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**Colorado Department  
of Public Health  
and Environment**

**TRAUMA CENTER DESIGNATION SCORING TOOL  
LEVEL II**

**November 2012**

**Facility Name:**

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**Review Date:**

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**Reviewers:**

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**State Observer:**

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**CDPHE  
HFEMSD-Trauma Program  
4300 Cherry Creek Drive South  
Denver, CO 80246-1530  
(303) 692-2983**

## SITE REVIEWER INSTRUCTIONS

Dear Site Reviewer:

The Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Medical Services Division, is requesting your assistance in meeting two goals during the trauma center designation review.

- The first goal is to determine whether the facility has the required resources and commitment for trauma center designation.
- The second goal is to provide information so the facility may improve trauma patient care.

The following scoring tool assesses a facility's ability to meet the minimum state standards (rules) found in 6 CCR 1015-4, Chapter Three. The facility must show commitment to providing the necessary resources for trauma patient care. It must develop and maintain a trauma service demonstrated by organizational structure, personnel, a trauma quality improvement program, and program documentation. To fully assess whether a facility has met the minimum standards for trauma center designation, the following sources of information may be used: 1) the facility's application; 2) facility staff interviews; 3) a physical tour of the facility; 4) patient medical records, quality improvement documents, and/or peer review minutes, 5) CME and credentialing files; and 6) other pertinent documents related to the facility's trauma program.

The CDPHE will use your information and recommendations in its trauma center designation decision. These legal decisions may be controversial and could result in appeal and/or further review. Careful documentation is imperative, as your descriptions will validate CDPHE decisions. Whenever possible, please refer specifically to people (by name or title), locations, documents, or medical records.

1. Familiarize yourself with this document before the review date.
2. Print legibly.
3. Read each standard carefully, and ask the state observer for clarification when necessary.
4. Check **Met** or **Not Met** for each standard. Include evidence to substantiate your findings. Document the rationale for any Not Met ratings and identify what needs to occur for the standard to be met. Comments must be objective and concise. For standards where the expectations are met but there is opportunity for improvement, please make recommendations for improvements.

**NOTE:** The CDPHE requires 100% compliance for a facility to maintain its trauma center designation. The designation decision process provides time and opportunity, prior to the Department's final decision, for facilities to institute corrective action in response to deficiencies identified during the site survey.

<b>1. PREHOSPITAL TRAUMA CARE INTEGRATION</b>		<b>Met</b>	<b>Not Met</b>
1. A. Participation in the development and improvement of prehospital care protocols and patient safety programs is demonstrated.			
1. B. The trauma medical director is involved in the development of the divert protocol as it affects the trauma service.			
1. C. A trauma surgeon is involved in any decision regarding divert as it affects the care of the trauma patient.			
1. D. A liaison from the emergency department participates in prehospital peer review/performance improvement.			
<b>MET</b> <b>Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		

<b>2. INTERFACILITY CONSULTATION AND TRANSFER REQUIREMENTS</b>		<b>Met</b>	<b>Not Met</b>
2. A. Direct physician-to-physician contact is included in the process of transferring a patient between facilities.			
2. B. The decision to transfer a patient is based solely on the clinical needs of the patient and not on the requirements of the patient's specific provider network or the patient's ability to pay.			
2. C. There shall be written transfer guidelines for patients requiring treatment for burns, reimplantation, pediatric trauma care or acute rehabilitation care, if not available in the facility.			
<b>MET</b> <b>Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		

<b>3. PERFORMANCE IMPROVEMENT PROCESS - A. General Provisions</b>	<b>Met</b>	<b>Not Met</b>
3. A. (1) There is demonstration of a clearly defined trauma performance improvement program that is coordinated with the hospital-wide program.		
3. A. (2) The facility demonstrates that the trauma patient population can be identified for separate review regardless of institutional performance improvement process.		
3. A. (3) Performance improvement is supported by a reliable method of data collection that consistently obtains valid and objective information necessary to identify opportunities for improvement. The process of analysis includes multidisciplinary review and occurs at regular intervals. The results of analysis define corrective strategies and are documented.		
3. A. (4) The facility demonstrates that the trauma registry is used to support the performance improvement program.		
3. A. (5) There are defined audit filters based upon regular review of registry and/or clinical data.		
3. A. (6) Appropriate, objectively defined standards are used to determine the quality of care.		
3. A. (7) Through the performance improvement program, there is demonstration of the appropriateness of admitting more than 10 percent of injured patients with an ISS greater than or equal to nine (excluding isolated hip fractures) to non-surgical services.		
3. A. (8) Identified problem trends are documented and undergo peer review by the Peer Review/Performance Improvement Committee.		
3. A. (9) A representative from the emergency department participates in prehospital peer review/performance improvement.		
3. A. (10) The facility reviews any diversion or double transfer (from another facility and then transferred for additional acute trauma care) of trauma patients.		
3. A. (11) If an internal trauma educational process is conducted in lieu of external trauma CME, the process is based, at least in part, on information from the peer review and the principles of practice-based learning.		
3. A. (12) The facility regularly evaluates its graded activation criteria.		
3. A. (13) There is demonstration of oversight of pediatric care through a pediatric-specific peer review/performance improvement process when children with single extremity orthopedic fracture or minor head trauma with a negative computed tomography exam are admitted.		
<b>OR</b>		
3. A. (14) Pediatric-specific peer review, which includes pediatric-specific process filters and outcome measures, occurs when children who have other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography exam are admitted.		
3. A. (15) Physician availability to the trauma patient in ICU is monitored by the peer review/performance improvement program.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>3. PERFORMANCE IMPROVEMENT PROCESS – B. Multidisciplinary Committee</b>	<b>Met</b>	<b>Not Met</b>
3. B. The committee addresses operational issues in the trauma program.		
3. B. (1) The committee continuously evaluates the trauma program's processes and outcomes.		
3. B. (2) The committee consists of, at a minimum, the trauma medical director or designee and all core surgeons as well as liaisons from orthopedic surgery, neurosurgery, emergency medicine, radiology and anesthesia. Each liaison attends at least 50 percent of meetings.		
3. B. (3) The committee format is multidisciplinary consisting of hospital and medical staff members who work to identify and correct trauma program system issues.		
3. B. (4) The minutes reflect the review of operational issues and, when appropriate, the analysis and proposed corrective actions. The process identifies problems and demonstrates problem resolution.		
3.B. (5) The committee monitors compliance with all required time frames for availability of trauma personnel, including, but not limited to, response times for general surgery, orthopedics, neurosurgery, anesthesiology, radiology, and radiology MRI or CT techs.		
3. B. (6) The committee monitors the availability of anesthesia services and the absence of delays in airway control or operations.		
3. B. (7) Radiologists are involved in protocol development and trend analysis that relate to diagnostic imaging.		
3. B. (8) The committee reviews and addresses issues related to availability of necessary personnel and equipment to monitor and resuscitate patients in the PACU.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>3. PERFORMANCE IMPROVEMENT PROCESS - C. Peer Review/Performance Improvement Committee</b>	<b>Met</b>	<b>Not Met</b>
3. C. (1) The committee is chaired by the trauma medical director or physician designee.		
3. C. (2) At a minimum, the committee includes the core group of general surgeons and a physician liaison from orthopedic surgery, neurosurgery, emergency medicine, radiology and anesthesia, each of whom attend at least 50 percent of the meetings.		
3. C. (3) Each liaison is available to the trauma medical director for committee issues that arise in his or her department.		
3. C. (4) The committee documents attendance and participation.		

3. C. (5) The committee reviews overall quality of care for the trauma service, selected deaths, complications and sentinel events with the objective of identifying issues and appropriate responses.		
3. C. (6) Care may be initially evaluated by individual specialties within usual departmental review structure; however, identified problem trends undergo review within the Performance Improvement Committee.		
3. C. (7) Morbidity and mortality review of trauma cases is provided by this committee or in another appropriate forum. All trauma deaths are systematically reviewed and categorized as preventable, non-preventable or potentially preventable.		
3. C. (8) Corrective actions are taken and documented when a consistent problem or inappropriate variation is identified.		
3. C. (9) The trauma medical director ensures dissemination of committee information to all non-core general surgeons with documentation.		
3. C. (10) The committee reviews and monitors the organ donation rate.		
3. C. (11) The committee demonstrates that the program complies with required surgical response times at least 80% of the time.		
3. C. (12) The peer review/performance improvement program will monitor changes in interpretation of diagnostic information.		

<b>MET</b> <b>Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>

<b>4. FACILITY ORGANIZATION AND THE TRAUMA PROGRAM</b>	<b>Met</b>	<b>Not Met</b>
4. A. (1) Facility Governing Body and Medical Staff Commitment - Demonstrates commitment through a written document which is reaffirmed every three years and is current at the time of the site review.		
4. A. (2) Facility Governing Body and Medical Staff Commitment - Administrative structure includes, at a minimum, an administrator, a trauma medical director and a trauma program manager.		
4. B. (1) Trauma Program - A multidisciplinary trauma committee continuously evaluates the trauma program's processes and outcomes.		
4. B. (2) Trauma Program - A member or a representative participates in state and regional trauma system planning, development and operation.		

4. B. (3) The Trauma Program - has authority to address issues that involve multiple disciplines. The trauma medical director has the authority and administrative support to lead the program.		
4. C. (1) The Trauma Medical Director - is a board-certified surgeon (not board-eligible) as described in "Clinical Requirements for General Surgery" below or shall be a Fellow of the American College of Surgeons with special interest in trauma care, who takes trauma call and has successfully completed an ATLS course.		
4. C. (2) The Trauma Medical Director - demonstrates membership and active participation in state and either regional or national trauma organizations.		
4. C. (3) The Trauma Medical Director - has the authority to correct deficiencies in trauma care and exclude from taking trauma call all trauma team members who do not meet required criteria and also has the responsibility and authority to determine each general surgeon's ability to participate on the trauma panel based on an annual review.		
4. C. (4) The Trauma Medical Director has accrued an average of 16 hours verifiable, external trauma-related CME annually or 48 hours in the three years prior to the designation site review, including no less than one national meeting per three years.		
4. D. (1) The Trauma Resuscitation Team - has defined criteria for activation.		
4. D. (2) The Trauma Resuscitation Team - has criteria for a graded activation that are clearly defined and continuously evaluated by the performance improvement program.		
4. E. (1) Trauma Service admission is a patient who is admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.		
4. E. (2) The Trauma Service - demonstrates or provides documentation that it has sufficient infrastructure and support to ensure the adequate provision of care.		
4. F. The Trauma Program Manager - is, at a minimum, a registered nurse and demonstrates the following qualifications: (1) Administrative ability, (2) Evidence of educational preparation (3) Documented clinical experience and (4) Has accrued an average of 16 hours verifiable, external trauma-related continuing education annually or 48 hours in the three years prior to the designation site review, including no less than one national meeting per three years.		
<b>MET</b> <b>Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	

<b>5. CLINICAL REQUIREMENTS FOR GENERAL SURGERY</b>	<b>Met</b>	<b>Not Met</b>
5. A. (1) Role/Availability - The on-call attending trauma surgeon is in the emergency department on patient arrival (maximum response time is 15 minutes, tracked from patient arrival, 80 percent of the time) for the highest level of activation with adequate notification from the field. Compliance of the attending surgeon's arrival time is monitored.		
5. A. (2) Role/Availability - A resident in postgraduate year four or five may begin resuscitation while awaiting arrival of the attending surgeon based on facility-defined criteria.		
5. B. Equipment/Resources - All necessary resources, including instruments, equipment and personnel, for current surgical trauma care are provided.		
5. C. (1) Qualifications/Board Certification - All general surgeons on the trauma panel are fully credentialed in critical care and board certified in surgery by the American Board of Surgery (ABS), or the Bureau of Osteopathic Specialists and Boards of Certification or the Royal College of Physicians and Surgeons of Canada; or are board eligible, working toward certification and less than five years out of residency. <b>OR</b> 5. C. (2) Qualifications/Board Certification -Are foreign-trained, non-ABS boarded surgeons with the foreign equivalent of ABS certification in general surgery, have clinical expertise in trauma care, an unrestricted Colorado license, and unrestricted credentials in surgery and critical care at the facility.		
5. C. (3) Qualifications/Board Certification - The performance of all surgeons on the trauma panel is reviewed annually by the trauma medical director.		
5. D. (1) Clinical Commitment/Involvement - All general surgeons on the trauma panel have general surgical privileges.		
5. D. (2) Clinical Commitment/Involvement - The general surgeon on-call is dedicated to one trauma facility when taking trauma call.		
5. D. (3) Clinical Commitment/Involvement - A published general surgery back-up call schedule is available. The back-up surgeon is present within 30 minutes of being requested to respond.		
5. D. (4) Clinical Commitment/Involvement - An attending surgeon is present at all trauma operations with presence documented.		
5. E. (1) Education/Continuing Education - All general surgeons on the trauma panel have successfully completed the American College of Surgeons ATLS course at least once.		
5. E. (2) Education/Continuing Education - All general surgeons who take trauma call have accrued an average of 16 hours annually of verifiable, external trauma-related CME or demonstrate participation in an internal educational process conducted by the program.		
5. E. (3) Education/Continuing Education - All general surgeons on the trauma panel are reviewed annually by the trauma medical director or designee to assure compliance with the CME policy.		
5. F. Participation in the Statewide Trauma System - The trauma facility provides a qualified surgeon as a state reviewer a minimum of one day per year if requested by the Department.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		
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<b>6. REQUIREMENTS FOR EMERGENCY MEDICINE AND THE EMERGENCY DEPARTMENT</b>	<b>Met</b>	<b>Not Met</b>
6. A. (1) Role/Availability - There is a designated emergency department physician director supported by additional physicians to ensure immediate care for injured patients.		
6. A. (2) Role/Availability - A physician is present in the emergency department at all times <b>OR</b> 6. A. (3) For facilities with emergency medicine residents, an in-house attending emergency physician shall provide supervision of the residents 24 hours/day.		
6. A. (4) Role/Availability - A designated emergency physician serves as the emergency medicine liaison to the trauma service.		
6. B. Equipment/Resources - All necessary resources, including instruments, equipment and personnel, for current emergency trauma care are provided.		
6. C. (1) Qualifications/Board Certification - All emergency physicians on the trauma panel are board certified in emergency medicine by the American Board of Medical Specialties (ABS) or the Bureau of Osteopathic Specialists and Boards of Certification or the Royal College of Physicians and Surgeons of Canada; or is board eligible, working toward certification and less than five years out of residency. <b>OR</b> 6. C. (2) Qualifications/Board Certification - a foreign-trained, non-ABS boarded emergency physician with the foreign equivalent of ABS certification in emergency medicine, clinical expertise in trauma care, has an unrestricted Colorado license, and unrestricted credentials at the facility.		
6. C. (3) Qualifications/Board Certification - The performance of all emergency physicians on the trauma panel is reviewed annually by the emergency medicine liaison or designated representative.		
6. D. (1) Clinical Commitment/Involvement - Roles and responsibilities of the emergency physician are defined, agreed on and approved by the trauma medical director.		
6. D. (2) Clinical Commitment/Involvement - Emergency physicians on the call panel are regularly involved in the care of the injured patient.		
6. E. (1) Education/Continuing Education - All emergency physicians on the trauma panel have successfully completed the American College of Surgeons ATLS course at least once.		
6. E.(2) Education/Continuing Education - Physicians certified by boards other than emergency medicine who treat trauma patients in the emergency department shall remain current in ATLS.		
6. E. (3) Education/Continuing Education - The trauma service emergency medicine liaison has accrued an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review.		
6. E. (4) Education/Continuing Education - All other emergency physicians on the trauma panel are reviewed annually by the emergency medicine liaison or designated representative to assure compliance with the CME policy.		
6. F. (1) Nursing Services - A qualified nurse is available 24 hours per day to provide care for patients during the emergency department phase of care. Nursing personnel with special capability in trauma care provide continual monitoring of the trauma patient from hospital		

arrival to disposition in Intensive Care Unit (ICU), Operating Room (OR), or Patient Care Unit.		
6. F. (2) Nursing Services - The nurse/patient ratio is appropriate for the acuity of the trauma patients in the emergency department.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>7. CLINICAL REQUIREMENTS FOR NEUROSURGERY</b>	<b>Met</b>	<b>Not Met</b>
7. A. (1) Role/Availability - A designated neurosurgeon serves as the neurological liaison to the trauma service.		
7. A. (2) Role/Availability - The facility has defined criteria for neurosurgical activation (attending and resident).		
7. A. (3) Role/Availability - Written primary and back-up call schedules are required if neurosurgeons take call at more than on facility (trauma or non-trauma). <i><b>If the combined volume of trauma-related emergency neurosurgical operative procedures at the facilities is less than an average of 25 per year, over the last three calendar years, written call schedules are not required.</b></i>		
7. A. (4) Role/Availability - An attending neurosurgeon is promptly available as defined by the facility to the trauma service when requested. Compliance with the facility defined availability criteria is monitored by the multidisciplinary trauma committee.		
7. B. Equipment/Resources - The facility provides all necessary resources, including instruments, equipment and personnel, for current neurotrauma care.		
7. C. (1) Qualifications - All neurosurgeons who take trauma call are board certified in neurosurgery by the American Board of Surgery (ABS) or the Bureau of Osteopathic Specialists and Boards of Certification or the Royal College of Physicians and Surgeons of Canada; or are board eligible, working toward certification and less than five years out of residency.  <b>OR</b> 7. C. (2) Qualifications - A foreign-trained, non-ABS boarded neurosurgeons with the foreign equivalent of ABS certification in neurosurgery, has clinical expertise in trauma care, an unrestricted CO license & unrestricted credentials in neurosurgery.		
7. C. (3) Qualifications - The performance of all neurosurgeons on the trauma panel is reviewed annually by the liaison or designated representative.		
7. D. (1) Clinical Commitment/Involvement - Neurosurgeons are credentialed by the hospital with general neurosurgical privileges.		

7. D. (2) Clinical Commitment/Involvement - Qualified neurosurgeons are regularly involved in the care of the head and spinal cord injured patients.		
7. E. (1) Education/Continuing Education - The trauma service neurosurgery liaison has accrued an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review.		
7. E. (2) Education/Continuing Education - All other neurosurgeons on the trauma panel are reviewed annually by the liaison or designated representative to assure compliance with the CME policy.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>8. CLINICAL REQUIREMENTS FOR ORTHOPEDIC SURGERY</b>	<b>Met</b>	<b>Not Met</b>
8. A. (1) Role/Availability/Specialists - A designated orthopedic surgeon serves as the orthopedic liaison to the trauma program.		
8. A. (2) Role/Availability/Specialists - There is an orthopedic on-call schedule dedicated only to this facility which is available 24 hours per day along with either a posted second call or a contingency plan that includes transfer agreements with another designated Level I or II facility. The Multidisciplinary Trauma Committee monitors compliance with the facility-defined availability criteria.		
8. A. (3) Role/Availability/Specialists - Plastic surgery, hand surgery and treatment of spinal injuries are available to the orthopedic patient.		
8. A. (4) Role/Availability/Specialists - A fully credentialed spine surgeon is promptly available, as defined by the facility, 24 hours per day.		
8. B. Equipment/Resources - The facility provides all necessary resources, including instruments, equipment and personnel, for current musculoskeletal trauma care.		
8. C. (1) Qualifications - All orthopedic surgeons who take trauma call are board certified in orthopedic surgery by the American Board of Surgery (ABS) or the Bureau of Osteopathic Specialists and Boards of Certification or the Royal College of Physicians and Surgeons of Canada; or are board eligible, working toward certification and less than five years out of residency.  <b>OR</b>		
8. C. (2) Qualifications -A foreign-trained, non-ABS boarded orthopedic surgeons with the foreign equivalent of ABS certification in orthopedic surgery, has clinical expertise in trauma care, an unrestricted Colorado license, and unrestricted credentials in orthopedic surgery.		
8. C. (3) Qualifications - Performance of all orthopedic surgeons on the trauma panel is reviewed annually by the liaison or designated representative.		

8. D. (1) Clinical Commitment/Involvement - Orthopedic surgeons are credentialed by the hospital with general orthopedic privileges.		
8. D. (2) Clinical Commitment/Involvement - If orthopedic surgeons take call at more than one facility (either trauma or non-trauma) at a time, there are written primary and back-up call schedules.		
8. D. (3) Clinical Commitment/Involvement - Orthopedic surgeons on the call panel are regularly involved in the care of the trauma patient.		
8. E. (1) Education/Continuing Education - The trauma service orthopedic surgery liaison has accrued an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review.		
8. E. (2) Education/Continuing Education - All other members of the orthopedic team on the trauma panel are reviewed annually by the liaison or designated representative to assure compliance with the CME policy.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>9. PEDIATRIC TRAUMA CARE</b> <i>(A. Pediatric trauma care refers to care delivered to children under age 15.)</i>	<b>Met</b>	<b>Not Met</b>
9. B. (1) All adult level II facilities - Provide evidence of safe pediatric trauma care to include age-specific medical devices and equipment as appropriate for resuscitation and stabilization of the pediatric patient.		
9. B. (2) All adult level II facilities - Assure the physician and nursing staff providing care to the pediatric patient demonstrate competency in the care of the injured child appropriate to the type of injured child.		
9. B. (3) All adult level II facilities - Demonstrate oversight of the pediatric care provided through a pediatric-specific peer review/performance improvement process.		
9. C. (1) A level II adult trauma facility admitting children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography has - all physicians providing care to pediatric trauma patients are credentialed for pediatric trauma care by the hospital's credentialing body.		
9. C. (2) A level II adult trauma facility admitting children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography has - appropriate pediatric medical equipment in the emergency department.		

9. C. (3) A level II adult trauma facility admitting children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography has - a pediatric intensive care area or a transfer protocol and transfer agreements for pediatric patients requiring intensive care.		
9. C. (4) A level II adult trauma facility admitting children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography has - appropriate pediatric resuscitation equipment in all pediatric care areas.		
9. C. (5) A level II adult trauma facility admitting children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography has - a pediatric-specific peer review/performance improvement process, which shall include pediatric-specific process filters and outcome measures.		
9. C. (6) A level II adult trauma facility admitting children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography has - nursing staff providing care to the pediatric patient with specialized training in the care of the injured child.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>10. COLLABORATIVE CLINICAL SERVICES - ANESTHESIA</b>	<b>Met</b>	<b>Not Met</b>
10. A. (1) (a) Role/Availability - A designated anesthesiologist serves as the anesthesia liaison to the trauma program.		
10. A. (1) (b) Role/Availability - Anesthesiology services are promptly available as defined by the facility for emergency operations and airway problems in the injured patient. The Multidisciplinary Trauma Committee monitors compliance.		
10. A. (1) (c) Role/Availability - Staff anesthesiologist on call is notified and present in the operating department when anesthesiology residents or certified registered nurse anesthetists are used to fulfill availability requirements. The performance improvement process monitors compliance.		
10. A. (2) (a) Qualifications - All anesthesiologists taking trauma call are board certified or board eligible, working toward certification and less than five years out of residency.		
10. A. (2) (b) Qualifications - The performance of anesthesiologists on the trauma panel is reviewed annually by the anesthesiology liaison or designated representative.		
10. A. (3) (a) Education/Continuing Education - The trauma service anesthesiologist liaison has accrued an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review.		

10. A. (3) (b) Education/Continuing Education - All other members of the anesthesiologist team on the trauma panel are reviewed annually by the anesthesia liaison or designated representative to assure compliance with the CME policy.			
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		
<b>Comments/Recommendations</b>			

<b>10. COLLABORATIVE CLINICAL SERVICES - OPERATING ROOM</b>	<b>Met</b>	<b>Not Met</b>
10. B. (1) (a) General Requirements - A dedicated operating room team is always available.		
10. B. (1) (b) General Requirements - A mechanism is in place to staff a second operating room if the primary operating room team is occupied.		
10. B. (1) (c) General Requirements - There is a facility-defined access policy for urgent trauma cases of all specialties.		
10. B. (2) (a) Equipment Requirements - The facility has - rapid infusers, thermal control equipment for patients and fluids, intraoperative radiological capabilities, equipment for fracture fixation, equipment for endoscopic evaluation (bronchoscopy and gastrointestinal endoscopy) and other equipment to provide operative care consistent with current practice.		
10. B. (2) (b) Equipment Requirements - The facility has - necessary equipment to perform a craniotomy.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>10. COLLABORATIVE CLINICAL SERVICES - POST ANESTHESIA CARE UNIT (PACU)</b>		<b>Met</b>	<b>Not Met</b>
10. C. (1) Qualified nurses are available 24 hours per day to provide care for the trauma patient, if needed, in the recovery phase.			
10. C. (2) If the availability of PACU nurses is met with an on-call team from outside the hospital, the availability of PACU nurses and the absence of delays are monitored by the peer review/performance improvement program.			
10. C. (3) All necessary resources are provided in PACU including instruments, equipment and personnel to monitor and resuscitate patients consistent with the facility-defined process of care.			
10. C. (4) Recovery of the trauma patient in a critical care unit is acceptable.			
10. C. (5) The peer review/performance improvement program reviews and addresses issues related to the availability of necessary personnel and equipment to monitor and resuscitate patients in the PACU.			
<b>MET</b> <b>Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		

<b>10. COLLABORATIVE CLINICAL SERVICES - RADIOLOGY</b>		<b>Met</b>	<b>Not Met</b>
10. D. (1) (a) Role/Availability - Qualified radiologists are promptly available as defined by the facility for the interpretation of imaging studies and respond in person when requested.			
10. D. (1) (b) Role/Availability - Personnel qualified in interventional procedures are promptly available as defined by the facility 24 hours per day when requested by a trauma surgeon.			
10. D. (1) (c) Role/Availability - A designated radiologist serves as the radiology liaison to the trauma program.			
10. D. (2) (a) Clinical Commitment/Involvement - Diagnostic information is communicated in written form in a timely manner as defined by the facility.			
10. D. (2) (b) Clinical Commitment/Involvement - Critical information deemed to immediately affect patient care is promptly communicated to the trauma team.			
10. D. (2) (c) Clinical Commitment/Involvement - The final report accurately reflects the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretation.			
10. D. (3) (a) Radiology Support Services - The facility has developed policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transport to and while in the radiology department.			

10. D. (3) (b) Radiology Support Services - Conventional radiography and computed tomography (CT) are promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.		
10. D. (3) (c) Radiology Support Services - An in-house radiographer and in-house CT technologist are promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.		
10. D. (3) (d) Radiology Support Services - Conventional catheter angiography and sonography is promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.		
10. D. (3) (e) Radiology Support Services - Magnetic resonance imaging capability is promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.		
10. D. (3) (f) Radiology Support Services - The peer review/performance improvement program reviews and addresses any variance from facility-defined response times.		
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	
<b>Comments/Recommendations</b>		

<b>10. COLLABORATIVE CLINICAL SERVICES - CRITICAL CARE</b>	<b>Met</b>	<b>Not Met</b>
10. E. (1) (a) Organization of the Intensive Care Unit (ICU) - The ICU is directed or co-directed by a qualified surgeon with expertise in the care of injured patients.		
10. E. (1) (b) Organization of ICU - The ICU may be staffed by critical care trained physicians from different specialties.		
10. E. (1) (c) Organization of ICU - Physician coverage of critically ill trauma patients is promptly available as defined by the facility 24 hours per day. These physicians are capable of rapid response to deal with urgent problems as they arise. The peer review/performance improvement program monitors availability.		
10. E. (1) (d) Organization of ICU - All trauma surgeons are fully credentialed by the facility to provide all intensivist services in the ICU and they have full hospital privileges for critical care.		
10. E. (2) (a) Responsibility for Trauma Patients - The trauma surgeon retains oversight of the patient while in ICU.		
10. E. (2) (b) Responsibility for Trauma Patients - The trauma service maintains oversight of		

the patient throughout the course of hospitalization.		
10. E. (3) (a) Nursing Services - A qualified nurse is available 24 hours per day to provide care for patients during the ICU phase of care.		
10. E. (3) (b) Nursing Services - The nurse/patient ratio is appropriate for the acuity of the trauma patients in the ICU.		
10. E. (3) (c) Nursing Services - The facility assures that the nursing staff providing care to the pediatric patient has specialized training in the care of the injured child.		
10. E. (4) (a) Equipment - The ICU has the necessary resources including instruments and equipment to monitor and resuscitate patients consistent with the facility-defined process of care.		
10. E. (4) (b) Equipment - Ventilatory support is available for trauma patients 24 hours per day.		
10. E. (4) (c) Equipment - Arterial pressure monitoring, pulmonary artery catheterization, patient rewarming, intracranial pressure monitoring and other equipment to provide critical care consistent with current practice is available.		
<b>MET Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	

<b>10. COLLABORATIVE CLINICAL SERVICES</b>	<b>Met</b>	<b>Not Met</b>
10. F. Other Surgical Specialties - The facility has a full spectrum of surgical specialists on staff including but not limited to: thoracic, peripheral vascular, obstetric, gynecological, otolaryngologic, urologic, ophthalmologic, facial trauma, spine and plastic.		
10. G. (1) Medical Consultants - The facility has medical specialists on staff including cardiology, infectious disease, internal medicine, pulmonary medicine and nephrology and their respective support teams.		
10. G. (2) Medical Consultants - A respiratory therapist is promptly available to care for trauma patient.		
10. G. (3) Medical Consultants - Acute hemodialysis is promptly available for the trauma patient.		
10. G. (4) Medical Consultants - Services are available 24 hours per day for the standard analyses of blood, urine and other body fluids, coagulation studies, blood gases and microbiology, including microsampling when appropriate.		

10. G. (5) Medical Consultants - The blood bank is capable of blood typing and cross matching and has an adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate and appropriate coagulation factors to meet the needs of injured patients.			
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		
<b>Comments/Recommendations</b>			

<b>11. REHABILITATION REQUIREMENTS</b>		<b>Met</b>	<b>Not Met</b>
11. A. (1) Services are available to the trauma patient within the hospital's physical facilities <b>OR</b> 11. A. (2) At a freestanding rehabilitation hospital with which the facility has an appropriate transfer agreement.			
11. B. (1) Physical, occupational and speech therapy services are available during the trauma patient's ICU and other acute phases of care.			
11. B. (2) Social services are available during the trauma patient's ICU and other acute phases of care.			
<b>MET</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		
<b>Comments/Recommendations</b>			

<b>12. TRAUMA REGISTRY</b>		<b>Met</b>	<b>Not Met</b>
12. A. Trauma registry data are collected and analyzed. It contains detailed, reliable and readily accessible information that is necessary to operate a trauma facility.			
12. B. Trauma data is submitted to the National Trauma Data Bank on an annual basis.			
12. C. The facility demonstrates that it uses the trauma registry to support the performance			

improvement program.			
12. D. Trauma data are submitted to the Colorado Trauma Registry within 60 days of the end of the month during which the patient was discharged.			
12. E. Appropriate measures are in place to assure trauma data confidentiality.			
12. F. The facility monitors data validity.			
<b>MET</b> <b>Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		

<b>13. OUTREACH AND EDUCATION</b>		<b>Met</b>	<b>Not Met</b>
13. A. Public Outreach and Education - Public education includes prevention activities, referral and access to trauma facility resources.			
13. B. Professional Outreach and Education - The facility engages in professional outreach and education activities that include internal and external trauma-related educational opportunities for physicians, nurses and allied health professionals.			
<b>MET</b> <b>Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		

<b>14. PREVENTION</b>		<b>Met</b>	<b>Not Met</b>
14. A. The facility participates in injury prevention and provides documentation of the presence of prevention activities that center on priorities based on local data.			

14. B. The facility demonstrates evidence of a job description and salary support for an injury prevention coordinator who is a separate person from but collaborates with the trauma program manager.		
14. C. The trauma service has developed an injury prevention program that incorporates, at a minimum, the following: (1) Selecting a target injury population (2) Gathering and analyzing data (3) Developing evidenced-based intervention strategies based on local data and best practices (4) Formulating a plan (5) Implementing the program (6) Evaluating and revising the program as necessary		
14. D. The facility demonstrates collaboration with or participation in national, regional or state injury prevention programs.		
14. E. The facility has a mechanism to identify patients who may have an alcohol addiction and has the capability to provide intervention for patients identified as potentially having an alcohol addiction.		
14. F. The facility collaborates with and mentors lower level trauma centers regarding injury prevention.		
<b>MET Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	

<b>15. ORGAN PROCUREMENT ACTIVITIES</b>	<b>Met</b>	<b>Not Met</b>
15. A. The facility has an established relationship with a recognized organ procurement organization (OPO).		
15. B. There is a written policy for triggering notification of the regional OPO.		
15. C. There are written protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death.		
<b>MET Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>	

<b>16. DISASTER PLANNING AND MANAGEMENT</b>		<b>Met</b>	<b>Not Met</b>
16. A. The facility meets the Emergency-Management-related requirements of the Joint Commission.			
<b>MET Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		

<b>17. RETAC INTEGRATON</b>		<b>Met</b>	<b>Not Met</b>
The facility demonstrates integration and cooperation with the Regional Emergency Medical and Trauma Advisory Council (RETAC). Evidence of such may include, but is not limited to: attendance at periodic RETAC meetings, participation in RETAC injury prevention activities, participation in RETAC data and or quality improvement project, etc.			
<b>MET Comments/Recommendations</b>	<b>NOT MET: Please identify what would need to occur for EACH criterion that is not met.</b>		

Facility

Name: \_\_\_\_\_

<b>Strengths</b>	<b>Weaknesses (Include recommendations to correct weaknesses.)</b>