Kentucky Trauma Care System

 **Hospital Application for**Level IV Verification and Kentucky Designation
as a Trauma Center

**[ ] Initial Verification and Designation
[ ] Re-Verification and Designation**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Facility

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application date

[ALL APPLICATIONS REQUIRING A SITE VISIT]
[Look at dates at least 4 weeks out from the application date.]

Suggested dates for Level IV Site Visit: (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suggested dates for Level IV Site Visit: (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suggested dates for Level IV Site Visit: (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Kentucky Cabinet for Health and Family Services
Department for Public Health
Commissioner, Department for Public Health
ATTN: Trauma Advisory Committee**

**Questions:**

Commissioner’s Office

275 E. Main Street, Mail Stop HS1GWA or
Frankfort, KY 40621
(502) 564-3970

Richard Bartlett (rbartlett@kyha.com)
Emergency Preparedness/Trauma Coordinator
KY Hospital Association
(502) 426-6220

**Instructions**

The complete application package consists of:

1. Application, completed and signed
2. A copy of the completed Pre-Review Questionnaire (PRQ)
3. An official hospital check in the amount shown required by 902 KAR 28:060 to cover both the Initial Verification/Designation OR Re-Verification/Designation Application Fee, and the projected cost for the KyTAC verification site visit.

Note that some questions will need to be answered on the PRQ,
and some materials will need to be assembled and available for review during the site visit.

The Kentucky Trauma Hospital Reference Manual, available on the Kentucky Trauma Care System section of the Kentucky Hospital Association website at <http://www.kyha.com>, is listed as a reference for completing this application and verification process.

Contact the Trauma Coordinator at KHA listed on the title page of this document for assistance or if you have questions while completing this application.

When you have completed the application:

1. Make a copy of the application and attachments for your records;
2. Enclose an official hospital check in the amount required by 902 KAR 28:060 to cover both the Initial Verification/Designation OR Re-Verification/Designation Application Fee, and the projected cost for the KyTAC verification site visit; and
3. Mail the application package to

**Kentucky Cabinet for Health and Family Services
Commissioner, Department for Public Health
ATTN: Kentucky Trauma Advisory Committee
275 E. Main Street HS1GWA
Frankfort, KY 40621**

Upon receipt of your application and the appropriate fee, the package will be reviewed for completeness. The Kentucky Trauma Advisory Committee (KyTAC) will then schedule a site visit to assess if the essential criteria have been met. They will review the site team's findings and forward their recommendation to the Commissioner of the Department for Public Health for final approval and designation.

If the KyTAC determines that deficiencies prohibiting designation exist in your facility, you will be contacted in writing and provided with a detailed description of how to remedy the deficiencies along with a time line to do so.

KENTUCKY LEVEL IV TRAUMA SYSTEM

**Demographic and facility contact information**

Facility's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility's *Physical* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Facility's Mailing Address (if different) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

\*Facility's main switchboard number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Preparedness Program planning region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*24 hour switchboard number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*24-hour monitored fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This fax is located at: [ ]ED [ ]Switchboard [ ]Admin [ ]Lab [ ]Other:\_\_\_\_\_\_\_\_\_\_\_\_

\*24 hour direct ED number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*24 hour direct ED FAX number (if not shown above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*** Are any of these numbers on the FCC's Telephone Service Priority (TSP) list for priority restoration?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(The following information is useful for directing helicopter and out-of-town resources to your location, especially if normal reference markers/signs are destroyed by disaster.)

Facility's latitude and longitude: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ W

(If there is a helipad or landing zone outside the ED, use the lat/long for center of LZ.)
(Facility lat/long info is also displayed on FCC license for hospital ED radio equipment.)
(If you cannot get this information, leave it blank.)

[Initial verification]

The facility started its trauma operation and data collection for purposes of this verification on:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date)

The facility is using this trauma software: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The facility [ ] has or [ ] has not been submitting data to the Kentucky Trauma Registry.

The facility [ ] has or [ ] has not been submitting data to NTDB.

As of this application, the facility's trauma register has \_\_\_\_\_\_\_\_\_\_\_ cases entered.

Who enters the data into the trauma registry? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KEY Personnel contact information**

Name of Chief Executive Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Contact Number for the Chief Executive Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of President of the Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if not at the hospital):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail for the President of the Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Trauma Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of the Trauma Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number of the Trauma Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After-Hours Contact Number of the Trauma Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail of the Trauma Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Trauma Services Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of the Trauma Services Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number of the Trauma Services Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After-Hours Contact Number of the Trauma Services Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail of the Trauma Services Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Department Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of ED Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number for ED Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After-Hours Contact Number for ED Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail for the ED Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your lead 911 EMS Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMS Agency Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of EMS Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number for EMS Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMS Dispatch number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After-Hours Contact Number for EMS Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail for the EMS Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your lead air medical transport provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Air medical contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of Air medical contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number for Air medical contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail for the air medical contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Air medical dispatch number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of air medical base: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response time from air medical base to facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of facility Emergency Preparedness Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title for facility Emergency Preparedness Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number for facility Emergency Preparedness Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After-Hours Phone for facility Emergency Preparedness Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail for facility Emergency Preparedness Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Page**

I hereby make application on behalf of this hospital for verification and designation as a Level IV trauma hospital by the Commonwealth of Kentucky.

I certify that:

* I have read and understand all of the criteria requirements of a Kentucky Level IV Trauma Center, referenced in 902 KAR 28:030, and this hospital meets or exceeds the criteria as set forth therein.
* The hospital will continue to maintain all criteria required of a Level IV trauma center.
* I will immediately notify the Kentucky Trauma Advisory Committee, other regional hospitals and EMS service providers if this hospital is unable to meet the required criteria at any time during the designation period.
* All information provided in or with this application is truthful and accurate to the best of my knowledge.
* All responses to the questions are full and complete, omitting no material information.
* I understand that all data submitted in or with this application may be subject to an Open Records request.
* I will allow representatives of the Kentucky Department for Public Health to perform on-site reviews of the hospital to verify compliance with designation standards.
* Pursuant to the articles of incorporation, bylaws, or resolution of the Board of Directors, I am authorized to submit this application on behalf of the hospital and bind it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CEO Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typed name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma Services Medical Director Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typed name:

**Kentucky Trauma Care System**

**Level IV Pre-Review Questionnaire (PRQ)**

**DEMOGRAPHICS**

1. Name of Hospital:
2. Hospital Address
3. City, State, ZIP

**PURPOSE OF SITE REVIEW**

Type of Review:

1. Consultation
2. Verification
3. Re-verification

Reporting year for this review (12 months and should not be older than 14 months)

From month/year

To month/year

If verified, date of verification

* Reviewer Names

Most recent review was for:

1. Verification
2. Re-verification
3. Focus
4. Consultation

Number of deficiencies cited at the last review (consultation, verification or reverification)

* + List any of the deficiencies and how they were corrected.

Number of weaknesses found at last review

* + List any of the weaknesses and how they were addressed.

Describe any program changes (Administrative) that have occurred since the last review.

What is the Payer Mix (Use whole numbers & do not use the % symbol.)

|  |  |  |
| --- | --- | --- |
| **Payer** | **All Patients** | **Trauma Patients** |
| Commercial |  |  |
| Medicare |  |  |
| Medicaid |  |  |
| HMO/PPO |  |  |
| Uncompensated/Indigent |  |  |
| Other |  |  |

* + Define Other

**Hospital Beds**:

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital Beds** | **Adult** | **Pediatric** | **Total** |
| Licensed |  |  |  |
| Staffed |  |  |  |
| Average Census % |  |  |  |

**Hospital Commitment:**

1. Have a copy of a signed resolution by the governing board indicating the facility’s commitment to the hospital’s trauma program and willingness to provide the resources necessary to achieve and sustain Level IV trauma center designation available for review during the site visit.
2. Have a copy of a signed resolution by the medical staff indicating their commitment to the hospital’s trauma program and willingness to provide the resources necessary to achieve and sustain Level IV trauma center designation available for review during the site visit.
3. Have an official organization chart illustrating how the trauma program fits into the hospital structure, and how it is organized.
4. Is there specific budgetary support for the trauma program such as personnel, education and equipment? (Yes/No)
5. If 'Yes' briefly describe (List items by numbers or bullet points)
6. If "No' briefly describe where financial support comes from for the trauma program.
7. Does the hospital trauma program staff participate in a state or regional trauma system planning, development, or operation? (Yes/No)
* If 'Yes', briefly describe

**PRE-HOSPITAL SYSTEM**

**Pre-hospital system description**

1. Have a map of your referral area available on site during the review.

2. List the other trauma centers and their level of verification within a 50-mile radius of the hospital.

**EMS**

1. Who establishes destination and treatment protocols over EMS?
2. City
3. County
4. Region
5. State
6. Other
	* If 'other', briefly define:
7. Have copies of the destination, diversion and trauma treatment protocols for the primary 911 EMS agencies that deliver patients to your hospital available on-site during the review.
8. Describe the air medical support services available in the area and the type
	1. Fixed wing or rotor wing
	2. Closest base:
9. Does the trauma program serve as a base station (control point) for EMS operations? (Yes/No)
10. Does the trauma program provide medical control? (Yes/No)
	* Is the Trauma Medical Director also the EMS Medical Control? (Yes/No)
11. Is the trauma program team involved in pre-hospital training? (Yes/No)
	* If 'Yes', briefly describe
12. Does the trauma program participate in pre-hospital protocol development and the EMS QI/PIPS program? (Yes/No)
	* If 'Yes', briefly describe and provide an example.
13. Is there a representative from the emergency department that participates in the pre-hospital QI/PIPS program? (Yes/No)
	* If 'Yes', who is the representative?

**TRAUMA SERVICE**

**Trauma Services Medical Director (TSMD)**

1. Name (first name, last name)

* Medical School:
* Year Graduated:
* Type of Residency:
* Post Graduate Training Institution:
* Residency Institution:
* Year Completed:
* Board Certified: (Yes/No)
	+ Year:
	+ Specialty:

2. Have the job description for the TSMD available on site during the review.

3. Does the Trauma Services Medical Director participate in trauma call? (Yes/No)

4. Is the Trauma Services Medical Director current in Advanced Trauma Life Support? (Yes/No)

5. Has the Trauma Services Medical Director taken or taught RTTDC? (Yes/No)

6. Is the Trauma Services Medical Director a member and an active participant in national or regional trauma organizations? (Yes/No)

7. Does the Trauma Services Medical Director have 15 hours in the most recent 3 years of documented and verifiable trauma-related CME? (Yes/No)

8. Does the Trauma Services Medical Director have sufficient authority to set the qualifications for the trauma service members? (Yes/No)

9. Does the structure of the trauma program allow the Trauma Services Medical Director to have oversight authority for the care of injured patients who may be admitted to an individual physician? (Yes/No)

* If 'No', please explain

10. Does the Trauma Services Medical Director have the authority to remove members from and/or appoint members to the trauma service? (Yes/No)

**Surgeons**

1. List all surgeons currently involved in trauma care.

2. Are all of the general surgeons US or Canadian board-certified/eligible? (Yes/No)

* If ‘no’ briefly explain.

3. Have all general surgeons on the trauma team successfully completed the ATLS course at least once? (Yes/No)

* If 'No', please explain

4. Do all the trauma surgeons who take trauma calls have documented 15 hours in the most recent 3 years of trauma-related CME? (Yes/No)

**Trauma Coordinator (TC)**

1. Name: (First name & last name only)

2. Education

1. Associate Nursing Degree (Yes/No)
2. Bachelor Nursing Degree (Yes/No)
3. Masters Nursing Degree (Yes/No)
4. Other Degree (Yes/No)
	* If 'Other' degree, please describe:

3. Does the trauma coordinator show evidence of educational preparation and clinical experience in the care of injured patients? (Yes/No)

1. If 'Yes', please describe:
2. RTTDC (Yes/No)
3. TNCC or other equivalent program (Yes/No)

4. TC reporting status. (Check all that apply)

1. TMD
2. Administration
3. ED Director
	* + Briefly describe
		+ Date of appointment to this position

5. How many years has the TC been in this position?

6. Have the TC job description available on site during the review.

7. What percentage of time is allocated to the trauma program?

**Clinical Qualifications**

**Emergency Department Provider**

1. Document emergency physician, nurse practitioner and physician assistant qualifications. A summary form is attached and should be used as a cover for any additional documentation that is provided for review during the site visit.
2. What plan is in place to ensure that new emergency department providers who are not board-certified in emergency medicine *obtain* and *remain current in* ATLS?

**Other Medical Staff Covering Emergencies, Including Locum Tenens**

1. Document locum tenens qualifications on the forms attached.
2. The hospital employs: (indicate all that apply)
* An agency that provides locum tenens (Yes/No)

 If so, what steps has the hospital taken to ensure that only physicians who meet the ATLS training requirement are provided?

* Its own locum tenens (Yes/No)

 If so, how does the hospital ensure that all physicians credentialed to work in the emergency department meet the ATLS training requirement?

**Orthopedic Surgeons**

If orthopedic surgical services are provided by the hospital, provide a copy of the credentialing letter(s) issued by the hospital with the other credentialing materials that are to be available during the site visit.

**Radiology**

Is there a radiologist who is appointed as liaison to the trauma program? (Yes/No)

* If 'Yes', what is his/her name?

**Nursing**

1. Describe the credentialing requirements for nurses who treat trauma patients in the ED:
	* What percentage of emergency department nurses are trained in TNCC or other equivalent in-house training? (If less than 100 percent, what plan is in place to train the remaining nurses?)
2. Describe any trauma-related continuing education for nurses working in the ED:
3. Extra certifications for ED nursing staff (use whole numbers):
	* % PALS:
	* % ACLS:
	* % Audit ATLS:
	* % CEN:
	* % ATNC:
	* % Other (enter description and percentage):
4. Provide a copy of job description(s) for nurses providing trauma care (i.e., emergency department) with the materials available during the site review.

**Clinical Capabilities**

**Emergency Medicine**

1. Emergency department provider is (Company name):
2. Are emergency department physicians present in the emergency department at all times? (Yes/No). If 'No', please explain:
3. Are all of the emergency physicians who care for injured patients U.S./Canadian board-certified/eligible? (Yes/No). If 'No', briefly describe
4. How does the hospital track the emergency providers’ response time?
5. Have a copy of the current month’s schedule for the emergency department provider available on site during the review.
6. Have a copy of the ED trauma flow sheet available on site at the time of the review.

**Orthopedic Surgery**

* 1. Orthopedic surgical services are not required of level IV trauma hospitals. Does the hospital provide orthopedic surgical services? (Yes/No). If yes, complete the Orthopedic Trauma Worksheet (attached) indicating which orthopedic conditions may be managed at your facility.

**Note:** If yes, have a copy of the current month’s on-call schedule for each orthopedic surgeon available on site during the review.

**Nursing Personnel**

* 1. Describe the nursing staff demographics in the ED and the trauma center
	(use whole numbers):
	2. Average years of experience:
	3. Annual rate of turnover:

**Blood & Clinical Laboratory**

1. Is the lab capable of standard analysis of blood, urine and other body fluids including micro sampling? (Yes/No)
2. Are laboratory services available 24 hours per day for the CBC, blood typing, coagulation profile, and ABG?(Yes/No)
3. Does your on call laboratory technician have a 20 minute response time? (Yes/No)
4. The blood bank is:
	* In-house (Yes/No)
	* Community/regional blood bank—Name of blood bank:
5. How much O-negative blood is kept in-house?
	* Does the facility have two units of uncross-matched blood immediately available? (Yes/No)
6. What is the turn-around time for type-specific blood?
7. How is additional blood acquired, if necessary?

**Radiology**

1. Is conventional radiography and computed tomography available 24 hours per day? (Yes/No)
* Describe radiology/CT technologist availability and on call responsibilities.
1. Are radiologists promptly available, in person or by tele-radiology, when requested for the interpretation of radiographs? (Yes/No)
* Please describe:
1. Does the Radiology department participate in the trauma PIPS program by at least being involved in protocol development and trend analysis that relate to diagnostic imaging? (Yes/No)
2. Describe FAST exam capabilities if available.
3. Is diagnostic information communicated in a timely manner? (Yes/No)
4. Is critical information verbally communicated to the trauma team? (Yes/No)

**Operating Room (IF APPLICABLE)**

1. Number of operating rooms?
2. Briefly describe the location of the operating suite related to the ED and ICU.
3. Describe the operating room and OR staff availability.
4. Describe the mechanism for opening the OR if the team is not in-house 24/7.
5. Are devices available for warming patient, fluid and room? (Yes/No)
6. Does the operating room have all essential equipment? (Yes/No)

**Anesthesiology and CRNAs (IF APPLICABLE)**

* Describe your facility’s anesthesia availability and on call process.

**PACU (Post-Anesthesia Care Unit) (IF APPLICABLE)**

* Describe your facility’s PACU availability and staffing.

**Rehabilitation Service (IF APPLICABLE)**

Which of the following services does the hospital provide?

1. Physical therapy (Yes/No)
2. Occupational therapy (Yes/No)
3. Speech therapy (Yes/No)
4. Social services (Yes/No)

**TRAUMA RESPONSE/ACTIVATION**

1. Does the facility have a multilevel trauma response program? (Yes/No)

* Have a copy of the trauma team activation protocol/policy available on site during the review.

2. For the highest level of activation which of the following are included?

1. Confirmed systolic blood pressure < 90 or age specific in children;
2. Respiratory compromise/obstruction and/or intubation;
3. Transfer patients from other hospitals receiving blood;
4. Emergency physician's discretion;
5. Gunshot wounds to the abdomen, neck or chest;
6. Glascow Coma Scale (GCS) < 8 with mechanism attributed to trauma

3. Describe the number of levels and criteria for each level of response.

1. Number of levels of activation
2. Describe the criteria for each level of activation

4. Who has the authority to activate the trauma team? (Check all that apply)

1. EMS
2. ED Physician
3. ED Nurse
4. Trauma Surgeon

5.

|  |
| --- |
| **Statistics for level of response** |
| **Level** | **Number of activations** | **Percent of total activations** |
| Highest |  |  |
| Intermediate |  |  |
| Lowest |  |  |
| **Total** |  |  |

6. The highest level of activation is instituted by:

1. group pager
2. telephone page
3. other

Define 'Other':

7. Which trauma team members respond to each level of activation?

|  |  |
| --- | --- |
|  | Activation Level |
| **Responder** | **Highest** | **Intermediate** | **Lowest** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

8. Does the facility have trauma protocols? **(**Yes/No)

* If 'Yes', have them available on site.

**TRAUMA TRANSFER AGREEMENTS**

* 1. Have a copy of the trauma transfer plan/protocol available on site during the review.
	2. Have copies of any transfer agreements for hemodialysis, burn care and acute spinal cord injury available on site during the review.
		+ Two burn care transfer agreements are required.
	3. Have copies of any transfer agreements with Level I, II or III trauma centers available on site during the review.

**TRAUMA/HOSPITAL STATISTICAL DATA**

1. Total number of emergency department (ED) visits for reporting year.

2. Total number of trauma-related ED visits for same reporting year, with ICD-9 code between 800.00 and 959.9

1. Blunt Trauma Percentage:
2. Penetrating Trauma Percentage:
3. Thermal Percentage:

3.

|  |
| --- |
| Distribution from ED for trauma patient admissions |
| **Disposition** | **Total Number** |
| ED to OR |  |
| ED to ICU |  |
| ED to Floor |  |
| Transfers Out |  |
| **Total** |  |

4. Injury Severity Score (ISS) and Mortality

|  |  |  |  |
| --- | --- | --- | --- |
| **ISS** | **Total Number of admissions** | **Deaths (from total)** | **% Mortality** |
| 0-9 |  |  |  |
| 10-15 |  |  |  |
| 16-24 |  |  |  |
| > or = 25 |  |  |  |
| **Total** |  |  |  |

5. Is there a mechanism for direct physician to physician contact present for arranging patient transfers? (Yes/No)

**TRAUMA BYPASS (DIVERSION)**

1. Does the facility have a bypass (diversion) protocol? (Yes/No)

* If 'Yes', have it on site at the time of the review.
* If 'Yes' provide documentation on when by-pass/diversion was used during the previous 12-month period, and if possible the number of patients diverted, and where they were diverted to.

**PERFORMANCE IMPROVEMENT AND PATIENT SAFETY**

 **Performance Improvement PI Program (PIPS)**

1. Describe the Performance Improvement and Patient Safety Plan.
2. Describe how the PI problems are identified, tracked, documented and discussed.
3. What PI filters are currently being used?
4. How does the hospital’s PI process review the duration of and reasons for going on “trauma divert”, "diversion" or "by-pass"?
5. Describe the staffing and administrative support for the PIPS process.
6. How is loop closure (resolution) achieved?
7. Who is responsible for loop closure of both system and peer review issues?
8. List one (1) example of loop closure involving peer review issues during the reporting year.
9. List one (1) example of loop closure involving system issues during the reporting year.
10. Specify the 12-month period used to respond to these questions.
11. Are nursing issues reviewed in the trauma PI Process? (Yes/No)

**TRAUMA MULTIDISCIPLINARY PEER REVIEW COMMITTEE**

Provide a description of the hospital’s Multidisciplinary Trauma Peer Review Committee which improves trauma care by reviewing selected deaths, complications, and sentinel events with objective identification of issues and appropriate responses.

1. Name of Committee?
2. What is the purpose of the committee?
3. Describe the membership using titles.
4. Name/Title of Chairperson?
5. How often does the committee meet?
6. Are there attendance requirements? (Yes/No)
* If “yes”, describe:
1. Attendance of panel members
	1. Trauma Surgeons
	2. Emergency Medicine
	3. Nursing
	4. Hospital Administration
	5. EMS
	6. Laboratory/Blood Bank
	7. Rehabilitation Services
	8. Other (describe)
2. Committee reports to whom?
3. Attendance of panel members
	1. Trauma Surgeons
	2. Emergency Medicine
	3. Nursing
	4. Hospital Administration
	5. EMS
	6. Laboratory/Blood Bank
	7. Rehabilitation Services
	8. Other (describe)
4. Committee reports to whom?

**Trauma Registry**

1. What registry program does the hospital use?
2. Are trauma registry data collected and analyzed? (Yes/No)
3. Are the trauma registry data submitted to the State Database? (Yes/No)
	1. Date of most recent data submission (mm/dd/yyyy):
4. Does the trauma registry support the PIPS process? (Yes/No)
5. Describe how the registry is used in the PIPS process to identify and track opportunities for improvement:
6. What are the selection criteria for patient entry into the trauma registry?
7. Does the trauma program ensure that trauma registry confidentiality measures are in place? (Yes/No)
	1. If 'Yes', please explain:

**Morbidity and Mortality Review**

* 1. Which healthcare providers make up the membership of the morbidity and mortality committee?
	2. How often does the morbidity and mortality committee meet?
	3. What is the attendance requirement for members of the committee?
	4. Records of the specific attendance results should be available during the site review.

**Trauma Death Audits**

1. How many trauma deaths were there during the reporting year?
(Include ED deaths, and in-house deaths.)

1. Total:
2. Deaths in ED:
3. In-hospital (include OR):
4. DOA:

2. List the number of deaths categorized as preventable, non-preventable, and possibly preventable.

1. Non-preventable:
2. Possibly preventable:
3. Preventable:

3. Autopsies have been performed on what percentage of the facility's trauma deaths?

4. How is the autopsy findings reported to the trauma program?

**EDUCATION ACTIVITIES/OUTREACH PROGRAMS**

Briefly describe the trauma education and injury prevention programs your facility has available.

**Orthopedic Trauma Worksheet**

*(Only complete this if YES above.)*

* The hospital routinely transfers all of these orthopedic conditions (Yes/No) - OR
* The hospital can manage the following orthopedic conditions in this hospital.

**Chest**

[ ]  Flail chest

[ ]  Multiple rib fractures

[ ]  Scapular fracture

[ ]  Clavicular fracture

[ ]  Sterno-clavicular dislocation

**Spine**

[ ]  Cervical spine fracture/dislocation

[ ]  T/L spinal fracture/dislocation w/ neuro impairment

[ ]  Vertebral body fracture

[ ]  Vertebral burst

[ ]  Spinal process fracture

[ ]  Compression fracture

**Pelvis**

[ ]  Open pelvic fracture

[ ]  Stable pelvic ring disruption

[ ]  Unstable pelvic ring disruption

[ ]  Acetabular fracture

[ ]  Pelvic fracture w/ shock

**Extremities**

[ ]  Open long bone fracture

[ ]  Two or more long bone fractures

[ ]  Fracture or dislocation w/ loss of distal pulses

[ ]  Extremity ischemia

[ ]  Fracture w/ abnormal neuro exam

[ ]  Compartmental syndromes

[ ]  Shoulder dislocation

[ ]  Acromioclavicular fracture/dislocation

[ ]  Proximal humerus fracture

[ ]  Distal humerus fracture

[ ]  Elbow fracture/dislocation

[ ]  Forearm fracture

[ ]  Distal radius fracture

[ ]  Hand/wrist comminuted fracture w/ nerve involvement

[ ]  Carpal dislocation

[ ]  Metacarpal fracture

[ ]  Hand amputation

[ ]  Finger amputation

[ ]  Fingertip amputation involving phalange

[ ]  Phalanx fracture

[ ]  Hip fracture

[ ]  Femur fracture

[ ]  Knee dislocation

[ ]  Proximal tibia fracture

[ ]  Distal tibia fracture

[ ]  Pilon fracture

[ ]  Ankle fracture

[ ]  Talus fracture

[ ]  Calcaneus fracture

[ ]  Midfoot dislocation

[ ]  Subtalar dislocation

[ ]  Metatarsal fracture

[ ]  Phalanx fracture

**Clinical Qualifications for Staff Emergency Department Physicians, NPs and PAs**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of provider** | **Credential** | **Date of current board certification (MD/DO only)** | **Board Eligible? (if not board-certified)** **(MD/DO only)** | **Specialty** **(MD/DO only)** | **ATLS Completion Date** | **PALS Completion Date** | **ACLS Completion Date** | **RTTDC Completion Date** | **% Attendance at morbidity & mortality review\*** |
|       | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  | [ ] Yes [ ] No |  |  |  |  |  |  |

\* See Performance Improvement section Attach additional pages as necessary

**Clinical Qualifications for Other Medical Staff/Locum Tenens**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of provider** | **Credential** | **Specialty****(MD/DO only)** | **ATLS Completion Date** | **PALS Completion Date** | **ACLS Completion Date** |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |
|  | [ ] MD/DO [ ] NP [ ] PA |  |  |  |  |

Attach additional pages as necessary

**Clinical Qualification for Orthopedic Surgeons**

Orthopedic surgical services are not required of Level IV trauma centers. Complete this form only if orthopedic surgical services are provided by the facility.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of surgeon** | **Credentialed by hospital?** | **Board certified?** | **Board eligible? (if not board-certified)** | **Specialty** | **% Attendance at morbidity & mortality review\*** |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |
|  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |  |       |

\* See Performance Improvement section Attach additional pages as necessary

[Note: If there is a need for more space to respond to a question please include this
as a referenced ATTACHMENT starting with number 1.]