Designation Criteria for Level IV Trauma Center

Criteria for designation are in place to verify the services and systems to ensure optimal care of the trauma patient. The following elements must be met for designation as a Level IV Trauma Center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve designation. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of designation is issued. During the following 12 months, if the trauma center successfully corrects the deficiencies, the period of designation will be extended to 3 years from the date of the initial verification visit. If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital may not be designated.

1. Trauma System	
Time Sensitive Emergencies (TSE)	
1.1 The center's trauma program staff has sufficient involvement in regional trauma system planning, development, and operation.	II
Center Mission	
1.2 There is a current resolution supporting the trauma center from the medical staff (See Trauma Toolkit).	II
1.3 There is a current resolution supporting the trauma center from the hospital board (See Trauma Toolkit).	II
1.4 There is sufficient infrastructure, staff, equipment, and support to the trauma program to provide adequate care.	I
2. Description of Trauma Center	
Description of the Trauma Center	
2.1 The trauma program is empowered to address issues that involve all applicable disciplines.	I
2.2 The center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care or admission.	II
Trauma Leadership	
Trauma Medical Director	
2.3 The trauma program has a Trauma Medical Director with the authority and administrative support to lead the program.	I
2.4 The Trauma Medical Director is current in Advanced Trauma Life Support (ATLS).	II
2.5 The Trauma Medical Director maintains personal involvement in patient care, staff education, and professional organizations.	II

2.6 The Trauma Medical Director must work with trauma team providers' (physicians and advanced practice providers) to ensure appropriate orientation, qualifications, and skill maintenance.	II
2.7 The Trauma Medical Director has the responsibility and authority to ensure compliance with designation requirements.	II
2.8 The Trauma Medical Director is accountable for all trauma care and exercises administrative authority for the trauma program.	I
2.9 The Trauma Medical Director participates in the Performance Improvement and Patient Safety (PIPS) program by attending at least 60% of meetings.	II
2.10 The PIPS program, comprised of at minimum the Trauma PI and Trauma Operations Committees, is chaired by the Trauma Medical Director or their designee. In the Trauma Medical Director's absence, a designee must be identified.	II
Trauma Program Manager	
2.11 The center has a Trauma Program Manager. The Trauma Program Manager shows evidence of educational preparation and clinical experience caring for injured patients.	II
2.12 The Trauma Program Manager is responsible for the use of trauma registry data for quality improvement and trauma education.	II
2.13 The Trauma Program Manager works with the Trauma Medical Director to address the multidisciplinary needs of the trauma program.	I
2.14 The Trauma Program Manager serves as a liaison to local Emergency Medical Services (EMS) agencies and referring/accepting centers.	II
3. Clinical Functions	
3.1 The criteria for graded activation must be clearly defined by the center and reviewed annually, with the highest level of activation including the seven required criteria listed in Table 1.	II
3.2 The center is staffed to ensure immediate and appropriate care to trauma patients during hours of operation.	I
3.3 The center must be able to provide the necessary human and physical resources to properly administer acute care consistent with ATLS.	II
3.4 The center must have written protocols outlining which types of trauma patients the facility is capable of providing inpatient services.	II
3.5 The center must be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers.	II
3.6 The center has established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient.	II
Trauma Team	
3.7 The team response to all trauma priority levels must be defined and reviewed annually.	II
3.8 All trauma/general surgeons, emergency physicians, and advanced practice providers who participate as a member of the Trauma Team have completed ATLS at least once and should remain current in ATLS.	II

3.9 Trauma Team members participate in both the Trauma PI and Trauma Operations Committees.	II
3.10 Trauma Team physicians and advanced practice providers are credentialed by the medical staff and governing board.	II
Emergency Department (ED)	
3.11 The physician or advanced practice provider will be in the Emergency Department (ED) on patient arrival for the highest level of activation, provided there is adequate notification from the prehospital providers. The maximum acceptable response time is 30 minutes from patient arrival in the ED. The PIPS program must demonstrate that the provider's presence is in compliance at least 80% of the time.	I
3.12 The center must have emergency coverage by a physician or advanced practice provider 24/7.	I
3.13 ED providers must have completed ATLS at least once.	II
3.14 Advanced practice providers who direct/lead the initial evaluation of trauma patients must maintain current ATLS certification.	II
3.15 The ED must evaluate its pediatric readiness and have a plan to address any deficiencies.	II
Collaborative Clinical Services	
Radiology	
3.16 Conventional radiography and CT services are available in-house 24/7 or on-call within 30 minutes. There is documentation by the PIPS program that technicians are available and delays are not occurring.	I
Other Surgical Specialists	
3.17 The center has a list of specialists who are promptly available from inside and outside of the center.	II
Laboratory	
3.18 Laboratory services are available 24/7 in-house or able to respond within 30 minutes for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate. The blood bank should be capable of blood typing and cross matching.	I
3.19 The center must have a transfusion protocol developed collaboratively between the trauma service and the blood bank.	I
3.20 The center must have a rapid reversal protocol in place for patients on anticoagulants.	II
Nutrition	
3.21 Nutrition support services are available.	II
Social Services	
3.22 The center has social services.	II
3.23 The center must screen all admitted trauma patients for alcohol misuse and provide a brief intervention if appropriate.	II

3.24 The center must have a protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider when required.	II
3.25 The center must have a process in place to assess pediatrics for nonaccidental trauma (NAT).	II
Additional Capabilities	
3.26 Centers offering services beyond those required for their level of designation must have a written plan for provision and monitoring of those services.	II
4. Prehospital Trauma Care	
4.1 The center collaborates with EMS agencies and provides feedback on patient care.	II
5. Interhospital Transfer	
5.1 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient.	II
5.2 There are transfer agreements in place with higher level trauma centers as well as specialty referral centers.	II
5.3 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.	II
5.4 The center must have guidelines addressing which patients should be transferred and the safe transport of those patients.	II
6. Process Improvement and Patient Safety (PIPS)	
6.1 The center must have a written and clearly defined PIPS plan that is updated annually. The program must ensure optimal care through continuous clinical review as well as operational procedures and must:	II
a. outline the organizational structure of the PIPS process;	
b. specify the processes of event identification;	
c. include audit filters;	
d. define levels of review; and	
e. specify the members of the PIPS Committee.	
6.2 The PIPS program is supported by a reliable method of internal data collection.	II
6.3 The PIPS program is, at minimum, comprised of two committees: Trauma Performance Improvement (PI) and Trauma Operations.	II
6.4 The Trauma PI Committee is a multidisciplinary committee that meets regularly to:	II
a. address patient care processes and outcomes;	
b. identify patient care opportunities for improvement; and	
c. reduce variability in care.	
6.5 The Trauma Operations Committee is a multidisciplinary committee that meets regularly to:	II
a. correct program deficiencies and optimize patient care;	
b. addresses system and processes issues; and	

c. includes all program-related services.	
6.6 The process of multidisciplinary review and analysis occurs at regular intervals to meet the needs of the program, takes attendance, and records minutes. All major disciplines within the center that are caring for trauma patients must be represented in the process.	II
6.7 The process demonstrates effective use of audit filters, problem identification, analysis, proposed corrective actions, resolution, and loop closure.	II
6.8 All trauma team activations must be categorized by priority of response and reported by number and percentage of total trauma patients.	II
6.9 The PIPS program must use evidence-based clinical practice guidelines and protocols.	II
6.10 Deaths are categorized as mortality with opportunity for improvement or mortality without opportunity for improvement.	II
6.11 The center must work with sending and receiving facilities to provide and obtain feedback on transferred patients.	II
6.12 The center must work with EMS agencies to provide and obtain feedback on transported patients.	II
6.13 The center must have a diversion policy that provides notification for dispatch centers and EMS agencies when on divert and must track the occurrence of diversions.	II
6.14 The PIPS program must review the following metrics to ensure appropriateness of care, rationale, adverse outcomes, and identify opportunities for improvement:	II
a. delay of timely access to care, equipment, or interventions in all care areas;	
b. admissions;	
c. transfers;	
d. non-surgical services (NSS) with a goal of <10%; and	
e. over/under triage.	
6.15 There must be at least 0.5 FTE dedicated Performance Improvement (PI) personnel when the volume of registry patient entries exceeds 500 patients. When annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.	II
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8. Time Sensitive Emergency (TSE) Registry	
8.1 Data is submitted to the Idaho TSE Registry per Idaho Code 46-920. At least 80% of cases are submitted within 180 days of hospital discharge.	I
8.2 There is a process in place to verify that TSE Registry data is accurate and valid.	II
8.3 The trauma program ensures that registry data confidentiality measures are in place.	II
9. Outreach & Education	
9.1 The center is engaged in trauma-related public outreach and education.	II
9.2 The center provides a mechanism for trauma-related education for clinical staff involved in trauma care.	II

10. Prevention	
10.1 The center participates in traumatic injury prevention and bases activities on local data. It is recommended to have a fall prevention program, but not required.	II
10.2 The center must have someone in a leadership position that has injury prevention as part of their job description.	II
11. Disaster Planning and Management	
11.1 The center has a disaster plan described in its Disaster Manual.	II
11.2 The Trauma Medical Director is a member of the center's disaster committee.	II
11.3 The center must participate in regional disaster management plans and exercises.	II
12. Organ Procurement	
12.1 The center has written protocols for declaration of brain death.	II