



Colorado Department
of Public Health
and Environment

TRAUMA CENTER DESIGNATION SCORING TOOL LEVEL V

January 2007

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

Facility Name: _____

Review Date: _____

Reviewers: _____

State Observer: _____

SITE REVIEWER INSTRUCTIONS

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 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.

We designed the following scoring tool to assess a facility's ability to meet the minimum state standards. 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.

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**, **Met with Reservations**, or **Not Met** for each standard. Document the rationale for any Met with Reservation or Not Met ratings. Include evidence to substantiate your findings. Comments must be objective and concise. Met with reservations should be used in cases where there is evidence of some degree of compliance with regulatory standards, but where further action is required for full compliance. Reviewers may then recommend a plan of correction or a re-review to document compliance

NOTE: The Department expects compliance with all criteria as defined in rule. 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 review.

NOTE: This scoring tool will be given to the State Observer after the exit interview and will NOT be returned to the facility. You will be asked, during the exit interview, to provide detailed verbal feedback to the facility staff based on this scoring tool. Please be prepared to refer back to the state standards to explain any items scored "met with reservations" or "not met." Please also feel free to provide comments to the facility about strengths of its current trauma program or suggestions about the future development of its program.

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. Commitment by administration and medical staff to support the trauma program demonstrated by written commitment from the facility's board of directors, owner/operator, or administrator to provide the required services.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	2. A written commitment to regional planning and system development activities.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION				
3. A trauma program with policies that identify and establish the scope of trauma care for both adult and pediatric patients, included but not limited to:	MET	MET WITH RES.	NOT MET	Comments or Explanation
a. Initial resuscitation and stabilization.				
b. Admission criteria.				
c. Hours of Operation. *				
d. Critical care, if available.				
e. Rehabilitation, if available.				
f. Written procedure for transfer of patients by fixed and rotary wing aircraft.				
*if the facility is not open 24 hours a day, the services as defined in the scope of trauma service policy shall include after-hours plan for availability of services.				

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	4. A physician designated by the facility as the Trauma Medical Director who takes responsibility for the trauma program.	
MET	MET WITH RESERVATIONS	NOT MET

Definition: Trauma Service Director — In Level V the Trauma Service Director may be a physician so designated by the hospital who takes responsibility for the program, including: service leadership, overseeing all aspects of trauma care, and administrative authority for the hospital trauma program including: trauma multidisciplinary committee, trauma quality improvement program, physician appointment to and removal from trauma service, policy and procedure enforcement, and peer review; participates in the on-call schedule; practices at own institution on a full time basis; and participates in all facility trauma-related committees.

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	4. Trauma Medical Director. Responsibilities include: a. Participation in trauma education activities for healthcare providers or the public.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	4. Trauma Medical Director. Responsibilities include: b. Leadership for the trauma program and oversight of the trauma quality improvement process.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	4. Trauma Medical Director. Responsibilities include: c. Administrative authority for the trauma program, including, recommendations for trauma privileges, policy and procedure enforcement, and peer review.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	5. A facility-defined trauma team activation protocol that includes who is notified and the response expectations. The protocol shall base activation of personnel on anatomical, physiological, mechanism of injury criteria and co-morbid factors as outlined in the pre-hospital trauma triage algorithms as set forth in 6 CCR 1015-4, Chapter 2, Exhibit A.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	6. A defined method of activating trauma response personnel consistent with the scope of trauma care provided by the facility.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	7. A staff person identified as the Trauma Coordinator with clinical experience in care of the injured patient, who is responsible for coordination of the trauma program functions	
MET	MET WITH RESERVATIONS	NOT MET
Definition: The terms "trauma nurse coordinator" and "trauma coordinator" are used interchangeably in these regulations (6 CCR 1015). The trauma nurse coordinator (TNC) works to promote optimal care for the trauma patient through the clinical program, administrative functions, and professional and public education. The TNC shall be actively involved in the state trauma system. The essential responsibilities of the TNC include maintenance of the trauma registry, continuous quality improvement in trauma care, and educational activities to include injury prevention.		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	8. An identified multidisciplinary committee involved in the development of a plan of care for the injured patient and is responsible for trauma program performance. Membership will be established by the facility and the committee will establish attendance. (See below for specifics from section 304.B.2)	
MET	MET WITH RESERVATIONS	NOT MET
The trauma multidisciplinary committee, is responsible for trauma program performance at each trauma center. Membership will be established by the facility and the committee will establish attendance requirements. Responsibilities include, but are not limited to: <ol style="list-style-type: none"> 1) The review of all services essential to the care and management of the trauma patient; 2) Meeting on a regular basis, but not less than quarterly for Level IV-V facilities, to assure timely review and corrective action. 3) Performance management functions include but are not limited to: <ol style="list-style-type: none"> a) Establishing and enforcing policies and procedures; b) Reviewing process issues, e.g., communications; reviewing systems issues, e.g., response times and notification times; and promoting educational offerings; and c) Reviewing and analyzing trauma registry data for program evaluation and utilization, with defined intervals for data collection and analysis. In level IV-V clinics or facilities shall fulfill the reporting requirement for the submission of data as required by regulation in Chapter 1 of the trauma rules. In level IV-V clinics or facilities with non-participation in the Colorado Hospital Association discharge data set, the trauma registry as defined in Chapter 1 of the trauma rules may, at a minimum, be in the form of a hard-copy abstract approved by the department. In addition the performance management function includes maintaining a system (such as a log) for tracking patient disposition, and deaths. 		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	<p>9. A quality improvement program as defined in Section 304. All designated Level III –V trauma centers shall have an organized, trauma quality improvement program that demonstrates a plan, process and accountability for continuous quality improvement in the delivery of trauma care. It is the responsibility of the trauma medical director in coordination with the trauma nurse coordinator to oversee the program. The plan should address the criteria as described in 6 CCR 1015-4, Chapter 3, 304.B.1 – see below.</p>	
MET	MET WITH RESERVATIONS	NOT MET
<p>A plan that shall address the entire spectrum of services necessary to ensure optimal care to the trauma patient, from pre-hospital to rehabilitative care. In Level IV-V clinics or facilities, this plan may be part of the hospital-wide quality improvement program, but must have specific defined trauma-related indicators and components. The plan should identify:</p> <ol style="list-style-type: none"> 1) The facility-defined standards of medical care for the trauma patient; 2) A process for corrective action, to include problem identification, action plan, resolution or outcome for loop closure; 3) The method for documentation and maintenance of minutes on site and readily available of special death audits, trauma multidisciplinary committee, or any other committees used in this process; 4) The process for prehospital trauma care review; 5) The data sources to support an effective monitoring system, to include but not be limited to retrospective and concurrent medical record review; 		

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MET	MET WITH RESERVATIONS	NOT MET
<ol style="list-style-type: none"> 1) A special audit of all trauma deaths with: <ol style="list-style-type: none"> a) Written documentation of the process to include the assessment, any corrective action and resolution; and b) The deaths shall be identified as: preventable, potentially preventable, or non-preventable, and c) Reporting a summary of the audit findings to the trauma multidisciplinary committee; 2) Prehospital trauma care review; 3) Collection of data to support an effective monitoring system, to include but not be limited to retrospective and concurrent medical record review; 4) Identification and review of facility-defined patient sentinel events, complications and trends; 5) Institution-specific nursing audits with: <ol style="list-style-type: none"> a) Evidence that nursing performance improvement issues are reviewed as part of the trauma program; b) Clinical filters for nursing documentation; and c) Ongoing monitoring and/or trending. 6) Multidisciplinary peer review to include a process of peer review as defined in C.R.S. § 12-36.5-104 et.seq. This process shall monitor compliance with, or adherence to facility-defined standards of medical care for the trauma patient. All trauma centers shall have a policy that includes the process and criteria for utilization of a resource outside the facility for peer review. Documentation of findings and recommendations must be maintained with an identified reporting process for loop closure. Qualifications of outside peer reviewer must be identified by the facility as defined in C.R.S § 12-36.5-104; 7) Case presentations of interest for educational purposes to improve overall care to the trauma patient to include: <ol style="list-style-type: none"> a) All aspects and contributing factors of trauma care from prehospital to discharge or death; and b) A review of any event that deviates from an anticipated outcome; and c) Documentation of the review shall include date, reason for review, problem identification, recommendations, resolution and education. 		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	<p>9. A quality improvement program as defined in Section 304. All designated Level III –V trauma centers shall have an organized, trauma quality improvement program that demonstrates a plan, process and accountability for continuous quality improvement in the delivery of trauma care. It is the responsibility of the trauma medical director in coordination with the trauma nurse coordinator to oversee the program. Accountability can be demonstrated by meeting criteria as described in 6 CCR 1015-4, Chapter 3, 304.B.1 – see below.</p>	
MET	MET WITH RESERVATIONS	NOT MET
<ol style="list-style-type: none"> 1) The trauma center [has an] organizational structure responsible for the administration of the [trauma quality improvement] plan, to include a description of who has the authority to change policies, procedures or protocols related to trauma care; 2) The trauma service director in coordination with the trauma nurse coordinator demonstrates responsibility for: <ol style="list-style-type: none"> a) The identification of and responsibility for the oversight of the plan; b) Initiation of corrective action as needed; c) A process for corrective action, to include problem identification, action plan, resolution or outcome for loop closure; 3) The development and evidence of on-going reporting and trending of institution-specific audit filters to facilitate the quality improvement program to identify at a minimum, but not limited to: <ol style="list-style-type: none"> a) Program structure (systems issues) with all trauma transfers in or out, except those with isolated extremity fractures; b) Program process (medical issues) with provider response times when the trauma team is activated; and c) Program outcomes with compliance with initial resuscitation and stabilization as defined in facility policy; 		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION				
10. Divert protocols to include:	MET	MET W/ RES.	NOT MET	Comments or Explanation
a. Coordination with the Regional Emergency Medical and Trauma Advisory Council				
b. Notification of pre-hospital providers				
c. Reason for divert				
d. A method for monitoring times and reasons for going divert.				
Definition: Redirection of the trauma patient to a different receiving facility. Redirection shall be in accordance with the prehospital trauma triage algorithm, as set forth in Chapter 2. Reasons for going on divert are limited to lack of critical equipment or staff; operating room, emergency department, or intensive care unit saturation; disaster or facility structural compromise.				

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	11. Inter-facility transfer criteria/guidelines as a transferring facility (if applicable).		
MET	MET WITH RESERVATIONS	NOT MET	

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	12. Inter-facility transfer policies and protocols.		
MET	MET WITH RESERVATIONS	NOT MET	

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	13. Participation in the state trauma registry as required in 6 CCR 1015-4, Chapter 1.		
MET	MET WITH RESERVATIONS	NOT MET	

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	14. Participation in the RETAC and statewide quality improvement programs as required in rule.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	15. STANDARD ONLY APPLIES If licensed as a Community Clinic with Emergency Care:	
a. A central log on each trauma patient/individual presenting with an emergency condition who comes seeking assistance and whether he or she refused treatment, was refused treatment, or whether the individual was transferred, admitted and treated, died, stabilized and transferred, or discharged.		
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	15. STANDARD ONLY APPLIES If licensed as a Community Clinic with Emergency Care:	
b. A policy requiring the provision of a medical screening of all individuals with trauma-related emergencies that come to the clinic and request an examination or treatment. The policy shall not delay the provision of a medical screening in order to inquire about an individuals' method of payment or insurance status.		
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	15. STANDARD ONLY APPLIES If licensed as a Community Clinic with Emergency Care:	
c. Provide further medical examination and such treatment as may be required to stabilize the traumatic injury within the staff and facility's capabilities available at the clinic, or to transfer the individual. The transferring clinic must provide the medical treatment, within its capacity, which minimizes the risk to the individual, send all pertinent medical records available at the time of transfer, effect the transfer through qualified persons and transportation equipment, and obtain the consent of the receiving trauma center.		
MET	MET WITH RESERVATIONS	NOT MET

B. CLINICAL CAPABILITIES	1. The physician must be present in the emergency department at the time of arrival of the trauma patient meeting facility-defined trauma team activation criteria, arriving by ambulance. For those patients where adequate prior notification is not possible, the emergency physician shall be available within 20 minutes of notification.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	1. Emergency Department with: a. Physicians who are credentialed by the facility to provide emergency medical care and maintain current Advanced Trauma Life Support (ATLS) verification.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	1. Emergency Department with: b. Registered nurses who provide continuous monitoring of the trauma patient until release from the ED. At least one registered nurse in-house during hours of operation who maintains current Trauma Nurse Core Course verification or equivalent.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES				
1. Emergency Department with equipment for the resuscitation of patients of all ages shall include but not limited to:	MET	MET W/ RES.	NOT MET	Comments or Explanation
1) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of all sizes, bag mask resuscitators, and oxygen				
2) Pulse oximetry				
3) End-tidal CO2 determination				
4) Suction devices				
5) Electrocardiograph-oscilloscope-defibrillator				
6) Standard intravenous fluids and administration devices, including large bore intravenous catheters				
7) a) Sterile surgical sets for airway control/cricothyrotomy				
7) b) Sterile surgical sets for vascular access to include central line insertion and I/O access				
7) c) Sterile surgical sets for thoracostomy – needle and tube				
8) Gastric decompression				
9) Drugs necessary for emergency care				
10) X-ray availability				
11) Two-way communication with emergency transport vehicles				
12) Spinal immobilization equipment				
13) Thermal control equipment for patients and fluids				
14) Medication chart, tape or other system to assure ready access to information on proper dose-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients				

C. FACILITIES/RESOURCES/ CAPABILITIES	2. If an operating room and/or intensive care unit are utilized for the trauma patient, there must be policies that identify and define the scope of care that include the supervision, staffing and equipment requirements that the facility will utilize. (Otherwise score N/A)	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	3. Radiological capabilities available during hours of operations with a radiology technician or person with limited certification in x-ray available within 30 minutes of notification of trauma team activation.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	4. Clinical laboratory services available during hours of operations. A spun hematocrit, dip urinalysis and the ability to collect blood samples to be sent with transferred patients must be available.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	5. Participates in local/regional/statewide Injury Prevention/Public Education.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	6. Continuing education for all physicians providing trauma care, with: a. Current ATLS.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	6. Continuing education for all physicians providing trauma care, with: b. 10 hours of trauma-related facility-defined CME annually or 30 hours over the 3 year period preceding any site review.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	7. Facility-defined, trauma-related continuing medical education requirements for nurses.	
MET	MET WITH RESERVATIONS	NOT MET