



Utah Department of Public Safety  
Bureau of Emergency Medical Services  
Trauma Center Designation



# UTAH LEVEL III TRAUMA CENTER CRITERIA 2025

Standard #	Standard Name	Type	LEVEL III CENTER Definition and Requirements
<b>1   Institutional Administrative Commitment</b>			Full support and continuous commitment from institutional leadership is vital to achieving and maintaining trauma center verification. Resource allocation (such as equipment, personnel, and administrative support), a commitment to patient safety, and an enduring focus on continuous PI are the hallmarks of strong institutional administrative support that ensures compliance with standards and the highest quality of care for trauma patients.
1.1	Administrative Commitment	TYPE I	<p>In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.</p> <p><b>Human resources include physicians, registered nurses, advanced practice providers (APPs), physician assistants, coordinators, and so forth.</b>  <b>This standard fully encompasses all staffing needs, physical structures, space allotments, and equipment needed for a trauma center to function optimally.</b></p>
<b>2   Program Scope and Governance</b>			The trauma program and its medical staff provide the structures, processes, and personnel to comply with trauma center verification standards in order to ensure optimal care of the injured patient. This staff includes the program leadership (TPM and TMD) to oversee key functions of the trauma program. There must also be ongoing commitment from the trauma multidisciplinary PIPS committee.
2.1	State and Regional Involvement	TYPE II	<p>All trauma centers must participate in the regional and/or statewide trauma system.</p> <p><b>Examples of participation may include the following:</b>            Participation in state and regional trauma advisory committees            Leadership in state and regional medical audit committees            Collaboration with regional trauma advisory committees, EMS, or other agencies to promote the development of state and regional systems            Participation in media and legislative education to promote and develop trauma systems            Participation in state and regional trauma needs assessment or injury surveillance            Participation in the development of a state or regional trauma plan or state trauma registry            Provision of technical assistance and education to hospitals and their providers within the region to improve system performance</p>



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2.1-a UTAH CD	State and Regional Involvement	TYPE II	Attendance and participation threshold at regional and State Trauma Systems meetings of 75% are required. (State Criteria) <b>Provide evidence of attendance at time of survey</b>
2.2	Hospital Regional Disaster Committee	TYPE II	All trauma centers must participate in regional disaster/ emergency management committees, health care coalitions, and regional mass casualty exercises.
2.3	Disaster Management Planning	TYPE II	All trauma programs must be integrated into the hospital’s disaster plan to ensure a robust surgical response: A trauma surgeon from the trauma panel must be included as a member of the hospital’s disaster committee and be responsible for the development of a surgical response to a mass casualty event.  The surgical response must outline the critical personnel, means of contact, initial surgical triage (including subspecialty triage when appropriate), and coordination of secondary procedures.  The trauma program must participate in two hospital drills or disaster plan activations per year that include a trauma response and are designed to refine the hospital’s response to mass casualty events.
2.6	Adult Trauma Centers Admitting Pediatric Patients	TYPE I	Adult trauma centers that care for 100 or more injured children under 15 years of age must have the following: <b>Pediatric emergency department area</b> <b>Pediatric intensive care area</b> <b>Appropriate resuscitation equipment, as outlined in the pediatric readiness toolkit</b>
2.7	Trauma Multidisciplinary PIPS Committee	TYPE I	All trauma centers must have a trauma multidisciplinary PIPS committee chaired by the TMD or an associate TMD.
2.8	Trauma Medical Director Requirements	TYPE II	In all trauma centers, the TMD must fulfill the following requirements: <b>Hold current board certification or board eligibility in general surgery or pediatric surgery by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), or Royal College of Physicians and Surgeons of Canada (RCPS-C)</b> <b>Serve as the director of a single trauma program</b> <b>Be credentialed to provide trauma care</b> <b>Hold current Advanced Trauma Life Support (ATLS) certification</b> <b>Participate on the trauma call panel</b> <b>Provide evidence of 36 hours of trauma-related continuing medical education (CME) during the verification cycle. For pediatric TMD, 9 of 36 hours must be pediatric-specific CME</b> <b>Level II or III trauma centers, the TMD must hold active membership in at least one regional, state, or national trauma organization and have attended at least one meeting during the verification cycle</b>  If a board-certified general surgeon who is not board-certified or board-eligible in pediatric surgery serves as the pediatric TMD, they must also: <b>Hold current Pediatric Advanced Life Support (PALS) certification</b> <b>Have a written affiliation agreement with a pediatric TMD at another verified Level I pediatric trauma center whose role is to assist with process improvement, guideline development, and complex case discussions</b>



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2.9	Trauma Medical Director Responsibility and Authority	TYPE II	In all trauma centers, the TMD must be responsible for and have the authority to: <b>Develop and enforce policies and procedures relevant to care of the injured patient</b> <b>Ensure providers meet all requirements and adhere to institutional standards of practice</b> <b>Work across departments and/or other administrative units to address deficiencies in care</b> <b>Determine (with their liaisons) provider participation in trauma care, which might be guided by findings from the PIPS process or an Ongoing Professional Practice Evaluation (OPPE)</b> <b>Oversee the structure and process of the trauma PIPS program</b>
2.10	Trauma Program Manager Requirements	TYPE II	In all trauma centers, the TPM must fulfill the following requirements: <b>Have 1.0 full-time equivalent (FTE) commitment to the trauma program</b> <b>Provide evidence of 36 hours of trauma-related continuing education (CE) during the verification cycle</b> <b>Hold current membership in a national or regional trauma organization</b>  In Level II and III trauma centers, at least 0.5 FTE of the TPM's time must be spent on TPM-related activities. The remaining time must be dedicated to other roles within the trauma program.
2.11	Trauma Program Manager Reporting Structure	Type II	In all trauma centers, the TPM must have a reporting structure that includes the TMD.
2.12	Injury Prevention Program	TYPE II	All trauma centers must have an injury prevention program that: <b>Has a designated injury prevention professional</b> <b>Prioritizes injury prevention work based on trends identified in the trauma registry and local epidemiological data</b> <b>Implements at least two activities over the course of the verification cycle with specific objectives and deliverables that address separate major causes of injury in the community</b> <b>Demonstrates evidence of partnerships with community organizations to support their injury prevention efforts</b>
2.13	Organ Procurement Program	TYPE II	In all trauma centers, an organ procurement program must be available and consist of at least the following: <b>An affiliation with an organ procurement organization (OPO)</b> <b>A written policy for notification of the regional OPO</b> <b>Protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death</b>
<b>3   Facilities and Equipment Resources</b>			The trauma program must maintain and provide the required facilities, services, and equipment for the care of the injured patient.
3.1	Operating Room Availability	TYPE I	Level III trauma centers, within 30 minutes of notification.
3.3	Operating Room for Orthopaedic Trauma Care	TYPE II	In a Level III trauma center, access to the OR must be made available for nonemergent orthopaedic trauma.
3.4	Blood Products	TYPE I	Level III trauma centers must have an adequate supply of red blood cells and plasma available.



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3.5	Medical Imaging	TYPE I	In Level III trauma centers, the following services must be available 24 hours per day and be accessible for patient care within the time interval specified: Conventional radiography—30 minutes CT—30 minutes Point-of-care ultrasound—15 minutes
3.7	Cerebral Monitoring Equipment	TYPE I	Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe traumatic brain injury (TBI), defined as Glasgow Coma Scale (GCS) of 12 or less at the time of emergency department arrival. Cerebral monitoring could include equipment to monitor intracranial pressure and/or measure cerebral oxygenation.
<b>4   Personnel and Services</b>			The trauma program must have access to a wide variety of personnel and services to provide timely care to the injured patient.
4.1	Trauma Surgeon Requirements	TYPE II	Trauma surgeons who are involved in the care of trauma patients must meet the following qualifications: <b>Complete the ATLS course at least once</b> <b>Have privileges in general and/or pediatric surgery</b> <b>Hold current board certification or board eligibility in general surgery, or have been approved through the Alternate Pathway Level I pediatric trauma centers must have at least two surgeons board-certified or board-eligible in pediatric surgery.</b>
4.2	Trauma Surgeon Coverage	TYPE I	In all trauma centers, trauma surgery coverage must be continuously available.
4.3	Trauma Surgery Backup Call Schedule	TYPE II	Level III trauma centers must have a documented backup call schedule or a backup plan for trauma surgery.
4.4	Trauma Surgeon Presence in Operating Room	TYPE II	In all trauma centers, the trauma surgeon must be present in the operating suite for the key portions of operative procedures for which they are the responsible surgeon and must be immediately available throughout the procedure.
4.5	Specialty Liaisons to the Trauma Service	TYPE II	The trauma program must have the following designated liaisons:  <b>LIII:</b> <b>Board-certified or board-eligible emergency medicine physician</b> <b>Board-certified or board-eligible orthopaedic surgeon</b> <b>Board-certified or board-eligible anesthesiologist</b> <b>Board-certified or board-eligible neurosurgeon (applies only to LIII-N)</b> <b>Board-certified or board-eligible ICU physician</b>  <b>Anesthesia Liaison</b> <b>In Level III trauma centers, certified registered nurse anesthetists (CRNAs) who are licensed to practice independently may serve as the anesthesia liaison.</b>



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4.6	Emergency Department Director	TYPE I	All trauma centers must have a board-certified or board-eligible emergency department physician medical director.
4.7	Emergency Department Physician Requirements	TYPE II	<p>In all trauma centers, emergency medicine physicians involved in the care of trauma patients must be currently board-certified or board-eligible, or have been approved through the Alternate Pathway.</p> <p>In Level I and II trauma centers, physicians must be board-certified or board-eligible in emergency medicine or pediatric emergency medicine. Physicians who completed primary training in a specialty other than emergency medicine or pediatric emergency medicine prior to 2016 may participate in trauma care.</p> <p>In Level III trauma centers, physicians must be board-certified or board-eligible in emergency medicine, pediatric emergency medicine, or a specialty other than emergency medicine.</p> <p>All emergency medicine physicians must have completed the ATLS course at least once. Physicians who are board-certified or board-eligible in a specialty other than emergency medicine must hold current ATLS certification.</p> <p><b>Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.</b></p>
4.10	Neurotrauma Care	TYPE I	<p>Level III-N trauma centers must have board-certified or board-eligible neurosurgeons.</p> <p>Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.</p>
4.11	Orthopaedic Trauma Care	TYPE I	<p>Trauma centers must have board-certified or board-eligible orthopaedic surgeons continuously available for the care of orthopaedic trauma patients and must have a contingency plan for when orthopaedic trauma capabilities become encumbered or overwhelmed.</p> <p><b>“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.</b></p>
4.13	Anesthesia Services	TYPE I	<p>In Level III trauma centers, anesthesia services must be available within 30 minutes of request.</p> <p><b>For Level III trauma centers in states where CRNAs are licensed to practice independently, CRNAs should follow local or institutional practices and may not require physician supervision.</b></p>
4.14	Radiologist Access	TYPE I	<p>In all trauma centers, a radiologist must have access to patient images and be available for imaging interpretation, in person or by phone, within 30 minutes of request.</p> <p><b>The time is measured from time of request to time of interpretation.</b></p>



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4.16	ICU Director	TYPE II	<p>All trauma centers must have an ICU surgical director who is board-certified or board-eligible in general surgery and actively participates in unit administration.</p> <p>“Active participation in unit administration” is defined as participating in the development of pathways and protocols for the care of trauma patients and in unit-based PI activities.</p> <p>It is expected that the ICU surgical director participate in the care of patients in the ICU where the majority of trauma patients are cared for.</p>
4.19	ICU Provider Coverage for Level III Trauma Centers	TYPE I	<p>In Level III trauma centers, provider coverage of the ICU must be available within 30 minutes of request, with a formal plan in place for emergency coverage.</p> <p><b>Coverage may include an intensivist, hospitalist, or APP.</b></p>
4.20	ICU Nursing Staffing Requirement	TYPE II	<p>In all trauma centers, the patient-to-nurse ratio in the ICU must be 1:1 or 2:1, depending on patient acuity as defined by the hospital policy for ICU nursing staffing.</p>
4.25	Medical Specialists	TYPE II	<p>Level III trauma centers must have internal medicine continuously available.</p> <p><b>“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.</b></p>
4.27	Allied Health Services	TYPE II	<p>Trauma centers must have the following allied health services available:</p> <p><b>LIII</b>  Respiratory therapy (24/7/365)  Nutrition support  Social worker  Occupational therapy  Physical therapy  Speech therapy</p>
4.28	Renal Replacement Therapy Services	TYPE II	<p>Level III trauma centers must have renal replacement therapy services available to support patients with acute renal failure or a transfer agreement in place if this service is not available.</p>



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4.29	Advanced Practice Providers	TYPE II	<p>In all trauma centers, trauma and/or emergency department APPs who are clinically involved in the initial evaluation and resuscitation of trauma patients during the activation phase must have current ATLS certification.</p> <p><b>This standard is not applicable to the following:</b>            APPs for neurosurgery and orthopaedic surgery            CRNAs            CAAs            Scribes</p>
4.30	Trauma Registry Staffing Requirements	TYPE II	<p>In all trauma centers, there must be at least 0.5 FTE dedicated to the trauma registry per 200–300 annual patient entries. The count of entries is defined as all patients who meet NTDS inclusion criteria, and those patients who meet inclusion criteria for hospital, local, regional and state purposes.</p> <p>Trauma centers must take into account the additional tasks, beyond the abstraction and entry of patient data, that are assigned to the registrar. Processes such as report generation, data analysis, research assistance, and meeting various submission requirements will decrease the amount of time dedicated to the meticulous collection of patient data. Electronic downloads into the trauma registry also create additional tasks, as does ongoing data validation before data acceptance. Additional staff will be required to perform these tasks to ensure the integrity and quality of registry data, which are used for prevention, PIPS, and other essential aspects of the trauma program.</p>
4.31	Certified Abbreviated Injury Scale Specialist	TYPE II	<p>In all trauma centers, at least one registrar must be a current Certified Abbreviated Injury Scale Specialist (CAISS).</p> <p><b>Evidence of CAISS Certification</b></p>
4.32	Trauma Registry Courses	TYPE II	<p>In all trauma centers, all staff members who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting, or data validation for the trauma registry must fulfill all of the following requirements:</p> <p>Participate in and pass the most recent version of the AAAM’s Abbreviated Injury Scale (AIS) course</p> <p>Participate in a trauma registry course that includes all of the following content:  <b>Abstraction</b>  <b>Data management</b>  <b>Reports/report analysis</b>  <b>Data validation</b>  <b>HIPAA</b></p> <p><b>Participate in an ICD-10 course or an ICD-10 refresher course every five years</b></p>
4.33	Trauma Registrar Continuing Education	TYPE II	<p>In all trauma centers, each trauma registrar must accrue at least 24 hours of trauma-related CE during the verification cycle.</p> <p><b>Trauma-related CE can be obtained internally, externally, or online.</b></p>



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4.34	Performance Improvement Staffing Requirements	TYPE II	<p>In all trauma centers, there must be at least 0.5 FTE dedicated performance improvement (PI) personnel when the annual volume of registry patient entries exceeds 500 patients. The count of entries is defined as all patients that meet NTDS inclusion criteria, and those patients who meet inclusion criteria for hospital, local, regional and state purposes.</p> <p>When the annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1 FTE PI personnel.</p> <p><b>Trauma centers are expected to have the necessary human resources to comply with the standards in Category 7—Performance Improvement and Patient Safety. Greater trauma center volumes might necessitate additional personnel.</b></p>
<b>5   Patient Care: Expectations and Protocols</b>			<p>The trauma program must utilize comprehensive clinical pathways and clinical practice guidelines that facilitate the standardization of patient care for the injured patient. This standardization improves the quality of care and enables the training of personnel.</p>
5.1	Clinical Practice Guidelines	TYPE II	<p>All trauma centers must have evidence-based clinical practice guidelines, protocols, or algorithms that are reviewed at least every three years. <b>Clinical practice guidelines, protocols, or algorithms with date of last revision</b></p>
5.2	Trauma Surgeon and Emergency Medicine Physician Shared Responsibilities	TYPE II	<p>In all trauma centers, the shared roles and responsibilities of trauma surgeons and emergency medicine physicians for trauma resuscitation must be defined and approved by the TMD.</p>
5.3	Levels of Trauma Activation	TYPE II	<p>In all trauma centers, the criteria for tiered activations must be clearly defined. For the highest level of activation, the following eight criteria must be included:</p> <ul style="list-style-type: none"> <li>Confirmed blood pressure less than 90 mm Hg at any time in adults, and age-specific hypotension in children</li> <li>Gunshot wounds to the neck, chest, or abdomen</li> <li>GCS less than 9 (with mechanism attributed to trauma)</li> <li>Transfer patients from another hospital who require ongoing blood transfusion</li> <li>Patients intubated in the field and directly transported to the trauma center</li> <li>Patients who have respiratory compromise or are in need of an emergent airway</li> <li>Transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint)</li> <li>Emergency physician's discretion</li> </ul>
5.4	Trauma Surgeon Response to Highest Level of Activation	Type I	<p>For the highest level of activation, at least 80 percent of the time, the trauma surgeon must be at the patient's bedside within 15 minutes (Level I or II trauma centers) or <b>30 minutes (Level III trauma centers) of patient arrival.</b></p>
5.5	Trauma Surgical Evaluation for Activations below the Highest Level	TYPE II	<p>The trauma program must define and meet the acceptable response time to trauma surgical evaluation for activations other than the highest level.</p> <p><b>The response time is measured from the initial trauma activation (or initial consultation) and trauma surgery team evaluation (as defined by the trauma program).</b></p>



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5.7	Assessment of Children for Nonaccidental Trauma	TYPE II	All trauma centers must have a process in place to assess children for non-accidental trauma.
5.8	Massive Transfusion Protocol	TYPE I	All trauma centers must have a massive transfusion protocol (MTP) that is developed collaboratively between the trauma service and the blood bank. <b>The MTP includes a trigger for activation, a process for cessation, and strategies for preservation of unused blood. Appropriate clotting studies should be immediately available.</b>
5.9	Anticoagulation Reversal Protocol	TYPE II	All trauma centers must have a rapid reversal protocol in place for patients on anticoagulants.
5.10	Pediatric Readiness	Type II	In all trauma centers, the emergency department must evaluate its pediatric readiness and have a plan to address any deficiencies.  <b>“Pediatric readiness” refers to infrastructure, administration and coordination of care, personnel, pediatric-specific policies, equipment, and other resources that ensure the center is prepared to provide care to an injured child. The components that define readiness are available in the Resources section below.</b>
5.11	Emergency Airway Management	TYPE I	All trauma centers must have a provider and equipment immediately available to establish an emergency airway.  <b>The emergency airway provider must be capable of advanced airway techniques, including surgical airway.</b>
5.12	Transfer Protocols	TYPE II	All trauma centers must have clearly defined transfer protocols that include the types of patients, expected time frame for initiating and accepting a transfer, and predetermined referral centers for outgoing transfers.
5.13	Decision to Transfer	TYPE II	In all trauma centers, the decision to transfer an injured patient must be based solely on the needs of the patient, without consideration of their health plan or payor status.  <b>Subsequent decisions regarding transfer to a facility within a managed care network should be made only after stabilization of the patient’s condition and in accordance with the ACS Statement on Managed Care and the Trauma System.</b>
5.14	Transfer Communication	TYPE II	In all trauma centers, when trauma patients are transferred, the transferring provider must directly communicate with the receiving provider to ensure safe transition of care. This communication may occur through a transfer center.
5.15	Trauma Diversion Protocol	TYPE II	In all trauma centers, diversion protocols must be approved by the TMD and include: <b>Agreement of the trauma surgeon in the decision to divert</b> <b>A process for notification of dispatch and EMS agencies</b> <b>A diversion log to record reasons for and duration of diversions</b>
5.16	Trauma Diversion Hours	TYPE II	All trauma centers must not exceed 400 hours of diversion during the reporting period.



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5.17	Neurosurgeon Response	TYPE II	<p>Neurosurgical evaluation must occur within 30 minutes of request for the following:  <b>Severe TBI (GCS less than 9) with head CT evidence of intracranial trauma</b>  <b>Moderate TBI (GCS 9–12) with head CT evidence of potential intracranial mass lesion</b>  <b>Neurologic deficit as a result of potential spinal cord injury (applicable to spine surgeon, whether a neurosurgeon or orthopaedic surgeon)</b>  <b>Trauma surgeon discretion</b></p> <p>In Level I, II, and III-N trauma centers, neurosurgical provider response times must be documented.          In all levels of trauma centers, the neurosurgery attending must be involved in clinical decision-making.</p> <p><b>Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.</b></p>
5.18	Neurotrauma Plan of Care for Level III trauma Centers	TYPE II	<p>All Level III trauma centers must have a written plan approved by the TMD that defines the types of neurotrauma injuries that may be treated at the center.</p>
5.19	Neurotrauma Contingency Plan	TYPE II	<p>Level III-N trauma centers must have a neurotrauma contingency plan that includes the potential for diversion and must implement the plan when neurosurgery capabilities are encumbered, overwhelmed, or unavailable.</p> <p>The plan must include the following criteria:  <b>A thorough review of each instance by the PIPS program</b>  <b>veness of the process by the PIPS program</b></p> <p><b>Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.</b></p> <p><b>Neurosurgery is encumbered or overwhelmed when there is an inability to meet standards of care for patients with time-sensitive injuries.</b></p> <p><b>Since Level III-N centers are not required to have continuous availability of neurosurgery, it is expected that there be an established plan for diversion of patients who might require time-sensitive neurotrauma care to lessen the need for secondary transfers.</b></p>
5.20	Treatment Guidelines for Orthopaedic Injuries	TYPE II	<p>All trauma centers must have treatment guidelines for, at minimum, the following orthopaedic injuries:</p> <p><b>Patients who are</b>  <b>Long bone fractures in patients with multiple injuries (e.g., time to fixation, order of fixation, and damage control versus definitive fixation strategies)</b>  <b>Open extremity fractures (e.g., time to antibiotics, time to OR for operative debridement, and time to wound coverage for open fractures)</b>  <b>Hip fractures in geriatric patients (e.g., expected time to OR (LI, LII, LIII))</b></p>



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5.21	Orthopaedic Surgeon Response	TYPE II	<p>In all trauma centers, an orthopaedic surgeon must be at bedside within 30 minutes of request for the following:            hemodynamically unstable, secondary to pelvic fracture            suspected extremity compartment syndrome            fractures/dislocations with risk of avascular necrosis (e.g., femoral head or talus)            vascular compromise related to a fracture or dislocation            trauma surgeon discretion</p> <p>The orthopaedic surgeon must be involved in the clinical decision-making for care of these patients.</p>
5.22	Operating Room Scheduling Policy	Type II	<p>All trauma centers must have an OR booking policy that specifies targets for timely access to the OR based on level of urgency and includes access targets for a range of clinical trauma priorities.</p>
5.23	Surgical Evaluation of ICU Patients	TYPE II	<p>In all trauma centers, trauma patients requiring ICU admission must be admitted to, or be evaluated by, a surgical service.</p> <p><b>There must be a policy that defines the hospital's expectation of the time frame within which a trauma consult is performed for an ICU trauma patient. For example, a tertiary exam can be done before the trauma service signs off, or completed within 2 hours, 6 hours, or 24 hours, or as determined by the hospital policy.</b></p> <p><b>The ICU policy includes notification of changes in care to the trauma service.</b></p>
5.24	Trauma Surgeon Responsibility for ICU Patients	TYPE II	<p>In all trauma centers, the trauma surgeon must retain responsibility for the trauma patient in the ICU up to the point where the trauma surgeon documents transfer of primary responsibility to another service.</p> <p><b>The trauma surgeon will retain responsibility while the trauma patient is under their care; this requires that they be kept informed of and concur with major therapeutic and management decisions dedicated ICU team.</b></p>
5.25	Communication of Critical Imaging Results	TYPE II	<p>In all trauma centers, documentation of preliminary diagnostic imaging must include evidence that critical findings were communicated to the trauma team. The final report must accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretations.</p>
5.26	Timely CT Scan Reporting	TYPE II	<p>In all trauma centers, documentation of the final interpretation of CT scans must occur no later than 12 hours after completion of the scan.</p>
5.27	Rehabilitation Services during Acute Phase of Care	TYPE II	<p>All trauma centers must meet the rehabilitation needs of trauma patients by:  <b>Developing protocols that identify which patients will require rehabilitation services during their acute inpatient stay</b>  <b>Establishing processes that determine the rehabilitation care, needs, and services required during the acute inpatient stay</b>  <b>Ensuring that the required services during acute inpatient stay are provided in a timely manner</b></p>
5.28	Rehabilitation and Discharge Planning	TYPE II	<p>All trauma centers must have a process to determine the level of care patients require after trauma center discharge, as well as the specific rehabilitation care services required at the next level of care. The level of care and services required must be documented in the medical record.</p>



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5.29	Mental Health Screening	TYPE II	<p>All trauma centers must meet the mental health needs of trauma patients by having: A process for referral to a mental health provider when required (LIII)</p> <p><b>Level III trauma centers are required to have a means of referral should a problem or risk be identified during inpatient admission.</b></p>
5.30	Alcohol Misuse Screening	TYPE II	<p>All trauma centers must screen all admitted trauma patients greater than 12 years old for alcohol misuse with a validated tool or routine blood alcohol content testing. Programs must achieve a screening rate of at least 80 percent.</p> <p><b>This standard applies to all admitted trauma patients, regardless of activation status. Screening methods are at the discretion of the individual center.</b></p>
5.31	Alcohol Misuse Intervention	TYPE II	<p>In all trauma centers, at least 80 percent of patients who have screened positive for alcohol misuse must receive a brief intervention by appropriately trained staff prior to discharge. This intervention must be documented.</p> <p>Level III trauma centers must have a mechanism for referral if brief intervention is not available as an inpatient.</p> <p><b>Appropriately trained staff will be determined and credentialed by the institution. This may include nurses, social workers, etc.</b></p>
<b>6   Data Surveillance and Systems</b>			<p>High-quality data are critical to inform quality improvement and measure the performance of trauma programs. This is dependent on having well-trained registry personnel working closely with trauma leadership. High-quality data also allow for focused quality improvement activities and maximize the value of trauma benchmarking programs.</p>
6.1	Data Quality Plan	TYPE II	<p>All trauma centers must have a written data quality plan and demonstrate compliance with that plan. At minimum, the plan must require quarterly review of data quality.</p> <p><b>The plan should allow for a continuous process that measures, monitors, identifies and corrects data quality issues and ensures the fitness of data for use.</b></p> <p><b>Ensuring data validity is an important part of a data quality plan. Validation may be internal or external. Examples of external data validation include the Trauma Quality Programs (TQP) Data Center Validation Summary Report and the TQP Data Center Submission Frequency Report.</b></p> <p><b>High-quality data are necessary for focused quality improvement efforts.</b></p>



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6.2	Trauma Registry Patient Record Completion	TYPE II	<p>In all trauma centers, the trauma registry must be concurrent, defined as having a minimum of 80 percent of patient records completed within 60 days of the patient discharge date.</p> <p><b>A completed record is one where all of the required data have been entered in the registry and the record has been closed. Timeliness of data collection is necessary so that centers can validate their data and identify opportunities for improvement at the earliest possible time.</b></p>
6.3	Trauma Registry Data Collection and Submission	TYPE II	<p>In all trauma centers, trauma registry data must be collected in compliance with the NTDS inclusion criteria and data element definitions, and must have been submitted to the TQP Data Center in the most recent call for data.</p> <p><b>The “most recent call for data” is defined as the most recent call for data that occurred more than 30 days prior to the site visit.</b></p> <p><b>As an example:</b>  <b>A TQP call for data closed on March 1st. The subsequent TQP call for data closed on June 1st. For a center with a visit on June 15th, they will have been required to collect the data in compliance with NTDS definitions and submitted their data by March 1st. For a center with a visit on August 15th, they will need to meet the standard for data submitted by June 1st. Data collection using standardized definitions is necessary to allow centers to compare their processes and outcomes with other centers. Timeliness of data collection and submission is necessary to ensure that opportunities for improvement are readily identified.</b></p>
<b>7   Performance Improvement and Patient Safety</b>			<p>Processes for identifying adverse events and implementing subsequent corrective action plans—measurable through patient outcomes—are inherent cornerstones of continuous performance improvement and patient safety (PIPS). Problem resolution, outcomes improvement, and assurances of patient safety (“loop closure”) must be readily identifiable through structured PI initiatives.</p>



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7.1	Trauma PIPS Program	TYPE II	<p>In all trauma centers, the trauma PIPS program must be independent of the hospital or departmental PI program, but it must report to the hospital or departmental PI program.</p> <p><b>The PIPS program must be empowered to identify opportunities for improvement and develop actions to reduce the risk of patient harm, irrespective of the department, service, or provider. The expected frequency and level of review require the PIPS program to function independently from the hospital/departmental PI program. However, the PIPS program must have a means to report events and actions to a departmental/hospital</b></p> <p><b>PI program so that events are aggregated across the organization.</b></p> <p><b>The hospital or departmental quality program must provide feedback and loop closure to the trauma program. Trauma care typically involves many providers across several disciplines and departments. The PIPS program is most effective when it brings the providers together to review and implement opportunities for improvement.</b></p>
7.2	PIPS Plan	TYPE II	<p>All trauma centers must have a written PIPS plan that:</p> <p><b>Outlines the organizational structure of the trauma PIPS process, with a clearly defined relationship to the hospital PI program</b></p> <p><b>Specifies the processes for event identification. As an example, these events may be brought forth by a variety of sources, including but not limited to: individual personnel reporting, morning report or daily sign-outs, case abstraction, registry surveillance, use of clinical guideline variances, patient relations, or risk management. The scope for event review must extend from prehospital care to hospital discharge.</b></p> <p><b>Includes a list of audit filters, event review, and report review that must include, at minimum, those listed in the Resources section</b></p> <p><b>Defines levels of review (primary, secondary, tertiary, and/or quaternary), with a listing for each level that clarifies: Which cases are to be reviewed</b></p> <p><b>Who performs the review</b></p> <p><b>When cases can be closed or must be advanced to the next level</b></p> <p><b>Specifies the members and responsibilities of the trauma multidisciplinary PIPS committee</b>  <b>Outlines an annual process for identification of priority areas for PI, based on audit filters, event reviews, and benchmarking reports</b></p>
7.3	Documented Effectiveness of the PIPS Program	TYPE II	<p>All trauma centers must have documented evidence of event identification; effective use of audit filters; demonstrated loop closure; attempts at corrective actions; and strategies for sustained improvement measured over time.</p>



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7.4	Participation in Risk-Adjusted Benchmarking Programs	TYPE II	<p>All trauma centers must participate in a risk-adjusted benchmarking program and use the results to determine whether there are <u>opportunities for improvement in patient care and registry data quality</u>.            TQIP meets the participation requirement for a risk-adjusted benchmarking program.  <b>Risk-adjusted benchmarking programs other than TQIP must meet criteria listed on the TOP website, found on <a href="http://www.facs.org">www.facs.org</a>.</b>  <b>Participation in a risk-adjusted benchmarking program with regular review of data provides the best opportunities for centers to understand where there might be gaps in their quality of care.</b></p>
7.5	Physician Participation in Prehospital Performance Improvement	TYPE II	<p>In all trauma centers, a physician from the emergency department or trauma program must participate in the prehospital PI process, including assisting in the development of prehospital care protocols relevant to the care of trauma patients.</p>
7.6	Trauma Multidisciplinary PIPS Committee Attendance	TYPE II	<p>All trauma centers must meet the following trauma multidisciplinary PIPS committee meeting attendance thresholds:            60 percent of meetings for the TMD (cannot be delegated to the associate TMD)            50 percent of meetings for each trauma surgeon            50 percent of meetings for the liaisons (or one predetermined alternate) from emergency medicine, neurosurgery, orthopaedic surgery, critical care medicine, anesthesia, and radiology</p>
7.7	Trauma Mortality Review	TYPE II	<p>In all trauma centers, all cases of trauma-related mortality and transfer to hospice must be reviewed and classified for potential opportunities for improvement.</p> <p>Deaths must be categorized as:  <b>Mortality with opportunity for improvement</b>  <b>Mortality without opportunity for improvement</b></p> <p><b>Mortalities include DOA, DIED, and patients who died after withdrawal of life-sustaining care.</b></p> <p><b>The goal of reviewing events is to identify potential opportunities for improvement.</b></p> <p><b>A death should be designated as “mortality with opportunity for improvement” if any of the following criteria are met:</b>            Anatomic injury or combination of severe injuries but may have been survivable under optimal conditions            Standard protocols were not followed, possibly resulting in unfavorable consequence            Provider care was suboptimal</p> <p><b>Reviewing each mortality and transfer to hospice provides the greatest assurance that the trauma program will identify opportunities for improvement. Transfers to hospice require review to ensure there were no opportunities for improvement in care that might have significantly changed the clinical course that ultimately led to the decision for hospice care.</b></p>



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7.8	Nonsurgical Trauma Admissions Review	TYPE II	<p>In all trauma centers, all nonsurgical trauma admissions must be reviewed by the trauma program.</p> <p>Nonsurgical admissions (NSA) without trauma or other surgical consultation, with ISS &gt; 9, or with identified opportunities for improvement must, at a minimum, be reviewed by the TMD in secondary review.</p> <p><b>Nonsurgical admissions with trauma or other surgical consultations, with ISS ≤ 9, or without other identified opportunities for improvement may be closed in primary review.</b></p>
7.9	Trauma Diversions Review	TYPE II	<p>In all trauma centers, all instances of diversion must be reviewed by the trauma operations committee.</p>
7.10	Prehospital Care Feedback	TYPE II	<p>All trauma centers must have a process of reviewing and providing feedback to:</p> <p><b>EMS agencies, related to accuracy of triage and provision of care</b></p> <p><b>Referring providers, related to the care and outcomes of their patients and any potential opportunities for improvement in initial care</b></p>
<b>8   Education: Professional and Community Outreach</b>			<p>Education and outreach programs are integral parts of the trauma program and are designed to help improve outcomes from trauma and minimize the effects of injury. Trauma centers have an obligation to educate future providers and ensure that the public has an opportunity to access educational resources relevant to injury care.</p>
8.1	Public and Professional Trauma Education	TYPE II	<p>All trauma centers must provide public and professional trauma education.</p> <p><b>Examples of public and professional trauma education include:</b>  <b>Advanced Trauma Life Support® (ATLS®)</b>  <b>International Trauma Life Support© (ITLS©)</b>  <b>Prehospital Trauma Life Support® (PHTLS®)</b>  <b>STOP THE BLEED®</b>  <b>Trauma Evaluation and Management™ (TEAM™)</b></p>



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8.2	Nursing Trauma Orientation and Education	TYPE II	<p>All trauma centers must provide trauma orientation to new nursing staff caring for trauma patients. Nurses must participate in trauma CE corresponding to their scope of practice and patient population served.</p> <p><b>Examples of orientation may include:</b>            Center-developed educational program that integrates PIPS-identified issues            Education specific to patient population served</p> <p><b>Nursing orientation may include simulation sessions, online learning, conferences, and annual training events.</b></p> <p><b>Examples of nursing education may include:</b>            ATCN—Advanced Trauma Care for Nurses            TNCC—Trauma Nursing Core Course            PCAR—Pediatric Care After Resuscitation            TCAR—Trauma Care After Resuscitation            TNATC—Transport Nurse Advanced Trauma Course</p>
8.3	Prehospital Provider Training	TYPE II	In all trauma centers, the trauma program must participate in the training of prehospital personnel.
<b>9   Research</b>			