

## GENERAL INFORMATION AND INSTRUCTIONS

### PURPOSE OF THE TRAUMA CENTER REQUEST FOR PROPOSAL ( RFP)

The North Carolina Office of Emergency Medical Services (OEMS) is actively involved in the process of identifying, as well as renewing, Level I, II and III trauma centers in North Carolina. Although North Carolina has been involved in Level I and II designation since 1982, criteria for Level III designation were not approved until January 1991. The most current criteria for all three levels are written in rule in the North Carolina Administrative Code effective January 1, 2009.

This Request for Proposal (RFP) has been prepared by OEMS in order to assist in ascertaining whether a hospital seeking initial or renewal trauma center designation meets the state's trauma center criteria. The criteria are based on guidelines developed by the American College of Surgeons (ACS) and approved by the State EMS Advisory Council. Each hospital in North Carolina interested in applying for initial or renewal designation must complete an RFP document and submit it for consideration by the state. This process has been a requirement since January 1, 1985.

This RFP has been designed primarily to allow each facility the opportunity to demonstrate its sincere commitment to meet North Carolina's criteria and to provide quality trauma care to the citizens of North Carolina. Any commitments required of a hospital, as pertain to staffing, equipment or other resources at the time of designation, must remain intact throughout the hospital's designation period.

### INSTRUCTIONS FOR COMPLETION OF THE RFP

#### **Need Help?**

Questions relating to initial or renewal designation procedures, trauma center criteria or the RFP should be directed to Ms. Nadine Pfeiffer, Assistant Chief, Health Systems, North Carolina Office of Emergency Medical Services. She can be reached at telephone (919) 855-3960; FAX # (919) 733-7021; or at email address [nadine.pfeiffer@dohs.nc.gov](mailto:nadine.pfeiffer@dohs.nc.gov). The trauma center designation policy and procedures can also be accessed via internet at <http://www.ncdohs.gov/dohs/EMS/trauma/guidelines.html>.

#### **FORMAT OF RFP**

The RFP, as well as the required tables for completion, are posted to the File Transfer Protocol (FTP) site <ftp://ftp.ncagrgis.com/oems/trauma>. All documents will be in a Microsoft Word for Windows format. The documents can be saved to your hard drive, completed, renamed and then reposted to the FTP site.

#### **REQUESTED DATA AND REPORTING PERIODS**

In numerous places in the RFP, the hospital is asked to provide data or other statistics. The reporting period for this document is defined as 12 months and can not be older than 14 months prior to the site visit. There must be 12 months of data in the trauma registry to schedule a visit. Each hospital shall consistently use the same reporting period throughout the RFP. The reporting time frame should be indicated in a mm/dd/yy format appearing as “ / / to / / “ in the document.

#### **Typing and Collating Instructions**

Single-spaced typing should be utilized to respond to all questions. All answers should be placed in the text box after each question.

Since the application is utilized for all three levels of designation, some questions may be irrelevant for the designation being sought, requiring no response, a “No” or “NA” for not applicable.

Under no circumstances is any question or section to be deleted from the document.

Some questions in the document have been set up to allow for a simple click of the box (); double-click on the box and select “checked” (from the pop-up table) as the default value.

Questions requiring a narrative response should be answered in the space immediately following the question. While unlimited space is provided, it is best to keep answers succinct.

In the event an answer can best be supplied by providing the copy of an existing policy or other document, it is acceptable to include a notation to this effect and to include this item as an attachment document file. It is up to each hospital to determine formatting of attachments to the RFP. It is best to avoid attaching an entire document or manual then refer to it as “the manual” numerous times in reference.

Answers that refer the reader to another section of the RFP should clearly identify this location. In turn, attachments should clearly identify the question being answered and named accordingly.

Prior to reposting the completed applications to the OEMS FTP site, the applicant should make sure the RFP is correctly repaginated and the completed document is renamed.

Prior to submission of the completed RFP on the OEMS FTP site, the required signatures must be obtained on the sign-off page. Please note all situations where someone is serving in an “acting” capacity. This signature page must be faxed to the OEMS at (919) 733-7021 to the attention of Ms. Nadine Pfeiffer the same day the completed RFP is posted to the FTP site. The original signature page must be available at the site survey.

A checklist has also been provided behind these instructions to help each hospital determine if it has remembered to include a number of requested items in the RFP.

Please do not include the general information, instruction pages, and the checklist pages with the completed RFP.

### **Required Submission, Transmittal Letter and Filing Instructions**

Level I, II, and III trauma center applicants must provide the completed application in the following format to OEMS:

- Microsoft Word via the FTP site

\*Electronic documents via email are no longer accepted by the state’s email system due to the inability of encryption of the state email system.

Hospitals seeking initial designation are required to submit an RFP 90 days prior to a proposed site visit.

Hospitals seeking renewal designation are required to submit completed RFPs to OEMS at least 30 days prior to the site visit.

Also accompanying the RFP in electronic format via the FTP site, Level I, II and III applicants must provide the following:

- A letter from the Chief Executive Officer of the hospital indicating, at a minimum, the action that is being requested of the State.
- A map that provides driving directions to the hospital, as well as directions to the initial meeting location the day of the survey.

## CHECKLIST FOR THE RFP

This checklist may be used by hospitals to assure the required documents are included in the Request for Proposal (RFP) before submission to OEMS. Some items on this checklist will not apply to all levels of designation. Please refer to the specific section of the RFP for further details. The list will not account for optional materials a hospital may choose to include with an RFP.

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### HOSPITAL ORGANIZATION, AFFILIATIONS AND COMMITMENT

- Organizational chart showing relationship of administration, departments and services
- Organizational chart showing relationship of the trauma personnel
- Resolution supporting trauma center (if one exists)

### **PRE-HOSPITAL PROGRAM AND DISASTER PLANS**

- 8 ½" by 11" map of EMS system's primary and secondary catchment areas
- If not included in previous map, a map of number and level of other trauma centers in catchment area
- Triage criteria for use of helicopters

### **TRAUMA SERVICE**

- Map defining hospital's primary catchment area for trauma patients
- Job descriptions and CVs for trauma medical director, trauma program manager, etc.
- Medical Staff and/or Depart. of Surgery document on privileges for general surgeons on trauma service
- Continuing education policy for physicians on trauma service
- If not included as part of the narrative, documentation of continuing education for trauma personnel
- Credentialing process/criteria for mid-level practitioners
- Names of nurses, cycles, hours of continuing education
- Policy requiring nursing staff to meet continuing education requirements
- Trauma director's policy on credentials for back-up surgeons
- Treatment protocols for trauma care
- Trauma diversion protocol
- Triage criteria that calls for bypassing community hospitals

### **HOSPITAL AND TRAUMA STATISTICAL DATA**

#### **DEPARTMENTS/DIVISIONS/SERVICES/SECTIONS OF THE HOSPITAL**

- Document on arrival times of surgeons to ED
- Policies/protocols for ortho/neuro on:
  - Early management of emergencies
  - Annual continuing education in management of emergencies
  - What constitutes an emergency

#### **HOSPITAL FACILITIES/RESOURCES/CAPABILITIES**

- ED trauma flow sheet
- Policy on freeing up OR
- Policy on x-ray priority for trauma patients
- Policy on lab priority for ED and ICU trauma patients

- Transfer agreement w/CARF rehab facility (if no full in-house rehab service)

**SPECIALTY CARE SERVICES**

- Signed transfer agreement for burn and spinal cord/head injured patients

**PERFORMANCE IMPROVEMENT**

**EDUCATIONAL ACTIVITIES/OUTREACH PROGRAMS**

**TRAUMA RESEARCH PROGRAM (if applicable)**

- List of ten peer reviewed trauma-related publications (if not in narrative)
- List of twelve trauma-related education/outreach presentations (if not in narrative)

**SUMMARY OF PROGRESS**

**REQUIRED TABLES FOR COMPLETION**

- Completion of a possible 7 tables (as applicable for level of designation)

**ATTACHMENTS**

- Identification of question being answered and named accordingly
- Two attachments (physician names, per instructions, and sample medical record)
- Separate files from the RFP

**ADMINISTRATIVE DETAILS REGARDING TYPING AND SUBMISSION OF RFP**

- Single-spaced typing
- Notation of time frame for all data
- Removal of general information, instruction sheets and this checklist prior to pagination
- All signatures on sign-off page prior to fax, fax same date as upload documents to FTP site
- Cover letter from CEO
- Map(s) with directions to hospital and/or location of initial meeting

**REQUEST FOR PROPOSAL (RFP)  
FOR INITIAL OR RENEWAL DESIGNATION AS A  
NORTH CAROLINA  
TRAUMA CENTER**

**The North Carolina Office of  
Emergency Medical Services  
Division of Health Service Regulation  
Department of Health and Human Services**

Legal Name of Hospital Seeking Designation:

\_\_\_\_\_

Type Review: Initial  Renewal

Level of Review: Level I  Level II  Level III

Name and Telephone Number of Contact Person for this Application:

\_\_\_\_\_

Date of Submission: \_\_\_\_\_

If a renewal, date current designation ends: \_\_\_\_\_

## KEY PERSONNEL SIGN-OFF SHEET

We, the undersigned, understand that this application has been prepared as part of a trauma center designation request. We have reviewed the contents of this document and certify that, to the best of our knowledge, it is an accurate representation of our facility with respect to current trauma care capabilities and future intentions.

### 1. HOSPITAL ADMINISTRATION:

Executive Officer:

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

Signature: \_\_\_\_\_

Administrator Responsible for Emergency Services:

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

Signature: \_\_\_\_\_

### 2. PHYSICIANS:

Chief of Staff:

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

Signature: \_\_\_\_\_

Chief, Department of Surgery:

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

Signature: \_\_\_\_\_

Physician Responsible for Trauma Program or Chief of Trauma Service:

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

Title: \_\_\_\_\_

Specialty: \_\_\_\_\_

Signature: \_\_\_\_\_

Physician Director, Emergency Department:

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

Specialty: \_\_\_\_\_

Signature: \_\_\_\_\_

### 3. NURSING:

Trauma Nurse Program Manager (or Trauma Nurse Coordinator):

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

Signature: \_\_\_\_\_

**I. HOSPITAL ORGANIZATION, AFFILIATIONS AND COMMITMENT**

1. On an attached sheet, to be placed behind this page, provide a hospital organizational chart that depicts the relationship of administration, major departments and services. At a minimum, this must include the following: the Board of Directors/Trustees, Chief Executive Officer, Department of Surgery, Department of Medicine, Department of Nursing, Department of Radiology, Department of Pathology, Clinical Laboratory Service, Emergency Department, Operating Room, Trauma Service, Education Department and Social/Rehabilitative Services.

In addition, provide an organizational chart(s) that specifically depicts the relationship of the trauma medical director, trauma program manager/trauma nurse coordinator, trauma registrar, RAC coordinator, etc., to each other and within the organizational structure. The chart(s) should clearly reflect the trauma director’s parameters of authority.

2. Describe any administrative changes at your facility that have impacted the trauma program since the last review. Not Applicable

(Insert Text Here)

3. Describe your hospital with respect to governance, as well as affiliations (with other hospitals, etc.).

(Insert Text Here)

4. Are all trauma activities within one facility? Yes  No   
If “No,” describe multi-facility relationships.

(Insert Text Here)

5. Has there been a resolution within the past three years supporting the trauma center by the hospital’s governing body? Yes  No   
If “Yes,” attach the resolution to this application.

(Insert Text Here)

6. Is there specific budgetary support for the trauma service? Yes  No   
If “Yes,” describe.

(Insert Text Here)

**Bed Information**

1. Please provide the following bed information.

Hospital Beds	Adult	Pediatric	Total
<b>Licensed</b>			
<b>Staffed</b>			
<b>Average Census</b>			

2. How many intensive care beds are routinely equipped and can be staffed for the care of multiply traumatized patients (i.e., including severe head injuries, post thoracotomy, pediatric patients, etc.)?

## II. PRE-HOSPITAL PROGRAM AND DISASTER PLANS

1. Describe your EMS system including primary and secondary catchment areas (geographic boundaries and population). Please provide an 8 ½" x 11" map of the primary and secondary catchment areas.

(Insert Text Here)

2. Identify the number and level of other trauma centers in your primary and secondary catchment areas and describe their relationships to your trauma center. (Use the previous or similar map for this.)

(Insert Text Here)

3. With whom does the day-to-day authority over EMS rest?  
 City     County     Region     State     Other

4. Define the "Air Medical" support services available in your primary and secondary catchment areas.

(Insert Text Here)

5. Do triage criteria exist for the use of helicopters for scene response in your service area?  
Yes     No

If "Yes," please provide a copy of this document.

6. Describe the EMS providers that serve your facility (i.e., level of care, primarily paid, volunteer, etc.), their governing body and medical leadership.

(Insert Text Here)

7. Does your trauma center provide online medical control to EMS providers?  
Yes     No

Please explain.

(Insert Text Here)

8. Describe your hospital's participation in the regional disaster plan.

(Insert Text Here)

9. Describe your hospital's capability to respond to hazardous materials (radioactive, chemical, biological, and other).

(Insert Text Here)

## III. TRAUMA SERVICE

**History** (Note: it may help to read through the questions that follow to avoid duplication.)

1. Provide a description on the history of your trauma service, (i.e., initial designation, growth of service, etc.). Be sure to address how the trauma medical director oversees all aspects of the multidisciplinary care from the time of injury through discharge.

(Insert Text Here)

2. Provide a map and short narrative (behind this page) defining your institution's primary catchment area for trauma patients.

(Insert Text Here)

3. How does your institution guarantee (i.e., with respect to ability to pay) access to care for the trauma patients?

(Insert Text Here)

**Personnel**

1. Please provide names for all the following that apply and attach a copy of their job descriptions and curricula vitae:

Trauma Service Medical Director \_\_\_\_\_

Trauma Program Manager \_\_\_\_\_

Trauma Nurse Coordinator \_\_\_\_\_

Trauma Registrar(s) \_\_\_\_\_

RAC Coordinator (Level I and II only) \_\_\_\_\_

2. There are \_\_\_\_\_ (#) practicing general surgeons on staff at the hospital. Of these, \_\_\_\_\_ (#) are routinely taking call for the trauma service.

3. Does the Medical Staff Credentialing Committee and/or Department of Surgery specify privileges for the attending general surgeons covering the Trauma Service?

Yes

No

If "Yes," provide documentation.

4. Provide a description of the procedure for removing physicians from the trauma call panel. For example, does the trauma director have the authority to remove members from/appoint members to the trauma panel?

(Insert Text Here)

5. Please provide documentation that specifies the continuing education policy for physicians who serve on the trauma service.

(Insert Text Here)

**Trauma Medical Director**

1. Does the Trauma Medical Director, in addition to being a board certified general surgeon, meet the following?

- a. Have a minimum of three year's clinical experience on a trauma service or have trauma fellowship training? Yes  No

Please provide details:

(Insert Text Here)

- b. Serve on the center's trauma service? Yes  No

- c. Participate in providing care to patients with life-threatening or urgent injuries?

Yes  No

- d. Participate in the North Carolina Chapter of the American College of Surgeons' (ACS) Committee on Trauma, as well as participate in other regional and national trauma organizations?  
Yes  No

Membership in N.C. Committee on Trauma since what year? \_\_\_\_\_

- e. Not only remain a current provider in the ACS' Advanced Trauma Life Support Course, but in the provision of trauma-related instruction to other health care personnel?  
Yes  No

Please provide details:

(Insert Text Here)

- f. If at a Level I, remain actively involved with trauma research and the publication of results and presentations?  
Yes  No  N/A

Please provide details:

(Insert Text Here)

- 2. Does the trauma medical director review the performance of the members on the trauma panel annually?  
Yes  No

**Other Surgeons on Trauma Call Panel**

- 1. Do any of the other surgeons who participate on the trauma call panel have any other specialized trauma training (i.e., a fellowship in trauma; previous experience as a director/member of a trauma service at other designated trauma center(s); military experience, etc.)?  
Yes  No

If "Yes," please specify name of individual and type of training.

(Insert Text Here)

- 2. Please list all surgeons taking trauma call on Table A entitled "Trauma Surgeons" (located at the end of this document).
- 3. Do you have a general surgery residency program?  
Yes  No  N/A   
If "Yes," please list all your residents in general surgery on Table B entitled "General Surgery Residents" (located at the end of this document).

**Trauma Program Manager/Trauma Nurse Coordinator**

- 1. Is the hospital's trauma program manager full-time?  
Yes  No

If "No," please specify percentage of time devoted to trauma program activities.

- 2. Is this individual a Registered Nurse?  
Yes  No

- 3. Describe the administrative reporting structure for this individual.

(Insert Text Here)

- 4. List this individual's support personnel (names, titles, and if FTEs)

(Insert Text Here)

- Provide documentation to verify that the trauma program manager/nurse coordinator completed twenty contact hours in trauma-related continuing education (beyond in-house in-services) during the last two year cycle (please specify). A list of courses, etc. with dates and hours will suffice. A review of the CME certificates may be requested at the time of the visit.

(Insert Text Here)

**Trauma Registrar**

- Is the hospital’s trauma registrar designated as full-time? Yes  No

If “No,” please specify percentage of time devoted to registry activities

- Provide documentation to verify that the trauma registrar has completed sixteen hours of trauma registry related or trauma-related continuing education during the last two year cycle (please define). A list of courses, etc. with dates and hours will suffice.

(Insert Text Here)

**Mid-Level Practitioners** (physician assistants and nurse practitioners)

- Please provide documentation from Department of Surgery as to credentialing process/criteria for any mid-level practitioners.

Don’t use mid-level practitioners on trauma service

(Insert Text Here)

- Mid-level practitioners routinely caring for trauma patients must have a minimum of sixteen hours of trauma-related continuing education every two-years. Please provide documentation of compliance for the last two-year cycle (please define) for each of these individuals. A review of the CME certificates may be requested at the time of the visit.

(Insert Text Here)

**Nursing Staff**

- Specify those units that are required by your institution to meet the nursing continuing education requirement (i.e., for RNs and LPNs, a minimum of sixteen hours per two years in continuing education related to trauma care). At a minimum, this must include the transport program, ED, primary ICUs and trauma floors. Specify, for each unit, the percent of compliance with the requirement for the last two-year cycle (please define). If an individual was not employed for the entire two year cycle, compliance should be determined by considering pro-rating for the months employed (i.e., 1 yr. = 8 contact hours).

UNIT	% COMPLIANCE


2. In an appendix (please specify), provide specific documentation of the above. At a minimum, for each unit, this must include the nurses' names, cycle periods, plus the hours for the previous and current cycle. A review of the CME certificates may be requested at the time of the visit.
3. Please provide a copy of the policy requiring the nursing staff to meet the above referenced continuing education requirements.

**Trauma Service , Policies & Procedures**

This section is devoted to numerous system issues and to further ascertaining how well the trauma care team and institution respond to the needs of the multiply traumatized patient. Of particular importance is the documentation of policies or procedures indicating that the institution places priority on the resuscitation and intensive management of the trauma patient. If you have included an answer as part of the response to a previous question, simply specify where the answer was previously addressed. Reference to attached sections of your trauma manual is also acceptable.

The same 12-month reporting period shall be used consistently from this point forward. Indicate the reporting period in a mm/dd/yy format: From / / to / /

**Trauma Response**

1. Provide the policy, procedure and/or algorithm that describes the protocol for alerting and mobilizing trauma team personnel and other on-call specialists for all tiers of trauma. The following information must be addressed:
  - a. What criteria are used to activate the trauma team, being sure to address criteria for prompt surgical evaluations and prompt surgical consults;
  - b. Who has the authority to activate the trauma team;
  - c. Are there multi-levels of response, if so, describe;
  - d. Who comprises the trauma team and the individual responsibilities of each team member, being sure to describe those on the team for each level of activation;
  - e. Who provides primary airway management;
  - f. If the above airway support is not provided by an anesthesia attending, how anesthesia is alerted to respond if needed;
  - g. The criteria utilized to determine when a trauma surgeon should respond to the emergency department to assess and resuscitate a trauma patient, and
  - h. Response times for team members, being sure to specify what constitutes promptly available, as for orthopedic and neurosurgical consults, with the understanding that these times establish the basis for monitoring compliance via the hospital's Performance Improvement Program.
2. For the reporting period, what number and percentage of trauma activations were highest level, modified level, and consult level (or specify using hospital's specific tiers).

(Insert Text Here)
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3. Does the hospital maintain separate call schedules for trauma and for general surgery?
 

Yes 
No

If "No," please explain.

(Insert Text Here)

4. Is a surgeon on the trauma team ever listed simultaneously on the trauma and general surgery schedule? Yes  No

If "Yes" and a Level I or II applicant, please describe how back up is guaranteed. N/A

(Insert Text Here)

5. Is the surgeon ever simultaneously on-call at more than one hospital? Yes  No

If "Yes," whether a Level I, II or III applicant, please describe how back up is guaranteed.

(Insert Text Here)

6. Provide documentation that indicates the trauma director has specified the specific credentials that each back-up surgeon must have.

(Insert Text Here)

**Initial Evaluation and Treatment**

1. Is evaluation and treatment of a trauma patient started by a trauma team that includes, at a minimum, a PGY4 or senior general surgical resident who is a member of the hospital's surgical residency program? Yes  No  N/A

2. Do you have a protocol manual for trauma? Yes  No

If "Yes," have available at time of visit.

3. Are there standard written protocols that are routinely updated with respect to trauma care management? Yes  No

If "Yes," please attach copies (or if trauma manual is provided, refer to section).

Who is responsible for updating these protocols?

(Insert Text Here)

4. How does the trauma service know who gets admitted to make sure each patient is picked up by the service?

(Insert Text Here)

5. Are all the hospital's multiply traumatized patients admitted to the trauma service? Yes  No

If "No," please explain. Be sure to address the situation, for example, where a patient arrives with a multiple system injury (i.e., with a ruptured spleen, severe head injury, and orthopedic problems). In this instance, who is in charge of the patient's care at admission and through discharge?

(Insert Text Here)

6. If your trauma system allows for the routine transport (from the scene or trauma center) of injured patients to an affiliated hospital, describe the criteria for this to occur. N/A

(Insert Text Here)

**Trauma Diversion**

1. Do you have a trauma diversion protocol? Yes  No   
 If "Yes," please attach it.  
 If "Yes," who has the authority to divert?

(Insert Text Here)

2. Identify frequency and reasons for diversion of trauma patients from the scene (to include while en route) by either air or ground transport during the 12-month reporting period.

(Insert Text Here)

For the same period, identify frequency and reasons for diversion of trauma patients from a referring hospital.

(Insert Text Here)

**Trauma Transfers**

1. With respect to trauma patients being transported from the scene by pre-hospital providers, do triage criteria exist in your primary service area that call for bypassing local community hospitals? Yes  No   
 If "Yes," provide a copy of this document.

2. Is there a defined policy to accept the transfer of trauma patients from referring hospitals? Yes  No

3. Describe the factors considered in the decision as to whether a trauma patient should/should not be transferred from a referring facility.

(Insert Text Here)

4. Who can accept incoming trauma transfers and how is this information then relayed to the trauma team?

(Insert Text Here)

5. If available, specify the number of trauma transfers in the specified reporting period.

TRANSFERS*	AIR	GROUND	TOTAL
Transfers In			
Transfers Out			

\* If a mixed transfer (for example, 1<sup>st</sup> ground and then air, report final method of transport. Air refers to both helicopter and fixed wing.)

6. Are there any formal agreements for transfer out of the hospital for acute injury management?  
 Yes  No

If "Yes", please list agreements.

(Insert Text Here)

7. With respect to the pre-hospital phase of care, describe what parameters (i.e., physiologic, anatomic, mechanism of injury, etc.) the hospital uses in determining whether to activate the trauma team.

(Insert Text Here)

**IV. HOSPITAL AND TRAUMA STATISTICAL DATA**

1. How many Emergency Department visits (including DOA and ED deaths) did your facility have in its reporting period?  
 Number
2. Total number of trauma ED visits for the reporting period including DOA and ED deaths, but excluding those patients who were treated and released.  
 Number
3. Trauma Admissions (not to include DOA and ED deaths)

Service	Number of Admissions
Trauma Service ((to include burn)	
Orthopaedic Service	
Neurosurgical Service	
Other Surgical Service *	
Non-Surgical Service **	
Total Trauma Admissions	

\*Other surgical would usually include cardio thoracic, ENT, general surgery, hand, ophthalmology, oral, pediatrics, plastics, urology, vascular, etc.

\*\*Non-Surgical would usually include cardiology, medicine, Ob-gyn, pediatrics, psychiatry, and other

<input type="text"/> % Blunt	<input type="text"/> % Penetrating
<input type="text"/> % Burns	<input type="text"/> % Not Available

4. Final Disposition from ED

Disposition	Total Number	Admitted to Trauma Service
ED to OR		
ED to ICU *		
ED to Floor **		
ED to Radiology***		
Transfer to another Hospital		
Death in ED		
Home (if collected)		
DOA		
<b>Total</b>		

\* to include burn units within same hospital  
 \*\* to include labor and delivery, step-down and telemetry  
 \*\*\* only to be used if final disposition is not known upon discharge from ED

5. Injury Severity and Mortality (for admissions only)

ISS	Number	Deaths	%Mortality
1-9			
10-15			
16-24			
≥ 25			

- a. Explain any inconsistency between total admissions, total disposition from ED and total ISS numbers.

- b. If you are a Level III or applying for Level III designation, are you routinely collecting ISS scores from your Level I and/or II that you transfer trauma patients to?  
 Yes  No  N/A

**V. DEPARTMENTS/DIVISIONS/SERVICES/SECTIONS OF THE HOSPITAL**

Indicate to the right of each specialty listing whether the specialty is present at your hospital and provide the name of the designated chair or physician liaison to the trauma program:

			<u>Name</u>
Anesthesiology	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Emergency Medicine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
General Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Neurologic Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Orthopedic Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

**Specialty Availability**

Do the following specialists maintain staff in-house 24-hours a day?

**SURGICAL SPECIALTIES**

General Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neurologic Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthopedic Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**NONSURGICAL SPECIALTIES**

Anesthesiology	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emergency Medicine	Yes <input type="checkbox"/>	No <input type="checkbox"/>

The following sections on General Surgery, Neurologic Surgery, Orthopaedic Surgery and Anesthesiology are a follow-up to the section above.

**General Surgery**

1. Specify whether surgery residents comprise any part of the above general surgery coverage. What level of surgery resident is on-call and, if residents are utilized, is a surgery staff specialist still available in-house or on-call? N/A

(Insert Text Here)

2. Do you have documentation and statistics of trauma surgeons' availability/response to the ED for Level 1 trauma alerts? Yes  No

If "Yes," please provide a summary document (using a code, versus a name, for each surgeon) for 12-month reporting period on their arrival times. At a minimum, specify how often each surgeon arrived in 20 minutes or less, from 21-30, 31-40 and after 40 minutes.

(Insert Text Here)

**Neurologic Surgery**

1. An attending neurosurgeon must be promptly available (as defined by the hospital's trauma system) to the hospital's trauma service. How is the in-house requirement being fulfilled?
- a)  An in-house attending neurosurgeon
  - b)  An in-house neurosurgery resident (PGY2 or higher); or
  - c)  An in-house trauma surgeon or emergency physician

If (c) was chosen, does the hospital have documented policies and protocols for the early management of neurosurgical emergencies and annual continuing education in the management of neurosurgical emergencies for these physicians? Yes  No

If "Yes", please provide copies of policies and/or protocols.

2. Is there a written document that defines what constitutes a neurosurgical emergency? Yes  No

If "Yes" to the above, please enclose a copy.

If "Yes", does this document also include what constitutes promptly available and immediately available for neurosurgical emergencies? Yes  No

3. Is the neurosurgeon ever simultaneously on call at a hospital other than the trauma center? Yes  No

If "Yes," is this ever a Level I or II trauma center? Yes  No

If "Yes" on call at another hospital, is there always a specified backup on a published call schedule? Yes  No

4. Please list all neurosurgeons taking trauma call on Table (C) entitled "Neurosurgeons" located at the end of this document. N/A

**Orthopedic Surgery**

1. For Level I/II centers, an attending orthopedist must be promptly available (as defined by the hospital's trauma system) to the hospital's trauma service. How is the in-house requirement being fulfilled?  
N/A

- a)  An in-house attending orthopedic surgeon  
b)  An in-house orthopedic resident (PGY2 or higher); or  
c)  An in-house trauma surgeon or emergency physician.

If (c) was chosen, does the hospital have documented policies and protocols for the early management of orthopedic emergencies and annual continuing education in the management of orthopedic emergencies for these physicians? Yes  No

If "Yes," please provide copies of policies and/or protocols.

2. For Level I/II centers, is there a written document that defines what constitutes an orthopedic emergency? Yes  No  N/A

If "Yes," please provide a copy.

If "Yes", does this document also include what constitutes promptly available and immediately available for orthopedic emergencies? Yes  No

If "No," please explain.

(Insert Text Here)

3. For Level I/II centers, is the orthopedist ever simultaneously on call at a hospital other than the trauma center? Yes  No  N/A

If "Yes," is this ever a Level I or II trauma center? Yes  No

If "Yes" on call at another hospital, is there always a specified backup on a published call schedule? Yes  No

4. Please list all your orthopedists taking trauma call on Table (D) entitled "Orthopaedic Surgeons" located at the end of this document. N/A

**Anesthesiology**

1. Specify whether residents and/or CRNA's comprise any part of the anesthesiology coverage specified at the beginning of this Specialty Availability section.

(Insert Text Here)

2. Are CRNAs in-house twenty-four hours per day? Yes  No

3. If utilizing anesthesiology residents to meet the requirement for anesthesiology coverage in-house 24-hours a day, are all these at least Clinical Anesthesiology Year 3 residents? Yes  No  N/A

4. When must a staff anesthesiologist be in-house? When is a staff anesthesiologist called/in attendance if a resident or CRNA is providing the coverage? What are the required response times in these cases?

(Insert Text Here)

5. If your facility does not have, at a minimum, CRNA's in-house 24 hours per day, explain how emergency airway stabilization (and the possible administration of anesthetic/paralytic agents) will be accomplished prior to the arrival of a representative from anesthesia.

(Insert Text Here)

### **Other Specialties**

Indicate whether the following specialties, at all times, have specialists on-call and promptly available (with a posted on-call schedule) if requested by the trauma team leader:

	<u>YES</u>	<u>NO</u>
Cardiac Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care*	<input type="checkbox"/>	<input type="checkbox"/>
Hand Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Microvascular/replant surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Neurosurgery**	<input type="checkbox"/>	<input type="checkbox"/>
Obstetric/Gynecologic Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmic Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Oral/Maxillofacial Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedics*	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Plastic Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Radiology*	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Urologic Surgery*	<input type="checkbox"/>	<input type="checkbox"/>

\*If a hospital does not have this particular specialist available and it is a desirable (versus essential) requirement, then there must be a written transfer agreement in place that specifies how this care will be rendered. The agreement must specify which patients are to be transferred; which hospitals patients may be transferred to; the method of transfer; and how long a patient will remain at the referring facility before transfer.

\*\*Note: If <25 neurosurgical operations are done in year and the neurosurgeon is dedicated only to one hospital, then a published back-up call list is not necessary.

## VI. HOSPITAL FACILITIES/RESOURCES/CAPABILITIES

### Emergency Department

1. How many Emergency Department rooms are specially designed and fitted for the treatment of multiply traumatized or hypovolemic patients?
2. If one exists, attach a copy of the ED trauma flow sheet. N/A

### Emergency Department Personnel

1. Name the designated physician director of the emergency department: \_\_\_\_\_
2. Is the designated physician director of the emergency department board certified in Emergency Medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine? Yes  No

If "No," please specify physician's board certification.

(Insert Text Here)

3. Describe the attending coverage in the emergency department (i.e., multiple physician coverage during peak hours, etc.)

(Insert Text Here)

4. If a Level I center, is at least one physician on every shift in the ED either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine)? Note: Emergency physicians caring only for pediatric patients may, as an alternative, be boarded in pediatric emergency medicine. Yes  No  N/A

If "Yes," is this individual always a designated member of the trauma team at least until the arrival of the trauma surgeon? Yes  No

5. If a Level II or III center, is an emergency medicine attending (who is either board certified or prepared in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice or American Board of Internal Medicine and practices Emergency Medicine as his primary specialty always a designated member of the trauma team? Yes  No  N/A
6. If there is ever a sole emergency department physician in the ED, does he/she have clinical responsibilities outside of the emergency department while on call? Yes  No  N/A

If "Yes," explain how the ED is covered when he/she leaves.

(Insert Text Here)

7. Please list all your emergency physicians who serve the trauma service on Table E entitled "Emergency Physicians" located at the end of this document.
8. Does your facility have Emergency Medicine Residents? Yes  No

If "Yes," please complete Table F entitled "Emergency Medicine Residents," located at the end of this document.

9. If your facility has Emergency Medicine Residents, are there instances where an emergency department Resident responds to a trauma team call without immediate supervision by an attending emergency physician? Yes  No  N/A   
 If "Yes," please explain. What level of Emergency Medicine Resident is acting in this capacity?

(Insert Text Here)

10. With respect to the nursing staff, please indicate the following:

List the members of the nursing staff for the highest trauma activation level and describe their roles.

RN Staff Member Title	Role Description

11. What percentage of the ED Nurses have passed the following?

Course Name	%
TNCC provider course	
TNCC instructor course	
ACLS provider course	
ACLS instructor course	

12. What percentage have passed or have certifications/credentials for the following?

Certification/Credential	%
ATLS (audit)	
BTLS	
CATN	
CCRN	
CEN	
ENPC	
MICN	
NC SANE	
PALS	
PEPP	
PHTLS	
OTHER (specify):	

**Emergency Department Equipment**

Please indicate whether the following capabilities or items of equipment are available in the emergency department for patients of all ages:

1. Airway control and ventilation equipment (including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitators, pocket masks, and sources of oxygen) Yes  No
2. Pulse oximetry Yes  No

- |     |  |                              |                             |
|-----|--|------------------------------|-----------------------------|
| 3.  | End-tidal CO <sub>2</sub> determination equipment  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4.  | Suction devices  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5.  | Electrocardiograph-oscilloscope-defibrillator w/internal paddles   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6.  | Apparatus to establish central venous pressure monitoring  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7.  | All standard intravenous fluids and administration devices, including large-bore intravenous catheters and intraosseous infusion devices | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8.  | Sterile surgical sets for:   |                              |                             |
|     | Airway control/cricothyrotomy  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|     | Thoracotomy  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|     | Vascular access  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|     | Thoracostomy   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|     | Peritoneal lavage  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|     | Central line insertion   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9.  | Apparatus for gastric decompression  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. | X-ray availability, 24-hours a day   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. | Two-way communication equipment for communication with emergency transport system  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. | Skeletal traction devices, including capability for cervical traction  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. | Arterial catheters   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 14. | Thermal control equipment (e.g., warming blankets, lights, etc.):  |                              |                             |
|     | a) for patients  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|     | b) for blood and fluids  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15. | Rapid infuser system   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 16. | Broselow tape  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 17. | Sonography   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18. | Doppler  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**Operating Suite Requirements**

- |    |  |                              |                             |
|----|--|------------------------------|-----------------------------|
| 1. | Please indicate if the following items are available for the operating suite for patients of all ages: |                              |                             |
| a. | Cardiopulmonary bypass capability  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. | Operating microscope   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. | Thermal control equipment (e.g., warming blankets, lights, etc.):                                      |                              |                             |
|    | a) for patients  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|    | b) for blood and fluids  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. | X-ray capability (including c-arm image intensifier) available 24-hours per day                        |                              |                             |

- e. Endoscopes and bronchoscopes Yes  No
- f. Craniotomy instruments Yes  No
- g. Capability of fixation of long-bone and pelvic fractures Yes  No
- h. Rapid infuser system Yes  No

2. How many operating room teams do you have available during the day, at night and on weekends? What is their response time? Are they in-house or on-call? Please indicate below:

SHIFT	# OF TEAMS	RESPONSE TIME	IN-HOUSE	ON-CALL

3. Who comprises these teams?

(Insert Text Here)

4. For a Level I and II center, an operating suite is to be immediately available 24-hours/day with 24-hour/day immediate availability of in-house staffing. A Level III center must have personnel available 24-hours/day, on-call within 30 minutes of notification unless in-house.

What happens during the day if all the operating rooms are tied up and a multiply traumatized patient arrives at the hospital? What is your policy for freeing up an operating room in this situation?

Provide documentation if available.

(Insert Text Here)

**Post anesthesia Care Unit (PACU):**

1. Is there any time when the surgical intensive care unit is utilized for recovery rather than the PACU? Yes  No  N/A

If "Yes," please explain.

(Insert Text Here)

2. Please indicate the existence of the following in the PACU:

a. Registered nurses in house 24-hours a day Yes  No

If "No," are these individuals on call and available within 30 minutes from inside or outside the hospital? Yes  No

b. Capability for resuscitation and continuous monitoring of temperature, hemodynamic, and gas exchange Yes  No

- c. Capability for continuous monitoring of intracranial pressure      Yes       No
- d. Pulse oximetry      Yes       No
- e. End-tidal CO<sub>2</sub> determination capability      Yes       No
- f. Thermal control equipment
  - a) for patients      Yes       No
  - b) for blood and fluids      Yes       No

**Intensive Care Units**

**ICU Personnel**

1. What are the names of the designated Medical Directors for the primary trauma intensive care units and what are the names of these units?

Medical Director	Unit

2. Which physician specialist maintains primary responsibility for the direction of trauma patients' care in the ICU? (Specify one.)
- Surgeon
  - ICU intensivist
  - Other (please explain)

3. Is a physician on duty in the ICU 24-hours a day?      Yes       No

If "No," is a physician immediately available to the ICU from in-house 24-hours a day?      Yes       No

If "No," how are emergencies in the ICU handled?

(Insert Text Here)
--------------------

If "Yes," is this individual responding from the ED?      Yes       No

If the physician is responding to the ICU from the ED, does this ever leave the ED without a physician (i.e., is the physician responding to the ICU sometimes the sole physician in charge in the ED)?      Yes       No       N/A

4. Is the nurse-patient ratio (excluding administrative staff) for trauma patients at least 1:2 or better on each shift in the ICU?      Yes       No
5. Do you ever use nurses in the ICU who are hired temporarily from an outside agency?      Yes       No

If "Yes," please explain frequency of use and training requirements.

(Insert Text Here)
--------------------

6. Of the nurses who work in the intensive care units and care for trauma patients, what percentage have passed or have certification/credentialing in the following?

Certification/Credential	%
ACLS	
ATLS (audit)	
CATN	
CCRN	
ENPC	
PALS	
TNCC	
OTHER (specify):	

**ICU Equipment**

Are the following capabilities or items of equipment routinely available in the ICU for patients of all ages?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators and pocket masks)   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Oxygen source with concentration controls   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Cardiac emergency cart  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Temporary transvenous pacemaker   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Electrocardiograph-oscilloscope-defibrillator   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ◆ with internal paddles  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Cardiac output monitoring capability  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Electronic pressure monitoring capability   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Mechanical ventilator   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Patient weighing devices  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Pulmonary function measuring devices   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. Temperature control devices  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. Intracranial pressure monitoring devices   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. Within 30 minutes of request, the ability to perform blood gas measurements, hematocrit level, and chest x-ray studies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**Radiological Capabilities**

1. Does the hospital provide the following?

- a. Level I and II: 24-hour-per-day in-house radiology technologist Yes  No  N/A   
 Level III: radiology technologist available within 30 minutes of notification Yes  No  N/A   
 Level III: documentation that procedures are available within 30 minutes Yes  No  N/A
- b. Level I and II: 24-hour-per-day in-house computerized tomography technologist Yes  No  N/A   
 Level III: CT technologist available within 30 minutes of notification Yes  No  N/A
- c. Sonography Yes  No
- d. Computed tomography Yes  No
- e. Angiography Yes  No
- f. Magnetic Resonance Imaging Yes  No
- g. Resuscitation equipment to include airway management and IV therapy Yes  No
2. What priority is given to trauma patients needing X-rays? Attach documentation of any policy relating to this matter.

(Insert Text Here)

3. Define how the trauma team has access to emergency computed tomography, arteriography, and MRI.

(Insert Text Here)

4. Define how the trauma team has access to ED ultrasound. (Please choose one)

- ED ultrasound is provided by the trauma surgeons and emergency physicians who have been trained in the FAST technique.  
 ED ultrasound is performed by the radiologists who are always available to provide this service.  
 Other (Please explain.)

(Insert Text Here)

5. Who interprets the radiographs after hours?

(Insert Text Here)

6. Is teleradiography available to augment the initial interpretations by a non-radiologist?

(Insert Text Here)

7. Who accompanies and monitors the trauma patient to the radiology suite?

(Insert Text Here)

**Blood Bank**

1. Is there a massive transfusion protocol to facilitate blood component therapy? Yes  No

How many transfusions are required to activate the protocol?

(Insert Text Here)

2. Do you have uncross-matched blood immediately available upon patient arrival? Yes  No

If "Yes," define mechanism.

(Insert Text Here)

3. What is the average turnaround time in minutes for an emergency?

	Minutes
Type specific blood	
Full cross matched	

4. Does your hospital have ready access to blood components (FFP, platelets cryoprecipitate, Factor VIII, and Factor IX)? Yes  No

**Clinical Laboratory Services**

1. Please indicate whether the following services or items are available to the emergency department and trauma service 24-hours a day:

- a. Standard analysis of blood, urine and other body fluids including micro-sampling when appropriate Yes  No
- b. Micro-sampling capabilities for children Yes  No
- c. Blood typing and cross-matching Yes  No
- d. Coagulation studies Yes  No
- e. Comprehensive blood bank or access to a community central blood bank with adequate storage facilities Yes  No
- f. Blood gases and pH determinations Yes  No
- g. Microbiology Yes  No

2. Please provide documentation of laboratory priority given to emergency department and ICU trauma patients.

(Insert Text Here)

3. Do the ED and ICU have priority access to clinical lab services 24-hours per day? Yes  No

4. Define circumstances under which you obtain drug screen/toxicology.

(Insert Text Here)

**Pharmacy Capability**

- Does the pharmacy have a pharmacist in-house 24-hours a day? Yes  No

If "No," please explain.

(Insert Text Here)

**Respiratory Therapy Availability**

Are respiratory therapists available 24-hours a day from in-house?

Yes

No

If "No," please explain.

(Insert Text Here)

**Hemodialysis Capability**

Describe the extent of hemodialysis capability for trauma patients (i.e., location, how many dialysis units are available, how many are mobile, for inpatient or outpatient usage, etc.). If patients leave the facility for dialysis, please specify if there is a written transfer agreement in place.

(Insert Text Here)

**Rehabilitation Medicine**

1. Describe the extent of your rehabilitative services (including physical, occupational and speech therapies) for trauma patients (including head and spinal cord injuries). Describe how the center ensures that major trauma patients have a functional assessment and recommendations regarding short and long-term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable.

(Insert Text Here)

2. Is there a physician-directed full in-house rehabilitation service equipped properly for the care of the rehabilitation patient? Yes  No  N/A
3. Do personnel trained in rehabilitative care of critically injured patients staff it? Yes  No  N/A
4. If no full in-house rehabilitation service, is there a written transfer agreement with a CARF accredited rehabilitative facility? Yes  No  N/A

If "Yes," please provide a copy of the agreement.

(Insert Text Here)

5. Describe the procedure that is followed to ensure that those patients requiring substance abuse evaluation and counseling are identified. N/A

(Insert Text Here)

6. Is substance abuse evaluation and counseling available in-house for patients requiring it?

Yes

No

If "No," please explain.

(Insert Text Here)

**Social Services**

1. Is there a dedicated social worker for the trauma service? Yes  No

If "No," what is the commitment from Social Services to the trauma patient?

(Insert Text Here)

2. Describe the support services available for crisis intervention and individual/family counseling.

(Insert Text Here)

**VII. SPECIALTY CARE SERVICES**

**Pediatric Trauma**

1. Define your pediatric population (by age).

(Insert Text Here)

2. Below, please specify the number of pediatric trauma admissions (not to include DOA & ED deaths) for the 12-month reporting period to your hospital. If these numbers are based upon a different pediatric age group than listed above, please indicate.

(Insert Text Here)

Service	Number of Admissions
Trauma Service	
Orthopaedic Service	
Neurosurgical Service	
Other Surgical Service	
Non-Surgical Service	
Total Trauma Admissions	

\*Other surgical would usually include cardio thoracic, ENT, general surgery, hand, ophthalmology, oral, pediatrics, plastics, urology, vascular, etc.

\*\*Non-Surgical would usually include cardiology, medicine, Ob-gyn, pediatrics, psychiatry, and other

3. Injury Severity and Mortality (for admissions only)

ISS category	Number	Deaths	% Mortality
1-9			
10-15			
16-24			
>25			

4. Are there separate pediatric resuscitation rooms in the ED? Yes  No

If "Yes," how many are there?

5. Is there a separate pediatric trauma team? Yes  No

If "Yes," please describe.

(Insert Text Here)

6. Is there a separate pediatric ICU? Yes  No
- a) Total pediatric ICU beds (exclude neonatal):
- b) If no PICU, is there a transfer agreement for PICU care? Yes  No
- c) Who is the director for the PICU and what is his/her training? N/A

7. Which physician specialist maintains primary responsibility for the direction of the pediatric trauma patient care in the PICU? (Specify one.) N/A
- Surgeon
- ICU intensivist
- Other (please explain)

8. What percent of your pediatric patients are transferred out and what criteria are utilized for this decision? Please have transfer agreements/protocols for pediatric patients available on site.

9. Is there pediatric resuscitation equipment in all patient care areas, where pediatric patients are treated or admitted? Yes  No

10. Describe, if applicable, the pediatric rehabilitation service. N/A

**Organized Burn Care**

1. Does your facility have a physician-directed burn center that is equipped properly for care of the extensively burned patient and staffed by nursing personnel trained in burn care? Yes  No

If "No," describe your institution's ability to care for burn patients. Include a statement on patient transfer policy and protocols for burns. Attach copies of signed transfer agreements and/or protocols.

2. Number of burn patients transferred for acute care during the 12-month reporting year:

In		Out	
----	--	-----	--

**Acute Spinal Cord/Head Injury Management Capability**

Describe your institution's ability to care for spinal cord and head injury patients. Include a statement on patient transfer policy and protocols for spinal cord care. Attach copies of signed transfer agreements and/or protocols.

## VIII. PERFORMANCE IMPROVEMENT (PI)

(Note: All PI programs are expected to comply with the “Performance Improvement Guidelines for North Carolina Trauma System” document. For the following questions, where appropriate, make sure you address pediatrics in your responses. For the site visit, have PI reports available on site. These must include examples of trend analysis, PI filters, and loop closure. Do not send any PI minutes, but these should also be available at the time of review.)

1. Describe your PI program including how issues are identified and tracked, selection of discretionary and non-discretionary filters, etc. Is your written PI plan integrated into the hospital's overall quality management program?

(Insert Text Here)

2. Who is responsible for loop closure of both system and peer review issues?

(Insert Text Here)

3. When resident physicians participate on the trauma team, does the hospital’s performance improvement program monitor the attending surgeon’s participation in the major therapeutic decisions and presence at operative procedures? Yes  No   
If “No,” please explain.

(Insert Text Here)

4. List several examples of trauma-related nursing PI activities that are nursing, trauma service or unit based.

(Insert Text Here)

5. Who is responsible for ensuring that these trauma-related nursing PI activities are carried out?

(Insert Text Here)

6. If an issue was identified through any of the above performance improvement activities, including trend analysis, how would resolution be reached or corrective action be taken? If specific procedures are followed for any of these, describe in detail.

(Insert Text Here)

### Trauma Registry

1. Please indicate your facility's degree of commitment and/or involvement in the statewide trauma registry (i.e., type and number of staff devoted to the registry, registry collection procedures, number of patients on registry, etc.).

(Insert Text Here)

2. Describe the criteria for patient entry into the trauma registry.

(Insert Text Here)

3. Describe the utilization of the trauma registry and its data to support your performance improvement activities.

(Insert Text Here)

4. If you are using any database program other than NTRACST<sup>™</sup> to support your PI program, please explain.

(Insert Text Here)

5. Do you have any state, regional, or national affiliation for your trauma registry beyond the NC Trauma Registry and NTDB™? Yes  No

If "Yes," please explain.

(Insert Text Here)

6. Which patients or data points, beyond those that are mandated by the state, are included in your trauma registry?

(Insert Text Here)

7. Are E-codes recorded on any or all of your trauma patients?

(Insert Text Here)

**Trauma Death Audits**

1. How many trauma deaths have there been during your 12-month reporting period? Include DOAs, ED deaths and in-house deaths?

DOA	
ED	
In-hospital (includes OR)	

2. Who reviews emergency department trauma deaths?

(Insert Text Here)

3. Are all trauma deaths reviewed by someone other than the trauma medical director and the trauma program manager/trauma nurse coordinator? Yes  No

Please describe the process.

(Insert Text Here)

Are any of these trauma deaths only reviewed by the attending of record and no other physician?

Yes  No

4. For the 12-month period you have been using, what percentage of your trauma deaths (including ED deaths, but not DOAs) have autopsies?

%  This is an estimate  Don't know

5. Provide a description of any committee with trauma PI involvement in Table (G) entitled "List of Performance Improvement Committees." Include system and peer review committees.

(Insert Text Here)

**IX. EDUCATIONAL ACTIVITIES/OUTREACH PROGRAMS**

1. Do you have a designated trauma outreach coordinator? Yes  No

2. How do you identify the outreach needs of your referral area?

(Insert Text Here)

3. Other than general surgery, do you have other specialty residency programs that routinely work in collaboration with the trauma program? Yes  No

If "Yes," list and define the relationship with trauma program.

(Insert Text Here)

4. Do you have a trauma fellowship? Yes  No

If "Yes," define which specialties.

(Insert Text Here)

5. Do you provide ATLS courses? Yes  No  N/A

6. Describe any trauma education programs for:

- a. Physicians
- b. Nurses
- c. Pre-hospital providers

(Insert Text Here)

7. Is there any hospital funding for physicians, nursing, or EMS trauma education? Yes  No

If "Yes," please describe.

(Insert Text Here)

8. Describe any other type of trauma outreach programs that you provide for health care professionals in the community and referring institutions (e.g., telephone and/or on-site consultations, as well as programs on accessing the center's resources and referring patients within the system).

(Insert Text Here)

9. What formal mechanisms have been established to provide referring institutions or healthcare professionals with information regarding definitive diagnosis, course of treatment, patient outcome, etc.?

(Insert Text Here)

10. Describe mechanisms or procedures for insuring the appropriateness of the advice that is rendered. For example, there might be established protocols, etc.

(Insert Text Here)

11. Describe the hospital's role in the development and/or maintenance of a Regional Advisory Committee (RAC).

(Insert Text Here)

12. Who is the designated injury prevention coordinator? \_\_\_\_\_

13. How do you identify the prevention/public education needs of your referral area?

(Insert Text Here)

14. List and briefly describe all injury prevention programs. Include any national, state or regional affiliations for your injury prevention programs.

(Insert Text Here)

15. Describe any epidemiology research to include studies in injury control, collaboration with other institutions on research, monitoring progress of prevention programs and consultation with qualified researchers on evaluation measures. N/A

(Insert Text Here)

16. If not addressed previously, provide an example(s) of trauma surveillance activities utilizing, for example, trauma registry data, field or emergency department data.

(Insert Text Here)

17. How do you monitor the progress and measure the effectiveness of prevention/public education programs?

(Insert Text Here)

**X. TRAUMA RESEARCH PROGRAM** N/A

(\*This section is mandatory for Level I applicants, but optional for Level II and III applicants.)

1. Do you have an identifiable institutional review board process? Yes  No

2. List a minimum of 10 peer reviewed trauma-related publications in the past three years. Please identify the number of trauma publications from general surgery, neurosurgery, orthopedic surgery, and emergency medicine during the past three years. Please do not send the articles themselves, although these materials should be available on-site if requested.

(Insert Text Here)

3. List a minimum of 12 trauma-related education/outreach presentations given outside your hospital in the last three years.

(Insert Text Here)

**XI. SUMMARY OF PROGRESS** (\*to be completed by renewal applicants only) N/A

Outline any significant progress that the trauma center has made with respect to trauma care since the last designation visit. No particular answer is necessarily being sought. It is an opportunity for the institution to provide any specific information that may not have been forthcoming within the context of the RFP. However, attention should be paid to any areas that were cited by the state as concerns during the facility's last review or since then.

(Insert Text Here)

**REQUIRED TABLES  
FOR  
COMPLETION**

# **APPENDICES**