: endoscopes; bronchoscopes; rapid volume infuser
Operating Room - Documentation to Submit with Application	
<input type="checkbox"/>	Policy/ procedure to ensure the availability of surgical suites for trauma cases;
<input type="checkbox"/>	RN and technician staffing patterns and back-up, including scrub and circulators, for days/eve/nights and weekends/holidays;
<input type="checkbox"/>	Policy/procedure for mobilizing additional surgical teams after hours and for multiple patients.
Operating Room - Documentation to be Available at Survey	
<input type="checkbox"/>	Report of average daily census or utilization for the operating room for the six (6) months preceding the survey;
<input type="checkbox"/>	Copies of trauma call schedules for OR personnel for three (3) months preceding the survey;
<input type="checkbox"/>	Educational activities specific to trauma patient care (when applicable).

8. Post Anesthesia Care Unit - Standards	
>	Level I, II, III: RN available 24 hours/day
>	Required equipment: pulse oximetry and thermal control;
>	Appropriate monitoring and resuscitation equipment for adult and pediatric patients; AND for
>	Level I, II: Intracranial pressure monitoring equipment (Required at Level III where neurosurgical patients are acutely managed.).
Post Anesthesia Care Unit - Documentation to Submit with Application	
<input type="checkbox"/>	RN staffing plan to cover 24 hours/day
Post Anesthesia Care Unit - Documentation to be Available at Survey	
<input type="checkbox"/>	Trauma call schedules for PACU nurses for the previous three (3) months;
<input type="checkbox"/>	Educational activities specific to trauma patient care (where applicable).

9. Critical Care Services - Standards	
>	Level I, II, III: Designated Medical Director
>	Level I: Surgical ICU service physician on-call or in-house 24 hours/day, and a surgically directed and staffed ICU service
>	Level I, II, III: Equipment for monitoring and resuscitation
>	Level I, II: Intracranial pressure monitoring equipment. (Required at Level III where neurosurgical patients are acutely managed.)
>	Initial 16 hour Health Division approved trauma life support course for nurses involved in the acute management of trauma patients; followed by:
>	Recertification, or 16 hours of trauma related CEUs over a period of four years.
Critical Care Services - Documentation to Submit with Application	
<input type="checkbox"/>	Completed educational chart for all ICU RNs (Chart D), including registry and traveler personnel working in the facility \geq 6 months;
<input type="checkbox"/>	Policy or method for obtaining additional staffed ICU beds for trauma;
<input type="checkbox"/>	Registered nurse staffing matrix or staffing plan reflecting availability for trauma response.
Critical Care Services - Documentation to be Available at Survey	
<input type="checkbox"/>	Level I: ICU surgical physician published call schedule for the prior three (3) months.
<input type="checkbox"/>	Copies of TNCC or TEAM cards for all Critical Care RNs caring for trauma patients;
<input type="checkbox"/>	Trauma patient specific policies and procedures used in the ICU, including care of pediatric patients in the adult ICU.
<input type="checkbox"/>	Policies/protocols for consultation by nutritional services, Rehab services, and social services for patients in the ICU who are critically or seriously injured.

10. Radiology, Lab and Transfusion Services - Standards

> X-ray capability:
Level I, II: 24 hours/day with in-house technicians.
Level III, IV: Technician on-call and promptly available to the patient upon arrival to the ED.

> Radiographic capabilities:
Level I: CT technician in-house.
Level II, III: CT technician on-call and promptly available.
> **Level I, II:** Angiography of all types.
> **Level I, II, III:** Sonography.

> Laboratory services:

- Standard analysis of blood, urine and other body fluids, including micro sampling;
- Coagulation studies;
- Blood gas analysis and pH determinations;
- Microbiology.

> Transfusion Services (Blood Bank)

- Blood typing and cross matching;
- Comprehensive Blood Bank; OR access to a community central blood bank and Red Cross approved hospital storage facilities.

Radiology, Lab and Transfusion Services - Documentation to Submit with Application

- Policies or procedures, addressing:
 - protocol and responsibility for clearing cervical spines;
 - who accompanies and monitors the trauma patient while in the radiology department;
 - who is responsible for resuscitation of adult and pediatric patients while in radiology suite, and the specific location of adult/pediatric emergency equipment;
 - who performs the initial reading and the final interpretation of radiologic films, including the QI process for disparate readings;
 - Copy of the variance when teleradiology is used.
- List of routine services available from the lab;
- Number of PRBC units available on site by type;
- Policy for obtaining blood in ED;
- Massive transfusion protocol;
- Policy for uncrossmatched blood administration to trauma patients.

Radiology, Lab and Transfusion Services - Documentation to be Available at Survey

- If no blood bank on site, copy of arrangement and service agreement for provision of blood and/or blood products to this facility for the trauma patient;
- Staffing pattern and schedule for CT technicians;
- Where teleradiology is used, presentation of QI data on turn-around-time for reporting reads, QI analysis, and loop closure.

11. Pediatric Services and Capabilities - Standards

- Facility:
 - Provides initial stabilization and resuscitation of pediatric trauma patients;
 - Describes the scope of care for pediatric trauma, including criteria for admission of pediatric patients OR Written transfer agreements and transfer policy for pediatric trauma care.

Pediatric Services and Capabilities - Documentation to Submit with Application

- Description of pediatric services available by clinical area OR a written transfer agreement for pediatric trauma patients.
- Interfacility transfer policy or protocol for pediatric trauma patients.

Pediatric Services and Capabilities - Documentation to be Available at Survey

- Pediatric trauma patient specific policies and procedures for each clinical area that provides care to the pediatric trauma patient, i.e. ED, ICU, OR, PACU, Med-Surg area.

12. Other Services and Capabilities - Standards	
>	Respiratory Therapy: Level I, II: Available in-house 24 hours/day Level III: On-call and promptly available 24 hours/day
>	Organ procurement process in place
Other Services and Capabilities - Documentation to Submit with Application	
<input type="checkbox"/>	Staffing pattern for Respiratory Therapy;
<input type="checkbox"/>	Policy or process for Organ Procurement activities, including the responsible individual(s) for requesting donation.
Other Services and Capabilities - Documentation to be Available at Survey	
<input type="checkbox"/>	Number of trauma patients referred for organ donation and number of trauma patient donors (if available);
<input type="checkbox"/>	Procedure for consultation of nutritional services for trauma patients (where available).

13. Rehabilitation Services - Standards	
>	Level I, II: Physical Therapy, Occupational Therapy, Speech Therapy, Social Services
>	Level III: Physical Therapy, Social Services
>	Written transfer agreements with an approved rehabilitation facility
Rehabilitation Services - Documentation to Submit with Application	
<input type="checkbox"/>	Description of process for trauma patient referral to rehabilitation services;
<input type="checkbox"/>	Copy of transfer agreement with Rehabilitation facilities;
<input type="checkbox"/>	Describe the services available for the trauma patient and family for crisis intervention and/or counseling.
<input type="checkbox"/>	Discharge planning policy or protocol for trauma patients cared for at the facility.
Rehabilitation Services - Documentation to be Available at Survey	
<input type="checkbox"/>	None specified

14. Inter-hospital Transfer - Standards	
>	Acute hemodialysis: Level I: Available in-house Level II, III, IV: Written transfer agreements
>	Organized Burn Care: Available in-house OR ability to resuscitate and stabilize burn patients and a written transfer agreement with the Burn Center.
>	Acute Spinal Cord / Head Injury Management: Available in-house OR written transfer agreement
Inter-hospital Transfer - Documentation to Submit with Application	
<input type="checkbox"/>	Process for identification of those patients with special trauma care needs exceeding the capabilities of the facility who are evaluated for transfer;
<input type="checkbox"/>	Transfer process for trauma patients going to another facility, to include the responsibility of the transferring hospital and of the receiving hospital;
<input type="checkbox"/>	Signed transfer agreements for a higher level of care for services not available to the specialty patient: Burn, Head injury, Spinal cord injury, Multi-system trauma; Hemodialysis.
Inter-hospital Transfer - Documentation to be Available at Survey	
<input type="checkbox"/>	QI review of cases meeting inter-hospital transfer criteria in Exhibit 5.

15. Trauma Registry - Standards	
>	Participation in the statewide system including submission of data to the Oregon Trauma Registry, including accurate and timely reporting
>	Level I, II, III: Use of trauma registry data in quality improvement activities
>	Designated trauma registry coordinator
Trauma Registry - Documentation to Submit with Application	
<input type="checkbox"/>	Describe the process by which data is abstracted for the Oregon Trauma Registry, including how the trauma patient population is identified at the hospital.
<input type="checkbox"/>	Job description of the trauma registrar, or person(s) responsible for the registry;
<input type="checkbox"/>	Describe the process by which trauma registry data is incorporated in the trauma service QI program.
Trauma Registry - Documentation to be Available at Survey	
<input type="checkbox"/>	Data collection tool or flow sheet that assures complete collection of data required for the trauma registry.

16. Quality Improvement Program - Standards	
>	QI processes are present to assure that trauma team leader is notified in a timely manner of trauma patient arrival and is present to direct the trauma team through the vital phases of resuscitation;
>	QI processes will monitor trauma team leader's response to trauma system patients, and document both the physician notification and arrival times on the trauma flow sheet.
>	Organized quality improvement program for trauma system patients, with evidence of processes demonstrating corrective actions which affect patient care;
>	Support of regional and statewide quality improvement; Participation in the review of pre-hospital and regional systems of trauma care as indicated the ATAB QI plan;
>	Special audit for all trauma deaths and other cases specified by the hospital trauma committee and ATAB;
>	Morbidity and mortality review of clinical care issues;
>	Multidisciplinary trauma conference including all members of the trauma team for the purpose of quality improvement through critiques of individual cases;
>	<p>Level I: Trauma Research</p> <ul style="list-style-type: none"> • Identifiable IRB process; • Four or more extramural educational presentations per year; • Scientific publication in peer-reviewed journals, 10 or more for the trauma program per 3 year period.
Quality Improvement Program - Documentation to Submit with Application	
<input type="checkbox"/>	QI Plan and reporting pathway for trauma patient QI must include a diagram of how committees interact to resolve trauma care and trauma system issues;
<input type="checkbox"/>	Method for trauma physician QI and the interface between trauma QI and medical staff credentialing;
<input type="checkbox"/>	Method for nursing QI and the interface between trauma QI and nursing services;
<input type="checkbox"/>	Method for reviewing trauma system issues;
<input type="checkbox"/>	Method for review of pre-hospital trauma care issues, including feedback process;
<input type="checkbox"/>	Audit filters and screening tools used for QI patient identification;
<input type="checkbox"/>	Copy of blank QI forms used at all levels of QI process.
<input type="checkbox"/>	Attendance by department, service, or specialty at the QI and/or peer review meetings over the past 12 months (table format preferred).
<input type="checkbox"/>	<p>Level I: Bibliography of papers and articles published in the previous 3 years and a list of current trauma research projects; Demonstration of the promotion of research involving surgical and nonsurgical specialists, nurses, and allied health professionals.</p>

Quality Improvement Program - Documentation to be Available at Survey

- Two complete examples of “closing the loop” on an identified QI issue, including issue identification, review process, recommendations, implementation, outcomes, re-evaluation and resolution;
- A summary list of all trauma cases reviewed through the trauma QI process over the past two years and the outcome of each case;
- A summary of audit filter analysis, including how data identified need for process and/or system changes;
- Number of trauma deaths over the past two years and the category of findings for each (preventable, not preventable and possibly preventable);
- Minutes of the trauma multidisciplinary committee meetings from the previous 12 months,
- Demonstration of participation in ATAB and/or STAB QI reviews.

17. Educational Requirements (Professional) - Standards

- > **Level I:** General surgery residency program; ATLS course provider/participant; Telephone and onsite consultation with physicians of the community and outlying areas; Continuing education programs provided by the hospital for staff physicians, nurses, allied health professionals, community physicians and pre-hospital personnel.
- > **Level II:** Telephone and onsite consultation with physicians of the community and outlying areas; Continuing education programs provided by the hospital for staff physicians, nurses, allied health professionals, community physicians and pre-hospital personnel.
- > **Level III:** Continuing education programs provided by the hospital for staff physicians, nurses, allied health professionals, community physicians and pre-hospital personnel.

Educational Requirements (Professional) - Documentation to Submit with Application

- List of internal trauma continuing education programs provided since the last survey for staff physicians, nurses, allied health professionals and pre-hospital personnel, to include program topic and target audience;
- List of external trauma education programs provided since the last survey for pre-hospital care providers and community health care providers, to include program topic and target audience.
- Level I:** Documentation of accreditation status by ACGME for general surgery residency program; List of residency programs which are involved in trauma care, with a description of how trauma patient management is integrated into the residency program.

Educational Requirements (Professional) - Documentation to be Available at Survey

- Level I, II:** Method of monitoring physician staff consultation communication with outlying hospitals.

18. Public Education and Prevention - Standards

- > **Level I:** Injury control studies; Collaboration with other institutions; Monitor progress/effect of prevention programs; Designated prevention coordinator/spokesperson for injury control; Outreach activities; Informational resources for public; collaboration with existing national, regional and state programs; Coordination and/or participation in community prevention activities.
- > **Level II:** Designated prevention coordinator/spokesperson for injury control; Outreach activities; Informational resources for public; collaboration with existing national, regional and state programs; Coordination and/or participation in community prevention activities.
- > **Level III:** Coordination and/or participation in community prevention activities.

Public Education and Prevention - Documentation to Submit with Application

- List injury prevention programs and outreach activities, including name, date, and target audience completed since last survey;
- List public or community education programs, including name, date, and target audience completed since last survey.
- Level I, II:** List duties of designated injury prevention coordinator/ spokesperson;

Public Education and Prevention - Documentation to be Available at Survey

- Injury prevention resource materials;
- Level I:** Description/display of injury control studies and outcomes of prevention programs.

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CHART A

Emergency Department Physicians

List all ED physicians currently responding to trauma patients.

Name	Board Certified (type and year)	ATLS Provider (P) or Instructor (I) status & Date of Expiration	Number of Trauma category I CME hrs in the past 4 years (If ATLS is expired)

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