The Texas Administrative Code Title 25, Section 157.125 Trauma Facility Designation Requirements were developed in 2005 and became effective in 2006. The American College of Surgeons, Resources for Optimal Care of the Inured Patient, revised the national trauma facility criteria in 2006, 2014, and again in 2020. The Texas stakeholder discussions regarding Texas trauma facility requirement revisions began in 2011 and have been continuing. The department has posted on its website a "Resource Document", containing potential trauma center designation revised rule language. In addition, to facilitate stakeholder discussions regarding the potential revisions of these rules and at the request of the Trauma System Committee and the GETAC Council in February of 2020, the department developed this "Evidence of Compliance" document to illustrate potential changes to designation elements. These standards reflect the current national standards recommended by the American College of Surgeons Verification Criteria, the American College of Surgeons Trauma Systems Consultation Process, issues brought forward to the GETAC Council and its committees, as well as the department's recommendations. This document is intended to facilitate discussion of the various designation elements with stakeholders.

It is important to note that the department is in the beginning phases of these discussions. All stakeholders will have an opportunity to provide comments at future GETAC Trauma System Committee meetings, GETAC Council meetings, and during the department's informal and formal rule comment periods.

Texas Administrative Code Title 25, Section 157.125, Trauma Facility Designation

Rule Discussion "Evidence of Compliance" Document

Level of Designation	Discussion Elements	Evidence of Compliance	COMMENTS
	Elements		
All Trauma Centers	C. 1. & 2. Application for designation is completed and submitted to the State, with the non-refundable, non-transferable designation fee.	Completed application is submitted requesting the level of designation. Note: Facilities wishing to increase their level of trauma center or move to a lower level of trauma center must complete an application and repeat the survey process.	
All Trauma Centers	C. 3. Trauma designation occurs every three years for existing designated facilities and must be completed prior to expiration of a current designation. The application and all survey documents must be submitted to the department a minimum of 90 days prior to the facility's current designation expiration date.	Re-designation occurs before the current designation expires. Application must be received within the timelines outlined.	
All Applicable Trauma Centers	C. 5. Facilities seeking their initial designation will complete a scheduled conference call with the department, and include the facility's CEO, CNO, Trauma Executive Leader (as appropriate), TMD, and the TPM. NOTE: These facilities must have their TMD, and TPM in place with documented job descriptions, documented trauma activation guidelines, documented standards of care to include their evidence-based practice guidelines, trauma performance improvement plan and established processes or their trauma performance improvement processes to include a formalized multidisciplinary peer review to move forward with their designation process.	Complete the conference call and address recommendations. The facility must have a documented Trauma Operations Plan forwarded to the department prior to the scheduled conference call. NOTE: These facilities must have their TMD, TPM in place with documented job descriptions, documented trauma activation guidelines, documented standards of care to include their evidence-based practice guidelines, trauma performance improvement plan and established trauma performance improvement processes to include a formalized multidisciplinary peer review committee , and then meet with their RAC leadership team to review their processes and documents	

		to request inclusion in the field triage criteria.	
All Applicable Trauma Centers	C. 6. Facilities designated with contingencies, or denial of designation will schedule a conference call with the department staff to discuss a corrective action plan. The call must include the facility's Chief Executive Officer, Chief Nursing Officer, Chief Medical Officer or Chief of Staff, TMD, and their TPM.	Completed conference call. NOTE: DSHS may waive the conference call.	
All Trauma Centers	D. Facilities must submit a completed application packet to the department 90 days prior to the facility's current designation expiration date. The completed application includes the following documents: • The completed departmental application and the pre-review questionnaire as indicated, the facility's trauma operational plan, requested trauma performance improvement plan summaries for the past three years, the past three years Trauma Registry data submission and validation reports, budget summaries, defined corrective action plan as needed, and the designation fee. • The completed designation survey report, to include the medial record reviews and any identified corrective action plans must be submitted to the department within 60 days of the site survey report.	All application documents are submitted within 90 days of the facility's current designation expiration date. The site survey report and plans of corrective action are submitted 60 days following the site survey date. The application packet will include a copy of identified documents and the designation fee.	
All Trauma Centers	D. If deficiencies or noncompliance are identified in the survey report, the facility includes the developed	Submission of the corrective action plan, to include the name and title of the responsible individual, monitoring	

	and implemented plan of correction, that includes: • Cited deficiency or noncompliant issue • Details of the corrective action plan • Title of individuals responsible for ensuring the corrective action plan is implemented within 30 days of the site survey • Defined data analysis of how the corrective action plan is monitored, and documented evidence of reporting progress through the trauma operations committee.	tools, and outcomes. Note: All documentation must be submitted with the application within 90 days of the site survey.	
All Trauma Centers	E. Documented evidence of participation in their Regional Advisory Council is included in the application packet. Initial designation facilities must have a documented 12 months of participation prior to their designation survey.	A documented letter from the Regional Advisory Council confirming annual participation for the past three years is included in the application. Hospitals seeking initial designation will submit a letter from the RAC confirming documented 12 months of participation prior to their designation survey.	
All Trauma Centers	F. Evidence of trauma registry data submission is included in the application packet. Facilities seeking initial designation must have a minimum of twelve months of data to include twelve months of data submission in the quarterly submissions to the state trauma registry.	DSHS registry submission reports must include data validation reports, and evidence of validation error corrections for the past three years. NOTE: Submission to the DSHS registry is quarterly. Registry inclusion criteria must align with the NTDB criteria, and definitions. Facilities seeking their initial designation will submit twelve months of data and the evidence of quarterly submission and data validations.	
All Trauma Centers	G. Documents requested by DSHS during the survey period are included in the application packet. The department will not process the application until all documents are received.	Facility is responsible to include all requested documents for a complete designation application packet.	

All Trauma Centers	9. NOTE: Facilities seeking initial designation that do not provide the complete requirements outlined, will have their application process held for 60 days for completion, a	Facilities must submit all required documents for their application to be processed.	
All Trauma Centers	11. The trauma facility designation application packet in its entirety is an element of the facility's trauma performance improvement, patient safety plan and there must be documented evidence of this external designation process written in the trauma performance improvement and patient safety plan to include all survey documents and all documents from the department specific to the survey. (Pursuant to confidentiality in the Health and Safety Code 773.095.)	The application, site survey documents, and the site survey report to include the medical record reviews are included in the "External Review" section of the facilities written Trauma Performance Improvement, Patient Safety Plan.	
All Trauma Centers	14. The hospital shall display the current trauma designation certificate in a public area of the designated facility that is readily visible to patients, employees, and visitors.	Document is displayed is a public area, such as the lobby, waiting rooms, or other defined public area of the hospital.	
All Trauma Centers	19. If a facility disagrees with the department's decision regarding designation status, the facility has the right to an appeal with the department director, and a second appeal with the defined trauma facility appeal workgroup, and the third step is a hearing, in accordance with the DSHS rules for contested cases, and Government Code 2001.	The request for the hearing shall be submitted following Government Code 2001 and documented. This request must be received within the defined timeline.	
	Exceptions and Notification		
All Trauma Centers	D. 1. The facility notifies EMS, all healthcare facilities that may be impacted, the Regional Advisory Council, and the department of an issue impacting the facility's ability to comply with a designation criteria to maintain their designation status, or the facility's decisions to increase their trauma	The facility maintains a copy of their documented notice to the EMS agencies, healthcare facilities, regional advisory council, and the department. NOTE: This documentation should include a brief corrective action plan and timeline, as appropriate. Issues where appropriate surgical coverage or equipment required to resuscitate	

	facility level of designation, or the facility's decision to their trauma center level of designation, and their regional integration through a documented notice within a timeframe that is conducive to patient care needs.	or manage a trauma patient must be immediately reported. Issues related to the criteria such as the loss of the TMD, TPM, or trauma registrar and there is not a back-up plan in place, or succession plan, must be reported within forty-eight hours. Other planned events such as a decision to upgrade trauma center level of designation or downgrade the level trauma designation must be report thirty days prior to implementation of change.	
All Trauma Centers	D. 2. If the facility is unable to comply with program requirements to maintain current designation, the facility shall submit to the department a plan of correction, and a request for temporary exception to criteria, in writing from their CEO. The department will review the request for exception and notify the facility of their decision within ten business days. The approved exceptions are for a three-month period. The facility can submit a request for a second, three-month exceptions. The second exception request must outline the facility's actions and progress of correction. If the facility is not able to meet the designation criteria after the second approved exception (total of six months), the department will downgrade the facility's level of designation to the appropriate level.	The request for temporary exception must define in detail how the variances in trauma program capabilities will impact trauma care and the facility's plan to ensure that optimal, timely trauma care will be maintained, and when services will return to normal operations. NOTE: The requested exceptions are for three months. If resources are not in place or issues corrected at the end of this three months, the facility must submit a revised plan and request a second exception for three months. If services or resources are not addressed within the end of the second three-month the department will downgrade the facility to the appropriate level of designation.	
	Program Requirements		
All Trauma Centers	K. 1. The facility maintains a written operational plan for their trauma program to include at a minimum: • Detailed description of the scope of services available for the trauma patient population and description of the trauma service	The written trauma program's operational plan meets the minimal requirements specific to the level of designation. The trauma registry is used to define the types of trauma patients evaluated in the trauma facility to include transfers and admissions. The trauma program defines the evidence-based practices to ensure all trauma patients receive optimal care from resuscitation through admission to	

	• Trauma population evaluated and treated by the facility to include those transferred • Trauma standards of care (to include all EVP, CPG, BPGs) in an appendix • Trauma policies and protocols (included in an appendix) • Staffing model • Staff and medical staff credentialing and educational requirements • Rounding and continuum of care follow-through • Data management • Processes to ensure the health and safety of patients • A documented and tested transfer plan for patients being transferred out of the facility • Trauma care specific to OR, ICU, and general units to include the nursing orientation for trauma, educational requirements with required certifications, and plan for trauma continuing education • Diversion and bypass (protocol needs to be in an appendix) • Support services capabilities to include Lab, Blood bank, Radiology, Interventional Radiology, Respiratory Therapy, Rehabilitation, and Psychosocial Services to include the Social Workers, and Chaplains • Trauma Operations Committee • Trauma Performance Improvement and Patient Safety Plan (as an attached appendix) • Processes to ensure all trauma designation requirements monitored for compliance • TQIP integration (included in an appendix) • Trauma registry protocols and processes (in an appendix) • Disaster management capabilities and how trauma services are integrated into	discharge, based on the current national standards and evidence-based practice or best practice guidelines. If 15% or greater of these patients are less than 15 years of age, then these guidelines need specific language to address the pediatric population. If more than 15% of these patients are 65 years of age or older, then the guidelines need specific language to address the geriatric patient population.	

	the all hazard disaster response • Injury Prevention capabilities • Outreach education services • Regional Advisory Council integration and collaboratives • EMS integration • Research support • Succession planning		
All Trauma Centers	K.1.A. The trauma program written operational plan and all associated policies, procedures, guidelines are reviewed and approved by the trauma operations committee and then forwarded to the governing body for review (Board, Medical Executive Committee, Senior Executive Team) a minimum of every three years.	The trauma program's operations committee reviews and approves all trauma protocols, standards of care, trauma performance improvement plan, and operational plan. Once approved at the operational level the documents are reviewed and approved by the governing body. There should be documented evidence of the trauma program operational plan is approved through the operations committee and forwarded to the Executive leadership for review every three years for review and approval.	
All Trauma Centers	K.1.A.i. The facility's Chief Executive Officer, Chief Nursing Officer, and Chief Medical Officer implement and maintain a Culture of Safety environment.	There is documented evidence of the Culture of Safety implementation and continued educational for all levels of staff.	
All Trauma Centers	K.1.A.ii. The facility's Chief Executive Officer, Chief Nursing Officer, and Chief Medical Officer implement and maintain Trauma-Informed Care practices at all levels.	There is documented evidence of the Trauma-Informed Care education and continued education for all levels of staff.	
All Trauma Centers	K.1.A.iii. The facility's Chief Executive Officer, Chief Nursing Officer, and Chief Medical Officer provide adequate resources to ensure the trauma program can be maintained 24/7/365, to ensure concurrent process are in place for the trauma program.	There is documented evidence of continual services and concurrent processes are maintained the trauma program.	
All Trauma Centers	K.1.A.iv. The facility's Chief Executive Officer and Chief Medical Officer have measures in place to monitor the trauma physician coverage and contract deliverables to ensure adequate trauma coverage with backup coverage when needed, and compliance to defined criteria such as education and training, timeliness of activation response, attendance at specific meetings, disaster response and planning, as well as regional integration in organizations that	Executive Officers monitor the contract deliverables and compliance of the defined contracts. The Executive Officers have the TMD and TPM provide updates to Senior Leadership and the Board (Board of Managers) to review trauma center performance and trauma outcomes. This is a documented element of their annual performance improvement review.	

	promote trauma system development and trauma quality care initiatives.		
All Trauma Centers	K.1.A.v. The Chief Executive Officer and Chief Financial Officer or designee in conjunction with the TMD and TPM have established processes to monitor and track the trauma activation fees and trauma patient charges to define an annual report that includes and defines the number and level of trauma activations initiated by the facility, the number of trauma admissions, and trauma transfers. The identified amount of uncompensated trauma care provided by the hospital. Patients must meet the trauma activation criteria and have evidence of review through the trauma performance improvement process for compliance to be included in this process. The trauma operational budget and the physician contract fees are included in the trauma center's annual financial report	The Executive Officers, TMD, and TPM are responsible for defining the cost of trauma care at their facility. This information will be required for the trauma uncompensated care grant and the annual report. Patients must meet the facility's trauma activation criteria to be included in this process.	
All Trauma Centers	K.1.B.i. The written trauma program operational plan shall include, at a minimum • Policies and trauma management guidelines based on national evidence-based standards of practice in trauma care, that are adopted, implemented, enforced and monitored for compliance by through the trauma performance improvement and patient safety plan, through all phases of care for all patient populations;	The trauma registry is used to define the types of trauma patients evaluated in the trauma facility to include transfers and admissions. The trauma program defines the evidence-based practices to ensure all trauma patients receive optimal care from resuscitation through admission to discharge, based on the current national standards and evidence-based practice or best practice guidelines. If 15% or greater of these patients are less than 15 years of age, then these guidelines need specific language to address the pediatric population. If more than 15% of these patients are 65 years of age or older, then the guidelines need specific language to address the geriatric patient population.	
All Trauma Centers	K.1.B.ii. All trauma care policies, procedures, and guidelines are reviewed for needed revisions every three years, or when there is a change in the TMD, TMD, change in the level of designation, or change in hospital ownership.	There is evidence the documents are reviewed and revised every three years or when the additional criteria are met.	
All Trauma Centers	K.1.B.iii Written and tested triage, stabilization, and transfer guidelines for the trauma patient that includes consultation with transport services. All trauma patients transferred out of the	The facility must have written triage, stabilization, and transfer guidelines that meet national standards and defines the collaboration with transport services and times for transfer process. Best practice of	

	facility must be transferred to a trauma center with a higher level of designation.	sharing obtained images between the transferring and the receiving facility to facilitate decision-making when the patient condition allows should be included in the transfer guidelines. These written guidelines must be tested and practiced ensuring 24/7 services are available and that they meet the patient's needs within the defined timelines. All trauma patients transferred out of the facility must be transferred to a trauma center with a higher level of designation.	
All Trauma Centers	K.1.B. iv. Written and tested assessment, treatment, referral and transfer guidelines for patients with the following: (I) burn injuries to include a plan to expedite the transfer of acute major and severe burn patients for specialized care; (II) identified neurologic deficit due to spinal cord injury and / or moderate to severe traumatic brain injuries (GCS of 11 or less, mass effect on CT scan, lateral signs), hypotension in combination with spinal cord injury or a traumatic brain injury, to include a plan to expedite the transfer of these acutely injured patients for specialized care; and (III) complex orthopedic pelvic and acetabular or long bone fractures, hemodynamically unstable pelvic fractures, fractures with the potential for vascular necrosis or vascular compromise, partial or complete amputation of a long bone/extremity to include a plan to expedite the transfer of these acutely injured patients (IV) suspected and/or confirmed maltreatment injuries of all patient populations (V) measures to prevent over-imaging, processes to share images with the receiving facility (VI) pain management standards are addressed.	The facility must have written evidence-based guidelines, best practice or clinical practice guidelines for the types of injuries cared for at the facility. At a minimum those listed must be addressed. The trauma registry must be utilized to define the frequency and incidence of these types of injuries cared for at the facility. These guidelines must be reviewed and revised every three years.	

	(VII) standards for implementing and managing massive transfusion resuscitations		
All Trauma Centers	K.1.B.v. Provisions for the availability of all necessary equipment and services to administer the appropriate level of care and support of the trauma patient population served.	The facility through its established standards of care and evidence-based practice will define the equipment and resources needed to meet these standards through all phases of care for all patient populations evaluated, transferred, and admitted by the trauma facility. The facility is responsible for integrating EMS agencies into this assessment to ensure transfers are expedited and any specialty equipment needs are addressed.	
All Trauma Centers	K.1.B.vii. All trauma centers must meet and maintain the Pediatric Readiness Criteria.	Facilities seeking trauma designation must have documented evidence of compliance to the Pediatric Readiness Criteria.	
All Trauma Centers	K.1.B.viii. Telemedicine utilization in rural Emergency Services must have written protocols and follow the facilities written standards of care and meet the 30,000 population per county. The advanced practice provider must respond to the patient's bedside within fifteen minutes of notification. The advanced practice provider must have a current ATLS verification and participate in the multidisciplinary performance improvement reviews. Must demonstrate the compliance to the standards of care and have the physician backup resource as needed.	Rural level IV trauma facilities rural criteria of 30,000 individuals in the county or less and must follow the telemedicine re utilize telemedicine requirements to have an advanced practice provider that is on site and immediately available to respond to all arriving trauma patients regardless of their mechanism and injury severity. The advanced practice provider or identified physician must have a current ATLS verification and be credentialed by the TMD and hospital for trauma resuscitations and treatment.	
All Trauma Centers	K.1.B.ix. Telemedicine in non-rural settings must have document protocols for utilization that include response times and written standards of care that are monitored through the facilities trauma performance improvement plan.	Non-Rural Level IV, Level III, II, and I trauma centers utilizing telemedicine capabilities for trauma patients must define when these resources are to be used, what level of provider is credentialed for telemedicine capabilities, and their response times to ensure standards of care, and evidence-based practice guidelines are met. It should be noted that	

		telemedicine cannot replace ongoing assessments and "rounding" for patient follow-up and the plan of care for patients admitted to the trauma center. Telemedicine utilization is monitored through the trauma performance improvement plan.	
All Trauma Centers	K.1.B.xi. Provisions for medical and healthcare staff education, including annual competencies and skill assessment appropriate to the patient population served, and team-based training at frequent intervals for high-risk events	The trauma facility will define the minimal training, educational standards, and credentials for the staff caring for the trauma patient population through all phases of care, and all population. The facility will utilize the trauma registry to define the common injuries and procedures for the trauma patient population served by the facility and ensures that staff have the skills, competency and credentialing to provide this care. The facility defines the team training necessary for multidisciplinary members of the trauma team to ensure optimal communication and coordination of care in compliance with the culture of safety. The facility identifies high-risk events associated with trauma care such as high acuity multisystem trauma patients, special populations with high acuity injuries, trauma patients requiring medical decontamination, multiple casualty events, and mass casualty then defines processes for team training, communication, and coordination of these events annually.	
All Trauma Center	K.1.B.xii. The role and expectations of the hospitalist/intensivist physician in the care of the trauma patient is documented and defined in the trauma standards of care and management guidelines.	The trauma program plan will define the role of the hospitalist and intensivist physician in the care of the admitted trauma patient to ensure the trauma standards of care and evidence-based practice guidelines as well as trauma facility requirements are met.	
All Trauma Centers	K.1.B.xiii. Identification of a program sponsor (administrative leader) who is a member of the	The trauma program operational plan identifies the executive leader responsible for the trauma program.	

	executive leadership team at the facility	This individual must have evidence and documentation of participation in the planning for the trauma facility designation survey, budget development to include systems for tracking, monitoring, and defining the cost of trauma care, and attendance at the trauma operations meeting.	
All Trauma Centers	K.1.B.xiv. Provisions of consistent participation by the TMD, TPM, Trauma Registrar, and/or other members of the trauma program in the RAC trauma and disaster committees and activities.	The trauma program operational plan will define the expected participation of the TMD, TPM, Registrar and other members of the trauma program at the Regional Advisory Council. The trauma facility must provide an annual participation tracking of these individuals for the past three years during the trauma site survey. (Note: If a Trauma Program Director is in place, this individual must meet at a minimum the same requirements and expectations of the Trauma Program Manager.)	
All Trauma Centers	K.1.B.xv. Contingency plans to ensure the immediate continuation of an active trauma program if the TMD and-or TPM positions becomes vacant; and	The trauma center operational plan will define a temporary succession plan for the TMD and TPM to ensure immediate continuation until full-time replacement is in place. If this cannot be accomplished, the trauma center must notify the regional advisory council and the department within twenty-four hours.	
All Trauma Centers	K.1.B.xvi. A trauma staff registered nurse as a representative on the nurse staffing committee as established in accordance with TAC 133.41(o)(2)(F).	The trauma program must be staffed to ensure all elements of the trauma program and requirements are consistently addressed to ensure a concurrent program. The trauma program manager or designee is a member of the nursing staffing effectiveness committee and organizationally structured to make decisions and recommendations specific to trauma care throughout the continuum that meet the national standards for staffing.	
All Trauma Centers	K.2. Medical Records. Maintain medical records that contain information to justify and support the immediate evaluation,	The TMD and TPM have input in the design and development of the trauma flow sheet and all documents specific to the continuum of trauma	

	activation, resuscitation, diagnosis, treatment, and describe the patient's progress and response to interventions from arrival in the emergency department through hospital discharge. Records include patient care reports provided by EMS to the facility receiving the trauma patient. Each area must have trauma documentation standards.	care (electronic or paper) to ensure the document facilitates the capture of the mechanism of injury, level of activation, trauma activation time, trauma response time, the primary survey, and secondary survey, diagnostic intervention, and injuries identified to ensure the timing and sequencing of data capture and documentation define the care and coordination of care provided. This includes the inpatient documentation for progress notes, consultation, specific injury or age-related documentation, and the plan of care for the trauma patient population. NOTE: The supervising manager of the staff must monitor the documentation standards for their unit and report findings to the Trauma Operations Committee.	
All Trauma Centers	K.3. Trauma Performance Improvement Patient Safety Plan. The facility shall develop, implement, maintain, and evaluate an effective, ongoing, facility-wide, data-driven, outcome-based, trauma performance (PI) improvement and patient safety plan that aligns with the Culture of Safety. The Joint Commission taxonomy to include the levels of harm, levels of review, and classification processes are integrated into the plan. The plan must define the levels of review and the TMD's role in the secondary and tertiary levels of review. The plan must use the defined terminology when reviewing trauma mortality: mortality without opportunity; mortality with opportunities; mortality with regional opportunity for improvement. The plan shall be individualized to the facility and population served, and meet the requirements described in this section.	The TMD and TPM will develop a written Trauma Performance Improvement Patient Safety Plan that monitors all phases of care and compliance to the standards of care, system performance, morbidity and mortality, and trauma center criteria compliance. The plan outlines the levels of review, what led to the event, corrective action plans, and event resolution. The plan outlines the committee structure for the trauma operations committee and the multidisciplinary trauma peer review committee. The plan outlines the reporting structure of the trauma operations committee to the hospital quality/risk performance improvement committees and processes to report to executive leaders and the governing body.	

All Trauma Centers	K.3.A. The trauma performance improvement and patient safety plan (TPIPS) shall be reviewed and approved by the facility's trauma operations committee and presented to the executive officers and governing body. The governing body and facility administration shall ensure the requirements of this section are implemented and enforced.	There is documented evidence the trauma operations committee reviewed the trauma performance improvement plan and it is then presented to the executive officers and governing body for review. The trauma PIPS plan is revised a minimum of every three years, or when a new TMD or TPM is hired, or when the facility decides to upgrade or downgrade its level of trauma designation. The trauma center must have an electronic process of capturing all trauma PI events and the performance improvement process.	
All Trauma Centers	K.3.B. The trauma PIPS plan shall include, at a minimum: (1) A description of the facility's trauma program and services provided. All facility services including those services provided under contract or arrangement shall focus on decreasing deviations from the trauma standards of care to ensure achievement of optimal trauma patient outcomes, patient safety standards, and cost-effective care. The plan includes how the facility will identify events or variations from the standards of care or system standards, complications, and death. Each event will have a defined level of harm that assists in triaging processes the event through to resolution, following the Culture of Safety practices. (ii) How the trauma program evaluates the standards of practice, provision of trauma care and patient services, identified opportunities for improvement, develops and implements improvement plans, and evaluates the plan's outcomes until resolution is achieved. (iii) Evidence to support that aggregate patient data, including	There is a documented trauma performance improvement patient safety plan that outlines processes to monitor system performance, patient outcomes, and trauma facility requirement compliance on a continual and scheduled basis with defined reports that are shared in the trauma operations committee and trauma peer review committee. The plan outlines process of how events are identified, documented, validated, to include the identified level of harm. It defines the processes through the levels of review and defines the contributing factors that lead to the event. All deaths must be reviewed through this process utilizing the standardized language. Standardized corrective action plans are outlined and how issues are tracked through resolution. The plan has specific processes in place to monitor participation and attendance at committee meetings. There is written summary of the twelve months trauma performance improvement and patient safety activities to include patient outcomes. There is written evidence that a twelve-month performance	

	identification and tracking of trauma patient complications, variances from the standards of care, and the tiered levels of review, are continuously evaluated for opportunities by the multidisciplinary trauma PI and peer review committees. (iv) Required members of the multidisciplinary PI and peer review committee(s) shall include at a minimum: (I) the TMD (II) the TPM (III) the Trauma Registrar (TR) (IV) an executive officer of the facility (Administrator/Vice President of Trauma, Chief Nursing Officer, or Chief Medical Officer) (V) a Trauma nurse(s) active in the management of adult/or pediatric trauma patients as applicable, (VI) physicians and surgeons that provide care to trauma patients, and (VII) other healthcare professions participating in the care of major or severe trauma patients. (v) Provisions to document the attendance, activities, actions, and follow-up of outcomes by the multidisciplinary trauma PI and peer review committee(s); (vi) Provisions to document evidence of ongoing monthly review of trauma facility regulatory compliance, trauma patient outcomes, and trauma system performance improvement from multidisciplinary trauma PI and peer review committee meetings; and (vii) documentation that a 12-month summary, of the trauma PI program activities, was provided to the governing body for review. (viii) facilities that participate in trauma outcomes benchmark reporting must have evidence that	improvement plan outcomes summary is shared with quality/risk program, the executive leaders, and the hospital governing body. The trauma center shares requested data at the regional advisory council's trauma system performance improvement committee to promote system performance improvement and outcomes.	

	this information is shared through the trauma operations committee and the governing body and measures to improve the "low performance" areas are defined and monitored for resolution.		
All Trauma Centers	K.4. The Texas EMS/Trauma Registry Requirements. All designated trauma facilities must submit accurate, timely, and complete trauma registry data to the Texas EMS/Trauma Registry quarterly, following the EMS/ Trauma Registry data inclusion criteria. Designated facilities must submit data to the Texas EMS / Trauma Registry quarterly and maintain records to demonstrate data validation and the correction of identified errors for inclusion in the designation application process. Level I, II, and III trauma facilities shall submit their data to the American College of Surgeons NTDB each quarter as they submit the data to the State Registry.	The trauma facility must define the resources and FTEs necessary to meet the designation requirements for their level of trauma center based on the potential number of trauma activations and their trauma registry inclusion criteria to ensure each record is reviewed and data abstraction begins during admission and is completed when patient is discharged to ensure a concurrent registry. The most current NTDB data definitions and inclusion criteria are utilized by the facility. There is documented evidence of the Level I, II, and III trauma facilities submitting their trauma registry data to the American College of Surgeons NTDB.	
All Trauma Centers	K.4. A. For initial designation, twelve full months of data must be submitted to and received by the Texas EMS/Trauma Registry prior to the initial designation survey.	The trauma registry data made available for the initial trauma designation survey must match the timeframe selected for the review to ensure the medical records reviewed during the survey have evidence of trauma registry data collection and submission to the state, quarterly. There must be evidence of data validation and data correction during this initial trauma registry process.	
All Trauma Centers	K.4.B. For renewal of designation, data shall be submitted to and received by the Texas EMS/Trauma Registry continuously throughout the three-year designation cycle.	The designation cycle is approximately three years. There must be evidence that the trauma registry data abstraction, entry, data validation, corrective action, and submission to the state is continual and data is submitted at a minimum quarterly. The data submitted for the trauma designation application regarding trauma activations, and trauma	

		registry entries, and the state registry data submissions should align.	
All Trauma Centers	K.4.C. Trauma data shall be submitted as defined in Chapter 103, Injury Prevention and Control.	There must be documented evidence of compliance to data validation and quarterly submissions.	
All Trauma Centers	K.4.D. Trauma data shall be completed within sixty days of patient discharge, with an 80% completion rate and submitted to the state trauma registry quarterly.	Trauma registry data abstraction should begin within 48 hours of the patient's arrival or next business day and be completed after discharge. Data validation and accuracy checks should be completed. The trauma center maintains a minimal threshold of 80% compliance to registry records being completed, validated, and corrected within 60 days of the patient's discharge. Recommended trauma registrar staffing is one full-time registrar for every 500 trauma registry admissions; a .8 registrar FTE for 300 up to 499 trauma registry admissions; and .5 registrar FTE for up to 299 trauma registry admissions to ensure a concurrent, accurate, and complete process. (NOTE: these trauma registrar staffing recommendations focus only on the data abstraction and data entry. If the registrar has other job functions other than the abstraction and data entry, these volume numbers will need to decrease.)	Will review the ACS Trauma Center Criteria which will be released in March of 2021 to evaluate need to align this section with the ACS criteria for all trauma centers.
All Trauma Centers	K.4.E. the Trauma Registrar and/or TPM must ensure ongoing internal data validation and accuracy for data submissions to the state registry.	The facility must include the documented evidence of the data validation and data submissions to the state registry that demonstrate a minimum of quarterly submission in the designation application.	
All Trauma Centers	K.4.F. Trauma patients, received at a provider-based department not contiguous with the designated facility but under the same hospital licensure, that meet trauma registry inclusion criteria must be included in the trauma registry and the trauma performance improvement process.	There must be data that identifies the number of trauma patients evaluated and managed at the provider-based department not contiguous but under the same hospital licensure, of the designated facility and evidence of trauma registry inclusion and reports reflect the trauma performance improvement review process.	

Level I, II, and III	K.5. Outreach and Healthcare Provider Education. A. There shall be an identified individual to coordinate the facility's outreach and education programs.	The facility must have an identified individual that has outreach education outlined job functions and responsibilities defined in their job description. If the trauma program has 500 or greater trauma activations, these functions are completed by someone other than the trauma program manager.	
Level I, II, and III	K.5.B. The facility shall provide training programs in trauma-related continuing education, for staff and community members involved in trauma care, based on needs identified from the trauma PI program including: (i) staff, specialty and community physicians (ii) nurses (iii) advanced practice clinicians, including Physician Assistants, Advanced Nurse Practitioners, and Certified Registered Nurse Anesthetists,	There must be documented evidence of these educational offering identified through PI or data review. The facility can address this issues by providing specific courses. There must be documented evidence to include the educational plan, and the course participants, available during the survey process. Example of courses are: PALS, ENPC, TNCC, ATCN, ATLS, ITLS, ATOM, ASSET, ABLS, DMEP, ADLS, TCAR/PCAR. Level IV Trauma Facilities can work with system facilities, and their regional advisory council to assist in providing this education. Documented evidence must be available at the designation survey.	
All Trauma Centers	K.6. Injury Prevention and Public Education A. There shall be an identified individual to coordinate the injury prevention and public education programs. This individual is responsible for the coordination of the facility's Stop the Bleeding Courses and tracking all course participation and submitting this documentation to the stopthebleed.org website, and the regional advisory council.	The facility must have an identified individual that has injury prevention and public education job functions and responsibilities documented in their job description. If the facility has greater than 500 trauma activations, this role is completed by an individual other than the trauma program manager. There is documented evidence of the Stop the Bleeding Course and the course participation. There is documented evidence the courses are submitted to the stopthebleeding.org website and shared with their regional advisory council.	
All Trauma Centers	K.6.B The facility shall provide evidence of coordination and/or	Injury prevention and public education should be defined by the	

	participation, in community and/or RAC injury prevention and public education activities, including common major injury incidents identified within the facility's service area.	trauma population and injuries identified in the hospital registry or the regional data base. Level IV trauma facilities may work with system facilities or the regional advisory council to provide injury prevention and/or public education.	
All Trauma Centers	K.7. Disaster Response Plan A. All trauma facilities shall have a comprehensive hospital all hazard response disaster plan and business continuity plan, including department specific guidelines or job action sheets.	There is evidence that the CEO and CNO foster a continual state of readiness for an all hazard response. The facility has a documented disaster plan for an all hazards response, and the TMD and TPM are involved in the development of the plan. Trauma facilities should engage, support, and participate in their regional EMTF teams.	
All Trauma Centers	K.7.B. The trauma facility shall have documented evidence of training all facility staff to respond to a mass casualty event and no-notice event, within an all hazard response plan.	Documented evidence of the dates and times of the facility training for all facility staff with the compliance rate for training must be available at the designation survey. All trauma service staff including the medical staff must have documented evidence of training regarding their role in the facility's mass casualty plan.	
All Trauma Centers	K.7.C. The facility shall have documentation of the response, with an after-action review, and performance improvement action plan.	If the facility has responded to an event (within the designation cycle) that activates the all hazard disaster response plan, real or an exercise response, the facility has a documented, timely, after-action review, and a performance improvement process to address the identified issues. The documentation includes the list of participants involved in the after-action review. The TMD, TPM, and members of the trauma service must have evidence of participation in the after-action review. The timelines for the corrective action process must be documented. This documentation must be available at the designation survey.	
All Trauma Centers	K.7.D. The facility response education and training can be	The trauma services should have evidence of training and response to a	

	through simulation training, a planned exercise, or response to an actual event.	mass casualty event. This training may be through simulation or an exercise. Documentation must reflect the situation, the attendance, and follow-up actions. This training must include the use of the incident command system and job action sheets. If a real event occurs the after-action report must be available for review (as outlined above).	
All Trauma Centers	K.8. EMS Communication A. There shall be two-way communication between the facility and all EMS personnel and/or vehicles.	This two-way communication must be continual, and the EMS communication apparatus must have an assigned hospital individual that monitors the communication always (individual can have other responsibilities). The two-way communication can be by radio, phone, telemedicine, or other technology such as body cameras. A backup communication plan must be identified. There must be an agreement defined guidelines for the communication between the EMS agency and the trauma center. The "MIST" communication process is used for all EMS and hospital hand-off communication.	
All Trauma Centers	K.8.B. The facility will share patient health outcome information with EMS providers for quality improvement if both entities have (or have had in the past) a relationship with the patients in question in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, within thirty days of the request.	The facility must have documented processes to provide EMS agencies feedback regarding patient outcomes within thirty days. There must be documented evidence of compliance to this requirement.	
All Trauma Centers	K.9. Medical Staff. The facility must have an organized, effective trauma service that is recognized in the medical staff bylaws and approved by the governing body. Medical staff credentialing shall include a process for requesting and granting delineation of privileges for trauma care.	The facility has a documented definition of their trauma service and members of the trauma service. The trauma program /service is recognized in the medical staff bylaws and approved by the governing body. This includes recognition of the trauma medical director's and trauma program manager's authority and	

		oversight for the facility's trauma care, the process for trauma credentialing and privileges, as well as the trauma performance improvement process, trauma registry management, injury prevention and outreach education specific to trauma. This is documented in the facility's trauma operational plan.	
All Trauma Centers	K.10. Trauma Medical Director There shall be an identified Trauma Medical Director (TMD) responsible for the provision of trauma care who is credentialed and privileged by the facility for the treatment of trauma patients through all phases of care to discharge. The TMD shall be a physician who:	The trauma medical director must have a defined job description that outlines their authority for the trauma program. The trauma medical director must be dedicated to a single trauma center and cannot serve as the trauma medical director at multiple facilities. If the role of the system TMD is used, there must be a designated trauma medical director with continual oversight and authority at the facility who has a reporting relationship with the CEO or Chief Medical Officer or Executive Officers at the facility.	
Level I, II, III	K.10.A. Trauma Medical Director is a trauma/general surgeon that demonstrates knowledge, experience, and expertise in caring for trauma patients;	The trauma medical director must have evidence of trauma surgical training and trauma program development. Each facility must have a defined job description that outlines the specific requirements for the TMD role. The level of trauma center may have different levels of requirements. NOTE: The level IV trauma facilities may have a member of the medical staff that is not a surgeon serving in the role of the trauma medical director, if no surgical cases are admitted to the OR or inpatient unit, or the facility does not have general surgeons available.	
All Trauma Centers	K.10.B. Trauma Medical Director regularly and actively participates in trauma care at the hospital where the trauma medical director serves are provided;	The trauma medical director must have documented evidence of covering a minimum of two call-shifts each month, plus co-chairing the trauma performance improvement process with the TPM, chairing the trauma operations, and multidisciplinary trauma peer review	

		committee, and representing the trauma program on various hospital committees, and participation in EMS related activities.	
All Trauma Centers	K.10.C. Trauma Medical Director holds current completion status of ATLS or a department recognized equivalent course;	The TMD maintains a current ATLS verification status. It is recommended the TMD be an ATLS instructor.	(Language will meet the ACS language)
All Trauma Centers	K.10.D. Trauma Medical Director demonstrates effective administrative skills and oversight of the trauma performance improvement program;	The TMD has evidence of completing a trauma performance improvement and a trauma medical director leadership / course or other course specific to the leadership and development of the trauma program within 18 months of starting the role. The trauma medical director's job description and contract should define the administrative hours required to prepare for the performance improvement activities that includes chart reviews, literature review to ensure national standards of care are met, planning the committee organization for the system PI meeting and the peer review, disaster management, verification/designation planning, as well as regional advisory council participation.	
All Trauma Centers	K.10.E. Trauma Medical Director completes an average of 16 hours of trauma-related continuing medical education annually;	The TMD's 16 hours of continuing trauma-related continuing medical education may include clinical care, courses specific to the role of the trauma medical director's job function, performance improvement, and system development or leadership development.	(Language will match the ACS)
All Trauma Centers	K.10.F. The Trauma Medical Director has evidence of disaster response education;	The TMD has documented evidence of education and training in the hospital incident command system such as the FEMA IS 100, 200, and 700 course or other courses that provide insight on the management of an all hazards response system (examples are the ACS Disaster Management Emergency Preparedness Course and the Advanced Disaster Life Support Course). The trauma medical director has documentation of the trauma	

		faculty education and training on their role in mass casualty events, and all hazard response, and the specific expectations outlined in the hospital's response plan. The TMD has evidence of training the trauma surgeons and trauma liaisons on their defined job action sheets utilized in a disaster response.	
All Trauma Centers	K.10.G. the TMD maintains active staff privileges as defined in the facility's medical staff bylaws.	Trauma Medical Director has documented privileges approved by the medical staff bylaws and there is documented evidence.	
All Trauma Centers	K.10.H. The TMD shall be a member of the Medical Executive Committee.	There is documented evidence in the current membership and attendance of the Medical Staff Committee demonstrating the TMD is a member of the Medical Executive Committee. If the TMD is not a member of the Medical Executive Committee, there is documented evidence that trauma surgery is represented by a defined surgeon that is knowledgeable of the trauma service and trauma designation process.	
All Trauma Centers	K.10.I. The TMD shall have responsibility for the overall clinical direction and oversight of the trauma service.	This documentation is reflected in the job descriptions, approval of the trauma standards of care, clinical practice guidelines, and is evident in the performance Improvement documentation and meeting minutes.	
All Trauma Centers	K.10.J. The responsibilities and authority of the TMD shall include but are not limited to:	The job functions of the TMD are documented in the Board Resolution, Medical Staff Resolution, the job description for the TMD, and the trauma center's operational plan.	
All Trauma Centers	K.10.J.i. reviewing credentials of medical staff requesting privileges for trauma call coverage and to participate in trauma patient care;	Specific criteria and defined process allowing the TMD to approve members for the trauma call panel is document and there is evidence of compliance to this credentialing process.	
All Trauma Centers	K.10.J.ii. making recommendations to the MEC for either approval or denial of trauma privileges;	These processes must be written and included in the trauma credentialing guidelines.	
All Trauma Centers	K.10.J.iii. ensuring a written, on-call schedule, and a backup on-call	The TMD is responsible for a written or electronic on-call schedule with	

	schedule/plan is readily available to relevant staff in the trauma/emergency department, for obtaining surgical care for the surgical specialties of surgical critical care, orthopedics and neurosurgery.	back-up surgeons available to assist for unplanned high-volume, high-acuity, or multiple casualty events.	
All Trauma Centers	K.10.J.iv. excluding those physicians from the trauma call coverage and patient care who do not maintain trauma requirement;	Written guidelines are in place that define the TMD's authority and processes to exclude a physician from the trauma call panel. These guidelines are standardized and documented in the trauma physician credentialing process	
All Trauma Centers	K.10.J.v. ensuring the use of medical staff case review outcomes, including deviations from trauma standards of care trending, when considering re-credentialing physicians providing trauma care;	The performance improvement case reviews, response times, and meeting attendance are included in the performance reviews of the trauma call panel credentialing process. This is written and included in the trauma credentialing process.	
All Trauma Centers	K.10.J.vi. developing and providing ongoing management of treatment protocols based on current standards of care;	The TMD is responsible for defining the standards of care based on the current national evidence and this function needs to be written in the TMD's job description. Standards of care, evidence-based practice guidelines, and any defined best-practice guidelines must be updated every three years to remain current. If 15% or more of the facility's trauma activations and trauma admissions are less than 15 years of age the facility must have documented pediatric standards of care. If 15% or more of the facilities trauma activations and trauma admissions are 65 years of age or greater, geriatric trauma protocols must be included in the standards of care. The TMD must review the national organizations evidence-based practice guidelines and define to implement these guidelines and identify key elements of these guidelines to integrate into the trauma performance improvement process in conjunction with the TPM.	

All Trauma Centers	K.10.J.vii. participating in the ongoing education of the medical, nursing, and ancillary staff in the care of the trauma patient;	This is a job function of the TMD and this function is documented in the TMD's job description. The TMD defines the education needed through performance improvement process, new care modalities, or updates and defines who should be providing the educations. There must be mechanisms to ensure the education is timely and completed.	
All Trauma Centers	K.10.J.viii. ensuring the multidisciplinary trauma PI and peer review committee meetings are specific to trauma care, ongoing, data- driven, and effective for needed changes.	This is documented in the TMD job function. This function and expectations are documented in the TMD's job description. The TMD is responsible for ensuring the trauma liaisons are notified of the cases selected for review and the focus of the discussion. The TMD needs documented evidence of specific training related to the trauma performance improvement process as previously outlined. These elements are included in the TMD's annual performance review.	
All Trauma Centers	K.10.J.ix. participating in the applicable RACs and reviewing the RAC's trauma system plan.	This is a job function of the TMD and there must be evidence of participation in the RAC meetings as well as evidence of discussion of the Regional Trauma System Plan and RAC activities in the trauma center's operations committee to ensure dissemination of information.	
All Trauma Centers	K.10.J.xi. participates in the facility and regional disaster preparedness activities	This is a TMD job function and should be documented in the TMD's job description. The TMD must have documented evidence of disaster training and education as previously defined. The TMD is responsible to educate and train the members of the trauma call panel on their role in a disaster response to include how they will be notified, the incident command structure, communication during an event, where to report, disaster standards of care, surge area expectations, how to request resources, and the use of job action sheets.	

All Trauma Centers	K.10.J.xii. providing evidence that he/she is aware of multidisciplinary team findings on all trauma patients.	This is a job function of the TMD and should be an element of the TMD's job description. Documented evidence must be present such as the TMD's secondary level of review of the PI process, chairing the multidisciplinary trauma peer review committee, and attendance at the trauma morning check-out when available.	
All Trauma Centers	K.11. Trauma Program Manager – Each trauma facility has a defined trauma program manager responsible for monitoring trauma patient care pre-hospital, trauma activation to admission, throughout the continuum of care through to discharges at each trauma facility. This role must be specific to the facility and cannot cover multiple facilities.	The Trauma Program Manager is essential to the success of the trauma center, for all levels of trauma center. There must be a written job description for this role with dedicated hours to ensure the job functions are concurrent and the reporting organizational structure ensures the TPM has the authority and oversight of all phases of trauma care and has the authority to make recommendations for trauma care or trauma system improvements in all areas caring for the trauma patient. The TPM ensures rounding on the trauma patients and units occur to identify issues and address needs: • EMS response, treatment, and timeliness are appropriate • Trauma activation compliance / and timeliness of activation • Trauma documentation meets expectations • Trauma team response times are appropriate • Response times of consultants are appropriate and timely • Transfer timeliness is appropriate • Timeliness of blood availability is appropriate • Timeliness and sequencing of diagnostics procedures is appropriate • Standards of care are followed • Response times in radiology and radiologic interpretations times are appropriate	

		• Response times of Interventional Radiology are appropriate • Response times in OR are appropriate • Appropriate equipment is available to manage the patient • Admission to the ICU or PACU is appropriate and timely • Inpatient standards of care are followed • Daily rounds and documentation by faculty trauma surgeons are available and define the plan of care • Inpatient consultants have timely response and appropriate documentation • Specific age criteria standards of care are followed • All complications and variations in care are identified and addressed through the trauma performance improvement process • All patients with trauma activations or missed activations that expire are reviewed through the trauma performance improvement process • All trauma deaths are reviewed through the trauma performance improvement process • Identified trauma performance improvement issues or events are tracked through to resolution • Trauma registry data extraction, entry, validation, and state submission meet the requirements • Trauma center criteria is tracked for compliance and	

		documented evidence is available	
All Trauma Centers	11.A. The TPM will have the authority and responsibility to address issues identified through the PI process with leaders from pre-hospital through the patient's discharge,	Job description needs to reflect the scope of authority and organizational structure to evaluate all trauma patients from pre-hospital, trauma activation, to admission through to the patient's discharge, rehabilitation, and evaluate care to identify opportunities for improvement and provide recommendations to all levels of management.	
All Trauma Centers	11.A.i. The TPM shall be a registered nurse that is a fulltime employee of the facility and hours dedicated to the TPM role is defined by the trauma activation volume and number of trauma admissions that need the continuum of care follow-up	The job description requires a full-time registered nurse and aligns with the hospital structure. This individual must be dedicated to the specific facility and cannot serve as a TPM for multiple facilities. (NOTE: If the facility utilizes the term Trauma Program Director instead of the Trauma Program Manager, these individuals are accountable to meet all the criteria specific to the Trauma Program Manager.)	Note: The RN is a full-time nurse at the facility to ensure they are current with all hospital activities. The hours dedicated to the trauma program are defined by the number of trauma activations and admissions.
All Trauma Centers	11.A.ii. The TPM demonstrates knowledge, experience, and expertise in caring for trauma patients;	The trauma program manager must have experience in managing trauma patients, have at a minimum current certification in TNCC or ATCN, ENPC or PALS when starting their role, and complete the Trauma Program Manager Course or equivalent within twelve-months of in-hire, and complete the AAAM Injury Scoring Class, and an ICD-10 coding class within eighteen months of in-hire. The TPM must complete a course in trauma performance improvement (Currently the TOPIC Course or Rural TOPIC Course) within twelve months of in-hire. The TPM must maintain current certification in ATCN or TNCC, and ENPC or PALS, and complete the TOPIC course a minimum of every four years.	Will evaluate the ACS criteria and define if Texas needs to align with the new ACS criteria.
All Trauma Centers	11.A.iii. The TPM regularly and actively participates in trauma care at the facility where the trauma program services are provided.	The TPM remains active in trauma patient oversight, and in the clinical role as necessary. The TPM must have the authority to evaluate trauma	

		patient care in all areas providing trauma care.	
All Trauma Centers	11.A.iv. The TPM is current in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses.	The TPM maintains certification in TNCC or ATCN, ENPC or PALS, to include geriatric trauma education when available. Courses such as TCAR and PCAR are also recommended.	
All Trauma Centers	11.A.v. The TPM has completed a department recognized course designed for his / her role which provides essential information on the structure, process, organization and administrative responsibilities of a trauma program within twelve months of beginning the role. The level IV facility TPM must attend the TETAF/TTCF Trauma Designation Course and their Trauma Data Management Course.	These courses include the TETAF/TTCF Trauma Designation Course, TCAA Courses, ATS Trauma Managers Course, or the ACS Advancing Leadership in the Trauma Center Course.	
All Trauma Centers	11.A.vi. The TPM has completed a course designed for his/her role which provides essential information of a trauma performance improvement program to include trauma outcomes and performance improvement or a department recognized equivalent course and remains current with the continual advances in performance improvement.	The current recommended course for completion within twelve months of in-hire is the STN TOPIC Course or Rural TOPIC Course and complete the course a minimum every four year.	
All Trauma Centers	11.A.vii. The TPM has completed a department recognized injury scoring and / or coding courses within eighteen months of becoming a the TPM. NOTE: If the Level IV Facility utilizes a central registry or outsources the registry the TPM is not required to complete the AAAM ISS Scoring and ICD-10 Coding Class.	This course currently is the AAAM Injury Scoring Class, and the ICD-10 Coding Course.	
All Trauma Centers	11.A.viii. The TPM has evidence of disaster response education.	The TPM has evidence of completing the IS 700, 800, 100, 200, and 300 training. It is recommended that the TPM attend a disaster course such as the Advanced Disaster Life Course or the Disaster Management Emergency Preparedness Course. Level IV trauma	

		facility TPM must have evidence of completing the IS 700, 100, and 200.	
All Trauma Centers	11.B. The Trauma Program Manager has the authority and oversight in collaboration with the TMD to 11.B.i. be responsible for the integration and monitoring of compliance of the trauma nursing standards of care;	This must be documented in the job description and there must be documented evidence that demonstrates that this process is continually throughout the year.	
All Trauma Centers	11.B.ii. The TPM has the authority to monitor trauma patient care, from prehospital and arrival, through Emergency Department (ED), surgical intervention(s), Intensive Care (ICU), rehabilitation, and discharge, through the trauma performance improvement (PI) program, and	This must be continual throughout the year and evident in practice and documentation in the PI process.	
All Trauma Centers	11.B.iii. The TPM monitors the clinical outcomes and system performance of the trauma program.	This must be continual throughout the year and evident in the trauma reports, operations committee, and peer review committee.	
All Trauma Centers	11.B.iv. The TPM participates in a leadership role in the facility through committee participation, facility-wide PI initiatives, critical care/resuscitation committees, emergency management and disaster response committee	There must be documented evidence in the committee minutes, attendance, and activities.	
All Trauma Centers	11.B.v. The TPM participates in RAC activities through committee membership, and regional emergency preparedness.	There must be documented evidence in the regional advisory council committee meeting minutes, and attendance. There is evidence that regional information is shared and discussed at the trauma operations committee.	
All Trauma Centers	12. Trauma facility who admit trauma patients to their resuscitation are, diagnostics / interventional areas, OR, ICU, inpatient areas must provide the national standards of care as demonstrated through best-practice guidelines and trauma performance improvement process.	The facility's Executive Leaders, TMD, and TPM are responsible to ensure these national standards of care are provided.	
Level I	L. Trauma Designation Level I (Comprehensive). The facility shall	The facility must have documentation that verifies that the facility is	

	meet the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center and the State requirements for all trauma centers.	compliant with the American College of Surgeons Level I trauma facility essential criteria and the defined State trauma designation criteria.	
Level II	M. Trauma Designation Level II (Major). The facility shall meet the current American College of Surgeons (ACS) essential criteria for a verified Level II trauma center and the State criteria for all trauma centers.	The facility must have documentation that verifies that the facility is compliant with the American College of Surgeons Level II trauma facility criteria and the State trauma designation criteria.	
Level III	N. Trauma Designation Level III (Advanced).	Facilities that admit and manage patients with traumatic brain injuries with a GCS of 10 or less, mass effect on head CTS scan, lateral signs, neuro deficits as a result of a potential spinal cord injury or hypotension trauma patients with combination injuries with a GCS of 10 or spinal cord injury, or hemodynamically unstable due to pelvic fractures, fractures or dislocations with the risk of vascular necrosis, or vascular compromise related to a fracture, dislocation or compartment syndrome (should / shall) designate at a higher level of trauma facility in their next three-year designation cycle to ensure the resources necessary for critical care, stabilization, supportive and rehabilitative care for these patients match the patient's care needs.	
	The facility shall meet TAC 157.125 (j) in this section; and the following requirements:		
Level III	N.1. Trauma Medical Director shall be a physician who:		
Level III	N.1.A. Is currently a board-certified or board eligible trauma/general surgeon according to current requirements; or	The general surgeon has evidence of board certification or board eligibility.	
Level III	N.1.B is a trauma/general surgeon that demonstrates knowledge, experience, and expertise in caring for trauma patients.	The surgeon is not board certified but is compliant with the hospital's medical staff bylaws and has maintained continual credentialing as a general surgeon at the hospital. This	

		must be approved by the hospital's Medical Executive Committee/Medical Staff Committee.	
Level III	N.2. All trauma/general surgeons who provide trauma care and participate in continuous 24 hours trauma call coverage shall:		
Level III	N.2.A. be present at the patient bedside upon arrival for a full trauma activation, with a maximum response time of 30 minutes from activation notification.	Response times must be continually monitored through the trauma PI process and reflected in reports at the Trauma Operations Committee. Tracking should include missed activations, wrong level of activations, and delayed activations.	
Level III	N.2.B. Be present at the patient bedside for a limited activation with a maximum response time of 60 minutes from activation notification.	Response times must be continually monitored through the trauma PI process and reported. Tracking should include missed activations, wrong level of activations, and delayed activations.	
Level III	N.2.C. be the admitting physician on all multi-system trauma patients requiring consultation of one or more specialty services or arrive hypotensive	This should be continually monitored through the trauma PI processes.	
Level III	N.2.D. be board-certified or board-eligible according to current requirements and have successfully completed one ATLS course.	The trauma medical director is responsible for validating and credentialing the trauma surgeons annually and must have documented evidence of the process.	
Level III	N.2.E. if not board-certified or board eligible:		
Level III	N.2.E.i. demonstrates significant knowledge, experience, expertise in caring for trauma patients, and a full understanding of the local EMS system.	The trauma medical director is responsible for monitoring this and documenting this through the annual trauma surgeons credentialing process. This decision is formulated from the trauma PI case reviews, compliance to trauma center criteria, and their admitted trauma patient outcomes.	
Level III	N.2.E. ii. holds current completion of ATLS course, or a department recognized equivalent; and	The trauma medical director is responsible for monitoring this and documenting this through the annual trauma surgeons credentialing process.	

Level III	N.2.E.iii. averages at least 16 hours of trauma-related continual medical education annually.	The trauma medical director is responsible for monitoring this and documenting this through the annual trauma surgeons credentialing process.	(This language will meet the new ACS criteria which will be available in March.)
Level III	N.2.G. maintain compliance with trauma treatment protocols as evidenced through the trauma PI program.	The TMD and TPM are responsible to monitor compliance to the defined standards of care and the associated PI events.	
Level III	N.2.H. participate in the trauma PI program and attend at least 50% of the multidisciplinary PI and peer review committee meetings.	The TMD is responsible for monitoring this and including compliance in the trauma credentialing process.	
Level III	N.2.I. be approved by the TMD; and	There must be documented approval in the trauma credentialing process.	
Level III	N.2.J. be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.	The TMD is responsible for reviewing this information and approving the trauma credentialing process.	
Level III	N.2.K. Surgical Residency Program: If the facility has a residency program:		
	N.2.K.i. the team of surgical residents that start the evaluation and treatment of the trauma patient, shall have at a minimum, a postgraduate year 4 (PGY-4) or more senior surgical resident who is a member of the facility's residency program	This is continually monitored through the trauma PI process and is the responsibility of the TMD to ensure compliance. This also applies to programs that have residents rotating in their facility.	
Level III	N.2.K.ii. the attending surgeon must be compliant with all response times. The presence of a surgical resident or advanced practice providers does not take the place of the attending surgeon; and	This is continually monitored through the trauma PI process and is the responsibility of the TMD to ensure compliance.	
Level III	N.2.K.iii. the attending surgeon shall participate in all major therapeutic decisions, be present in the emergency department for major resuscitations, and be present during all phases of operative procedures.	This is continually monitored through the trauma PI process and is the responsibility of the TMD to ensure compliance.	
Level III	N.3. In addition to continuous trauma/general surgery coverage, the facility shall have continuous 24	The administrator and TMD are responsible for the oversight of the orthopedic coverage for the trauma center.	

	hours a day orthopedic surgical coverage.		
Level III	N.4. All orthopedic and neurosurgeons who provide trauma coverage or participate in continuous trauma call coverage will:		
Level III	N.4.A. be present at the patient bedside for a full trauma team activation within 30 minutes from activation notification as defined by trauma activation criteria, when they are requested.	This is continually monitored through the trauma PI process and is the responsibility of the TMD to ensure compliance. Thirty-minute response times are required for the following injuries: Neurosurgery: traumatic brain injury with a GCS of 11 or less, mass effect on head CT scan, lateral signs, neurologic deficit as a result a result of potential spinal cord injury, Orthopedics: hemodynamically unstable secondary to pelvic fracture, fractures or dislocations with a risk of a vascular necrosis, vascular compromise related to a fracture, dislocation, partial /complete amputee of a long bone	
Level III	N.4.B. be present at patient bedside for a limited trauma team activation within 60 minutes from activation notification, when they are requested.	This is continually monitored through the trauma PI process and is the responsibility of the TMD to ensure compliance.	
Level III	N.4.C. be board-certified or board-eligible according to current requirements, or	This is monitored through the trauma credentialing process and is the responsibility of the TMD to ensure compliance.	(Language will match the ACS criteria)
Level III	N.4.D. if not board-certified or board-eligible, demonstrates significant knowledge, experience, and expertise in caring for trauma patients.	This is continually monitored through the trauma PI process and is the responsibility of the TMD to ensure compliance.	
Level III	N.4.E. maintain compliance with trauma treatment protocols as evidenced through the trauma PI program.	This is continually monitored through the trauma PI process and is the responsibility of the TMD to ensure compliance.	
Level III	N.4.F. participates in the trauma PI program.	This is an element of trauma credentialing and is the responsibility of the TMD. The Orthopedic and Neurosurgical Liaisons are responsible	

		to review and participate in trauma patient reviews for outcomes and assist the trauma medical director in preparing for the trauma multidisciplinary peer review process for their service's specific cases.	
Level III	N.4.G. Orthopedic surgeons and Neurosurgeons maintain a published, on-call schedule and can only be on-call at one center during their call shift.	This is monitored by the TMD who is responsible for the oversight of the on-call schedule for trauma physicians.	
Level III	N.4.H. be approved by the TMD; and	TMD has the authority to approve the on-call schedule.	
Level III	N.4.I. be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.	This is monitored by the TMD and is an element of the trauma credentialing process.	
Level III	N.4.J. Designated liaison and predetermined alternates, for orthopedic surgery, and neurosurgery, shall attend at least 50% of the multidisciplinary PI and peer review committee meetings, and average at least 16 hours of trauma related continuing medical education annually, if not current with board certification or board eligibility.	The liaison is appointed by the TMD. The liaison is expected to attend a minimum of 50% of the trauma multidisciplinary peer review committee and operations committee. The liaisons must have completed a minimum of 16 hours of documented trauma-related continuing education. This is monitored by the TMD and is an element of the trauma credentialing process.	(CME language will follow the ACS requirements which will be released in March)
Level III	N.5. Emergency Medicine. The Emergency Medicine physicians providing trauma call coverage shall:		
Level III	N.5.A. be in-house 24 hours a day and arrive at the patient bedside appropriately upon trauma activations.	This is monitored through the trauma PI process and the TMD is responsible for compliance.	
Level III	N.5.B. be board-certified or board eligible in Emergency Medicine and have successfully completed ATLS; or	This is monitored through the trauma credentialing process and is the responsibility of the TMD.	(Language will match the ACS requirement)
Level III	N.5.C. if not board-certified or board eligible:	If the Emergency Medicine physician is not board certified or board-eligible then he/she must be compliant with the next three requirements.	
Level III	N.5.C.i. demonstrates significant knowledge, experience, and	It is the TMD responsibility to follow-up and ensure compliance to these standards.	

	expertise in caring for trauma patients;		
Level III	N.5.C.ii. hold current completion status of ATLS, or a department recognized equivalent course; and	It is the TMD responsibility to follow-up and ensure compliance to these standards.	
Level III	N.5.C.iii. average at least 16 hours of trauma-related continuing medical education annually.	It is the TMD responsibility to follow-up and ensure compliance to these standards.	(Language will match the ACS)
Level III	N.5.D. maintain compliance with trauma treatment protocols as evidenced through the trauma PI program.	This is addressed through the continual trauma PI monitoring and oversight.	
Level III	N.5.E. participate in the multidisciplinary trauma PI program.	There is evidence in the attendance and minutes from the meeting of participation.	
Level III	N.5.F. be approved by the TMD; and	The TMD must approve through the ED Liaison or trauma representative through the trauma credentialing process and is responsible for monitoring compliance to the above standards.	
Level III	N.5.G. be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.	This is addressed through the Medical Staff Committee. The TMD has access to these credentialing records.	
Level III	N.5.H. A designated liaison, or predetermined alternate liaison, shall attend at least 50% of the multidisciplinary trauma PI and peer review committee meetings.	There must be documented evidence of attendance.	
Level III	N.6. Advanced Practice Providers, Physician Assistants (PA), and Nurse Practitioners (NP), shall not be a substitute for the required physician response, in patient care planning, nor in trauma PI activities. Advanced Practice Providers who participate in the care of major and severe trauma patients shall:	If Advanced Practice Providers participate in trauma care they must have a documented orientation process for their role and be integrated with the team to ensure consistent communication and patient care continuum of care.	
Level III	N.6.A. demonstrate knowledge, experience, expertise in caring for major and severe trauma patients, and a full understanding of the local EMS system.	The documented orientation process must include the skills credentialing for the procedures the Advanced Practice Providers are approved to complete with defined supervision levels and include an orientation to the local EMS system.	

Level III	N.6.B. hold current completion status of ATLS or a department recognized equivalent course.	The ATLS verification should not expire before it is renewed to remain in good standing.	
Level III	N.6.C. average at least 16 hours of trauma-related continuing medical education annually;	The medical director is responsible for monitoring compliance to this standard.	(Language will match the ACS)
Level III	N.6.D. maintain compliance with trauma treatment protocols as evidenced through the trauma PI program.	Compliance is monitored through the trauma PI reviews. It is the TMD responsibility to ensure compliance.	
Level III	N.6.E. participates in the multi-disciplinary trauma PI program.	There must be documented evidence in the attendance and minutes from the meeting.	
Level III	N.6.F. be approved by the TMD; and	Must be approved for trauma credentialing by the TMD.	
Level III	N.6.G. be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.	Must be approved by the Medical Staff Committee for hospital privileges.	
Level III	N.7. Anesthesia services shall be in compliance with 25 TAC 133.41 Hospital Functions and Services.		
Level III	N.7.A. An anesthesiologist providing trauma care shall:		
Level III	N.7.A.i. be board-certified or board-eligible in specialty.	There must be documented evidence of compliance.	
Level III	N.7.A.ii. if not current with board maintenance of certification or board-eligibility, average at least 16 hours of continuing medical education annually, and have a current ATLS verification;	There must be documented evidence of the continuing education hours and current ATLS verification that is reviewed and approved by the TMD.	(Language will match ACS)
Level III	N.7.A.iii. maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;	This is routinely monitored through the trauma PI process.	
Level III	N.7.A.iv. be approved by the TMD; and	Individual must be credentialed to participate in trauma by the TMD.	
Level III	N.7.A.v. be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.	Individual must be credentialed by the Medical Staff Committee to participate at the facility level.	
Level III	N.7.B. A designated liaison, or predetermined alternate, shall attend at least 50% of the	The TMD appoints the liaison and then is responsible to monitor attendance. There must be documented	

	multidisciplinary trauma PI and peer review committee meetings.	compliance of 50% participation in the attendance and meeting minutes.	
Level III	N.7.C. Certified Registered Nurse Anesthetist (CRNA) providing trauma care shall:		
Level III	N.7.C.i. average at least 16 hours of continuing education annually;	Documented evidence of compliance must be available and tracked through the credentialing process.	(Language will match ACS)
Level III	N.7.C.ii. maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;	The trauma performance improvement process identifies if events and variations from the standards of care are evident.	
Level III	N.7.C.iii. participate in the multi-disciplinary trauma PI program;	The documented meeting attendance and minutes reflect participation.	
Level III	N.7.C.iv. be approved by the TMD, and	The TMD is responsible for credentialing all physicians and advanced practice providers to participate in the trauma program. Documented evidence of the process and approval must be present.	
Level III	N.7.C.v. be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.	The hospital Medical Staff Committee is responsible for the hospital credentialing process.	
	N.8. Radiology		
Level III	N.8.A. A radiologist shall be on-call 24 hours a day and promptly available within 30 minutes of request. The radiologists' response times shall be continuously monitored.	Radiology must have systems in place to document the on-call schedule and to monitor the requested call-back response time. These response times are reported through the trauma operations committee to document compliance. Preliminary findings must be documented, and any over-read changes must be documented and reviewed through the trauma performance improvement process. Any case selected for trauma peer review must have defined action plans and follow through to resolution.	
Level III	N.9. Nursing Services. Nursing administration shall:		
Level III	N.9.A. ensure the trauma nursing positions, including the TPM and TR, have adequate time dedicated to the trauma program to ensure	The dedicated resources to the trauma program ensures that trauma patient oversight, trauma performance improvement, and trauma registry data extraction must	

	compliance with TAC 157.125 requirements.	be continuous and ensure that oversight is occurring daily, the trauma performance improvement process is concurrent (while the patient is admitted), and the trauma registry is maintaining 80% compliance of completing all registry records within 60 days of discharge. Registry submissions and PI annual reports must be submitted with the trauma designation application to ensure continual compliance.	
Level III	N.9.B. commit to advancing the education and understanding of trauma standards of care for all nursing staff caring for the trauma patient;	Evidence of commitment to advancing trauma nursing education to ensure the required education is compliant and provides resources to implement and monitor best-practice guidelines for the categories of trauma patients cared for in the facility. There is documented evidence that systems are in place to support processes for advancing trauma nursing knowledge and skills. This may include programs to assist in advanced nursing degrees and certifications such as CEN, TCRN, and CCRN for the staff caring for trauma patients. TCAR and PCAR are also recommended for consideration. There is evidence of commitment to disaster training and education for staff.	
Level III	N.9.C. approve and utilize an acuity-based patient classification system to define workload and number of nursing staff to provide safe patient care for all trauma patients throughout their hospitalization to ensure patient care needs, patient to nurse ratios and skill mix are appropriate in the ED, radiology, OR, PACU, ICU, general unit; and	The nurse staffing plan meets the national standards and has evidence of flexibility to meet high acuity and high-volume situations.	
Level III	N.9.D. develop a written facility plan for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, volume, multiple emergency procedures, and admissions.	Nursing must participate in an all hazard disaster management plan to is scalable to meet the current system and patient care demands and have evidence of exercising the plan with an after-action review annually.	

Level III	N.10. Emergency nursing staff who participate in the care of the major and severe trauma patients shall have		
Level III	N.10.A. all registered nursing staff, responding to and participating in initial resuscitations for full and limited trauma activations, has completed a defined trauma orientation process, have current credentials in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses;	All registered nurses responding to trauma activations must have documented trauma orientation, defined trauma skills credentialing, and current certifications TNCC or ATCN, ENPC or PALS, and ACLS.	
Level III	N.10.B. emergency nursing documentation for trauma patients that is systematic, meets the trauma registry guidelines, and includes at a minimum, trauma activation times, primary and secondary surveys with interventions, sequencing of care, diagnostic evaluation(s), serial vital signs and neurologic assessment(s), outcomes, plan of care with disposition, and the response times of all trauma team members and consultants.	This is typically a trauma flow sheet, paper or electronic, and all nurses responsible for completing the documentation have documented and skills credentialing to complete the trauma flow sheet. Documentation review is included in the trauma performance improvement plan and there is documented evidence of this outcome. This is typically managed by the trauma program manager unless there is a level of harm to the patient and then it must be reviewed in the secondary level of review with the TMD.	
Level III	N.11. All Nursing Staff who participate in the care of trauma patients throughout the continuum of care shall:		
Level III	N.11.A. have ongoing documented knowledge and skills in trauma nursing for patients of all ages including trauma specific orientation, annual skills competencies, education and training specific to the trauma program approved trauma protocols, evidence-based practices, and continuing education.	Each nurse involved in trauma care must have a documented orientation plan and checklist that is specific to the trauma patient population they care for and an associated skills checklist as well as the required documentation for trauma care and trauma center compliance. There must be documented evidence available that demonstrates the orientation and skills credentialing process. Documentation of the trauma continuing education based on the PI findings and education that supports the specific certification for	

		the areas such as TCRN, CCRN, or Pain Certification, or other nationally recognized certification in the specific areas must be available.	
Level III	N.11.B. have written standards of trauma nursing care for all, (i.e. Emergency Department (ED) Radiology, Operating Suite (OR), Intensive Care Unit (ICU), Post Anesthesia Care Unit (PACU), and the general inpatient units with evidence of appropriate skills credentialing for trauma patients cared for in their assigned areas, and	Compliance to the orientation process and completion of the annual skills credentialing process is the responsibility of the unit manager or director but should be reported through the operations committee to track compliance and potential needs. Compliance to the standards of care is monitored through the trauma performance improvement process and outcomes are reported through the operations committee. PI issues identified requiring education as tracked and processed through the operations committee.	
Level III	N.11.C. documented nursing care for trauma patients is systematic, meets the trauma registry guidelines, and includes at a minimum: EMS or arrival and history of pre-hospital activities, patient assessments with interventions, sequencing of care, serial vital signs and neurologic assessment(s), diagnostic evaluations, consultant time requests and response times, rehabilitation services requested and response times and services provided, and ancillary care services provided, outcomes, and a current plan of care with dispositions.	The nursing units involved in the continuum of trauma care must understand their role and requirements in trauma care and trauma center designation to ensure their documentation reflects the registry criteria, and standards of care provided, as well as the services involved in the trauma patient care. The unit's manager or director is responsible for the compliance to this criterion.	
Level III	N.12. Trauma Registrar. There shall be an identified Trauma Registrar, separate from, but supervised by the TPM, who has:	The trauma registrar is responsible for trauma registry data abstraction and registry data entry, as well as injury coding and scoring. Recommended trauma registrar staffing is one registrar for every 500 trauma registry admissions; a .8 registrar FTE for 300 up to 450 trauma registry admissions; and .5 registrar FTE for up to 299 trauma registry admissions to ensure a concurrent, accurate, and complete process. (NOTE: these trauma	Will review the ACS criteria to evaluate the need for Texas to align with the ACS.

		registrar staffing recommendations focus only on the data abstraction and data entry. If the registrar has other job functions other than the abstraction and data entry, these volume numbers will need to decrease.) There must be a documented trauma registry inclusion criteria guideline that aligns with the current NTDB standards. Specific protocols regarding requesting data from the registry with measures to ensure that all HIPAA requirements are addressed must be documented. Protocols that specifically address the data reporting to the State Registry as well as the American College of Surgeons NTDB are documented and monitored by the TPM. Systems are in place to revise these protocols as the NTDB standards are updated.	
Level III	N.12.A. completed appropriate education and training within 18 months of hire into the position of trauma registrar which includes:	A documented job description and orientation plan with a skills competency check-list that is completed by the trauma program manager and the registrar. This should include knowledge of the local EMS system, an anatomy check-off, trauma terminology, access to the medical record and where to abstract certain data elements consistently, the injury scoring process, processes for data validation, and report generation at a minimum. The registrar should attend the ATS Registrar Course, or the TETAF Data Management Course within 18 months of in-hire to gain a full understanding of how the data is processed and utilized to ensure accurate, timely, reliable data.	
Level III	N.12.A.i. a department recognized injury scoring and/or coding course;	To-date this is the AAAM Injury Scoring Course. The trauma program manager and the trauma registrar should attend this class and the ICD-10 Coding Class. The trauma registrar should attend this course within 12 months of in-hire.	(Language may align with the ACS criteria)

Level III	N.12.A. ii. a comprehensive trauma registry educational and training course or department recognized equivalent course, and	The trauma registrar should attend this course within 18 months of in-hire to ensure accurate data and scoring.	
Level III	N.12.B. maintain four hours of continuing education annually specific to trauma data quality.	The facility must provide continuing education for the trauma registrar(s). The registrar should have the opportunity to complete the Trauma Registrar Certification once they reach the appropriate hours. This will require additional continuing education but will enhance the knowledge, skills, and competencies of the registrar and improve the data quality for the facility.	
Level III	N.13. Emergency Services. Equipment and services for critically or seriously injured patients, complex neurosurgical patients, or orthopedic injured patients, of all ages shall be available for evaluation: • EMS communication • Resuscitation and life support • Hemodynamic monitoring • Temperature management • Hemorrhage control and the massive transfusion protocols/equipment • Orthopedic management • Burn care • Pain management • Electronic processes to transfer images as needed for pending transfers	This equipment must be immediately available in the trauma resuscitation area. Staff must demonstrate knowledge and skills of when to use the equipment, for what patients/situations, and how to use the equipment. Documented evidence is available in their orientation plan and skills credentialing check-list.	
Level III	N.14. Surgical Services. Equipment and services to provide care for trauma patients requiring operative interventions shall be available, including resuscitation, hemodynamic monitoring, temperature management, hemorrhage control, orthopedic	Resuscitation equipment should be the same as the equipment in the trauma resuscitation area for continuity of care.	

	management, pain management, and burn care.		
Level III	N.14.A. Operating rooms and appropriate personnel shall be available 24 hours a day.	There must be a documented schedule and a schedule for off-hours of who is to be called-in that is published and available in the trauma/emergency department and in the OR.	
Level III	N.14.B. An operating room shall be ready to accept an acute trauma patient within 30 minutes of notification.	The time the OR is notified of the acute trauma patient and the time the OR is ready, and the time the skin is cut should be monitored by the OR leadership and reported through the trauma operations committee to demonstrate consistent compliance.	
Level III	N.14.C. Post-anesthesia care shall be provided by registered nurses and other essential personnel available 24 hours a day in PACU or ICU.	There must be written criteria that defines which trauma patients are recovered in the ICU verses the PACU that is included in the trauma written standards of care and approved by the trauma medical director. The nurses in the PACU must have documented evidence of trauma orientation and trauma skills credentialing specific to the trauma patient population managed by the facility.	
Level III	N.15. Intensive Care Services. Intensive care services shall be available for trauma critical care patients, to include:	The TMD and the ICU Surgical Director must have documented trauma standards of care for the patients that are admitted to the ICU. These standards will include a description of the Trauma Service and the ICU service and who is responsible for the on-going care of the trauma patient. These standards include the ICU trauma admission criteria. Trauma patient in critical or serious conditions may require 1:1 nursing or 1:2 nursing based on the complexity of the injury and overall patient condition.	
Level III	N.15.A. A designated physician surgical director or surgical co-director who is:	The TMD must approve and credential the ICU Surgical Director. The TMD may also serve as the ICU Surgical Director.	
Level III	N.15.A.i. a board-certified or board-eligible surgeon, preferably double	The ICU Surgical Director has a written job description that is approved by the TMD and CMO/Chief of Staff, that	

	boarded in surgery and surgical critical care;	outlines the responsibilities for trauma oversight in the ICU and their role in the trauma performance improvement process, and compliance to the written trauma standards of care. (NOTE: The TMD can serve as the Surgical Critical Care/ICU Director.)	
Level III	N.15.A. ii. responsible for developing, implementing, and enforcing policies, protocols, and evidence-based management guidelines related to trauma ICU patients;	The ICU Surgical Director is responsible for the specific tasks of developing, implementing, and enforcing policies, protocols, and evidence-based management guidelines for trauma care in the ICU. These job functions are written in the job description and approved by the TMD and the CMO. The TMD should monitor the compliance to these job functions and provide a performance review of the ICU Surgical Director annually.	
Level III	N.15.A.iii. maintains compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;	The ICU Surgical Director is responsible for the oversight of trauma care in the ICU and compliance to written standards, best-practice guidelines, and protocols specific to the trauma patient population. If issues develop, the ICU Surgical Director in collaboration with the TMD and TPM, and the ICU Intensivist address issues through the trauma performance improvement process to include the operations committee and multidisciplinary trauma peer review committee. This requires a collaborative partnership with the Pulmonologist / Intensivist in the ICU.	
Level III	N.15.A.iv. participates in the multi-disciplinary trauma PI programs;	The ICU Surgical Director must have continuous participation in the performance improvement process and have documented evidence of attendance at least 50% of the trauma operations and trauma peer review committees.	
Level III	N.15.A.v. approved by the TMD; and	The TMD is responsible for the ICU Surgical Director's written job description and performance	

		management. The TMD approves the ICU Surgical Director's trauma credentialing.	
Level III	N.15.A.vi. be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma critical care patients.	The individual in the ICU Surgical Director role must first be credentialed by the hospital to participate in resuscitation and treatment of critical care patients, prior to being credentialed for the trauma panel.	
Level III	N.15.B. Physicians providing intensive care shall:		
Level III	N.15.B.i. be immediately available 24 hours a day onsite or on-call if not in-house, to promptly arrive at the patient bedside within 30 minutes of requested notification;	Compliance to this criterion must be monitored and documented and reported through the trauma operations committee. The TMD is responsible for this oversight.	
Level III	N.15.B.ii. be privileged in surgical critical care; or	Privileging in surgical critical is most optimal for the surgeons working in the level III trauma center.	
Level III	N.15.B.iii. have trauma/general surgeon on-call to provide surgical coverage of surgical emergencies, and routine care for trauma patients, if a non-surgically trained intensivist is present or on-call;	The TMD, CMO/Chief of Staff are responsible for the call schedule to ensure that a trauma credentialed surgeon is available to the ICU when a non-surgically educated and trained intensivist or hospitalist is covering the ICU.	
Level III	N.15.B.iv. maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;	The TMD and TPM are responsible for monitoring compliance to all established trauma protocols through the trauma PI process and identifying variations in care (events) and processing them through the levels of review to event resolution.	
Level III	N.15.B.v. participate in the multi-disciplinary trauma PI program;	Members of the trauma call panel and the defined trauma liaisons must attend a minimum of 50% of the trauma operations and trauma multidisciplinary trauma peer review committees. There must be documented evidence of their participation in the attendance sheet and the body of the minutes.	
Level III	N.15.B.vi. be approved by the TMD; and	All physicians participating on the trauma call panel must be approved and be credentialed for the trauma	

		panel by the TMD. There must be documented evidence of this process.	
Level III	N.15.B.vii. be credentialed and privileged by the facility to participate in resuscitation and treatment of trauma critical care patients.	Members of the trauma call panel who have trauma credentialing by the TMD must first be credentialed by the medical staff to provide resuscitation and treatment to trauma critical care patients. There must be a documentation of the trauma credentialing process.	
Level III	N.15.C. The on-call physician coverage and response times shall be monitored through the trauma performance improvement program.	There must be documented evidence of compliance and documented response times that are presented to the trauma operations committee for review.	
Level III	N.15.D. Intensive care equipment and services for critically or seriously injured patients of all ages shall be available for evaluation: • Resuscitation and life support • Hemodynamic monitoring • Temperature management • Hemorrhage control to include the massive transfusion procedures and equipment • Orthopedic management; and • Burn care • Pain Management • Transport equipment	The hospital has standardized the equipment used for trauma patients across the facility when possible. Staff have documented evidence of education and training on the trauma management protocols/guidelines. Staff have the appropriate skills training and competencies to use the equipment and resources.	
Level III	N.16. Clinical Support Services		
	N.16.A. Cardiopulmonary Services. Cardiopulmonary personnel appropriate for the patient population served shall be in-house and available 24 hours a day.	This is defined by the medical staff bylaws and is then monitored and tracked when consulted for a trauma patient. Documentations must track their consult time and response times.	
Level III	N.16.B. Clinical Laboratory Services Laboratory Services and personnel shall be onsite and available 24 hours a day. The laboratory shall have current policies and procedures developed and implemented collaboratively between the trauma service and the blood bank to include emergent	There must be written procedures for emergent blood release and the massive transfusion process. Staff must demonstrate knowledge of the process and their role in the transfusions. The timelines in the medical records for blood product release should reflect those identified in the protocols.	

	blood release and a massive transfusion process.		
Level III	N.16.C. Standard Radiological Services. Radiological services and appropriately educated and trained personnel shall be available as defined by the facility's trauma plan to include:	Radiological Services and equipment will be current with the national standards. National imaging guidelines such as the TQIP Trauma Imaging Best Practice Guidelines should be used to define practice.	
Level III	N.16.D.i. Computerized Tomography (CT). Appropriate equipment and trained personnel shall be available onsite or on-call 24 hours per day.	Radiology is responsible for monitoring services to ensure there are no interruptions in services and if interruptions occur, a backup plan for imaging trauma patients must be in place.	
Level III	N.16.D.i.I. Personnel shall arrive onsite promptly within 30 minutes of request/notification.	Processes to track the imaging orders, notification, and the response times must be in place and documentation must be available.	
Level III	N.16.D.i.II. On-call personnel response times and CT availability shall be documented and continuously monitored through the trauma performance improvement program.	CT availability and response times must be monitored and reported through the trauma operations committee. Imaging read times and availability of reports for decision making must be periodically reviewed to ensure delays in care are not present.	
Level III	N.16.D.ii. Sonography	Sonography evaluation should be available for trauma evaluations. Individuals performing the sonography must have evidence of education, training and credentialing. The timeliness of the sonography should be monitored to ensure no delays occur. Systems must be in place to capture the sonography images in the medical record.	
Level III	N.16.D.iii. Angiography	Physicians performing angiography are credentialed by the medical staff. Protocols that define when angiography in trauma patients are written and approved by the TMD. Protocols must be in place to define the response times of the interventional radiology team to ensure the acutely injured patient needs are met. Hypotensive patients moving to IR require a 30-minute	

		response time with 60-minute needle to groin.	
Level III	N.17. The facility shall have the following services available for all trauma patients. (A) Physical therapy; (B) Occupational therapy; (C) Speech therapy; (D) Social services (E) Pastoral Care (F) Trauma-Informed Care Practices (G) Abuse / Neglect / Trafficking Screening.	The trauma management guidelines must define when these services are to be consulted and their defined response times. These standards are approved by the TMD. The responses of these services should be monitored through the trauma performance improvement process. Staff caring for the trauma patients across all phases of care must have access to trauma-informed care education and training. All trauma patients cared for by the facility must have documented screening for abuse/neglect/trafficking. Appropriate resources procedures must define steps to manage these situations. All staff must be educated and have documented training on Human Trafficking as required by Texas Occupational Code Chapter 116.	
Level III	N.18. Specialized Services		
Level III	N.18.A. Acute hemodialysis. A written transfer plan which shall be implemented if the facility does not have the capability for this standard.	The transfer plan must be defined in the trauma operational plan and standards of care and approved by the TMD. Any transfer out of the facility shall monitored through the trauma performance improvement plan for opportunities.	
Level III	N.18.B. Rehabilitation Medicine.		
Level III	N.18.B.i. A physician-directed rehabilitation service, staffed by personnel educated and trained in rehabilitation care and equipped properly for care of the critically injured patient; or	The TMD integrates rehabilitation medicine into the trauma operational plan and the written standards of care. The rehabilitation physician is a member of the trauma operations committee and multidisciplinary trauma peer review committee. The	

		admitting physician can serve as in this role.	
Level III	N.18.B.ii. A written and tested transfer plan to expedite the transfer of trauma patients that require integration of rehabilitation resources	The written and tested transfer standards are monitored through the trauma performance improvement process. All transfers from the facility should be reviewed through the trauma performance improvement process.	
Level IV	(O) Trauma Designation Level IV (Basic) The Level IV trauma designated facility shall meet the following requirements:	Facilities that have general surgeons on-call for the emergency department with operating room capabilities, and evidence of acutely injured trauma patients being admitted to the OR by general surgeons for operative management or accepting trauma transfers from other facilities or admitting acutely injured patients for surgical subspecialty care with injuries that exceed a single system injury (excluding isolated hip fractures or planned elective surgery) (should /shall) designate at a higher level of trauma facility to ensure the resources necessary for critical care, stabilization, supportive and rehabilitative care for these patients match the patient's care needs.	
Level IV	O.1.The Trauma Medical Director shall be a physician who:	There must be a documented TMD job description that defines this individual's authority to oversee the facility's trauma program from pre-hospital arrival, trauma activation to admission or transfer, and all inpatient care to include the OR, ICU, and inpatient general units to discharge, develop and approve the trauma treatment protocols/guidelines/standards of care, the trauma performance improvement process, trauma registry, trauma outreach education, injury prevention, disaster response, regional integration, and the credentialing and oversight of all physicians and advanced practice providers participating in trauma care at the facility. The TMD role and these	

		job functions must be supported in the Medical Staff Bylaws, Board Resolution, and the Medical Staff Resolution.	
Level IV	O.1.A. is currently board-certified or board-eligible general surgeon according to current requirements if surgical procedures are regularly performed on trauma patients; or	If there is documented evidence that trauma patients are admitted to the OR by general surgeons, or other specialty services (excluding the IHF) the trauma medical director should be a general surgeon.	
Level IV	O.1.B. is currently board-certified or board-eligible in emergency medicine, if no surgical procedures are regularly performed on trauma patients; or	If there is no history of trauma patients being admitted to the OR for operative procedures by general surgeons, or subspecialty surgeons the facility may chose a trauma medical director that is a board-certified or board eligible emergency medicine physician.	
Level IV	O.1.C. demonstrates knowledge, experience, and expertise in the stabilization and transfer of trauma patients, if all major and severe trauma patients are immediately transferred.	Physicians with a history in the facility may be approved who are not board-eligible or board-certified if all major and severe trauma patients are immediately transferred and the physician has current ATLS verification. The physician's care and practices are reviewed through the trauma performance improvement process for compliance to standards.	
Level IV	O.2. The Emergency Medicine physicians providing trauma care in a Level IV facility not utilizing telemedicine services shall:		
Level IV	O.2.A. be available 24 hours a day onsite or on-call if not in house, to promptly arrive at the patient bedside within 30 minutes of request/notification.	This emergency medicine physician's notification time and response times must be documented and reviewed through the trauma performance improvement process to ensure compliance.	
Level IV	O.2.B. be currently board-certified or board-eligible in emergency medicine and has completed ATLS successfully; or	This is monitored by the TMD and is an element of their job description.	(Language will meet the ACS recommendations)
Level IV	O.2.C. if not board-certified or board-eligible in emergency medicine shall;		

Level IV	O.2.C.i. demonstrate knowledge, experience, and expertise in caring for major and severe trauma patients appropriate for the population served; and	The TMD is responsible for monitoring this and evaluates care through the trauma PI processes.	
Level IV	O.2.C.ii. holds current completion of ATLS or department recognized equivalent course.	The TMD is responsible for monitoring this through the trauma panel credentialing process.	
Level IV	O.2.D. if not current with board maintenance of certification or board eligibility, average at least 16 hours of trauma-related continuing medical education annually;	The TMD is responsible for monitoring this, and documented evidence of these 16. hours of continuing medical education annually must be available during the survey. The physician and TMD are responsible for validating these educational hours are trauma-related.	(Language will align with the ACS standards.)
Level IV	O.2.E. maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;	The TMD and TPM monitor compliance through the trauma performance improvement program. Events identified related to a physician's compliance to the standards of care are addressed by the TMD through the secondary level of review.	
Level IV	O.2.F. participate in the multidisciplinary trauma PI program;	Physicians participating in trauma care at the level IV facility must attend at least 50% of the multidisciplinary PI meetings. This should be tracked and reported. The TMD will identify liaisons for the specialty services and an alternate to serve as a liaison to the multidisciplinary performance improvement meetings. If there is evidence of trauma patients being routinely admitted to the OR, ICU, and inpatient units, the trauma program must have a trauma peer review process.	
Level IV	O.2.G. Be approved by the TMD; and	The TMD must have a documented trauma panel credentialing process. All physicians participating in trauma care shall be reviewed through this process and approved by the TMD.	
Level IV	O.2.H. be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.	All physicians must be credentialed by the hospital before being reviewed and credentialed for the trauma panel by the TMD.	

Level IV	O.2.I. designated liaison, and one pre-determined alternate liaison who shall attend at least 50% of the multidisciplinary PI and peer case review committee meetings.	The TMD shall appoint the liaison and the alternate liaison. These liaisons are required to attend 50% of the trauma operations committee / multidisciplinary PI committee and 50% of the trauma peer review committee meetings (if there is routine evidence of trauma patients being admitted to the OR or ICU). The TPM shall track and report the attendance compliance at the trauma operations committee.	
Level IV	O.3. The Emergency Medicine physicians consulting for trauma care, in a Level IV facility located in a county with a population of less than 30,000 utilizing telemedicine medical services to collaborate care with a physician or an advanced practice provider.	County must meet the rural criteria to utilize the telemedicine for trauma care.	
Level IV	O.3.A. be available 24 hours a day to promptly respond via telemedicine medical services within 30 minutes of request/notification and patient's arrival.	Physicians must be available 24/7 to respond. This should be monitored and tracked through the trauma PI program and reported through the trauma operations committee.	
Level IV	O.3.B. be board-certified or board-eligible in Emergency Medicine;	Credentialing for physicians participating in trauma care at the facility is the responsibility of the TMD.	
Level IV	O.3.C. have completed ATLS successfully;	Credentialing for physicians participating in trauma care at the facility is the responsibility of the TMD.	
Level IV	O.3.D. if not current with board maintenance or certification or board eligibility, average at least 16 hours of trauma-related continuing medical education annually;	Credentialing for physicians participating in trauma care at the facility is the responsibility of the TMD. The TMD is responsible for monitoring the hours of continuing medical education and that they are trauma-related.	(Language will align with the ACS)
Level IV	O.3.E. maintain compliance with trauma treatment protocols as evidenced through the trauma PI program;	This is monitored and reported through the trauma PI program, and the findings are used in the trauma credentialing.	
Level IV	O.3.F. be approved by the TMD;	The TMD has documented evidence of approval to participate in trauma care.	

Level IV	O.3.G. be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.	Physicians must be credentialed by the hospital prior to being credentialed by the TMD to participate in trauma care.	
Level IV	O.4. Advanced Practice Providers including Physician Assistants (PA), and Nurse Practitioners (NP), who participate in the care of major and severe trauma patients shall:	In rural counties of a population of 30,000 individuals or less, Advanced Practice providers may assist in coverage in the emergency department with the use of telemedicine.	
Level IV	O.4.A. be available 24 hours a day and on-call if not in house, to promptly arrive at the patient bedside within 15 minutes of request / notification.	The time notified, and the response times are tracked through the trauma performance improvement process and reported through the trauma operations committee.	
Level IV	O.4.B. demonstrate knowledge, experience, education, training, and expertise in caring for major and severe trauma patients;	The orientation process, and skills competency are documented and approved by the TMD.	
Level IV	O.4.C. holds current completion status of ATLS or department approved equivalent course.	The current ATLS verification is available for review.	
Level IV	O.4.D. average at least 16 hours of trauma-related continuing medical or nursing education annually as appropriate;	The hours of continuing education must be documented and tracked. It is the TMD job function to oversee this and define the approval for trauma-related education.	(CME requirements will match the ACS language.)
Level IV	O.4.E. maintain compliance with trauma treatment protocols as evidence through the trauma performance improvement program;	This is monitored through the trauma PI process. It is the TMD job function to address events related noncompliance of trauma treatment guidelines/protocols.	
Level IV	O.4.F. participate in the trauma multidisciplinary PI program;	There should be documented evidence of a minimum of 50% attendance at the multidisciplinary PI program meetings.	
Level IV	O.4.G. be approved by the TMD; and	There must be documented evidence of credentialing and approval to participate in trauma care by the TMD.	
Level IV	O.4.H. be credentialed and privileged by the hospital to participate in resuscitation and treatment of trauma patients.	The individual must be approved and credentialed through the medical staff before they can be credentialed for trauma care.	
Level IV	O.5. Radiologist Services		
Level IV	O.5.A. A radiologist shall be on-call and promptly available within 30	The TMD in collaboration with the Radiologist defines the trauma written	

	minutes of request. The radiologist call-back response times shall be continuously monitored through the trauma PI program.	standards or best practices for imaging to ensure trauma care and transfer are not delayed for images. These written protocols are monitored through the trauma PI program for compliance. Images for transferred patients should be electronically forwarded to the receiving hospital (disk or cloud). If off-site radiologist services are provided for interpretation of the images, the radiologist must respond to request within 30 minutes.	
Level IV	O.5.B. Changes in preliminary and final interpretations of radiologic studies shall be routinely monitored and reviewed with the radiology department. Identified cases shall be reviewed to determine the reason for misinterpretation, adverse outcomes, and opportunities for improvement.	The TMD, TPM, and Radiologist will monitor any changes in care due to imaging over-reads and compliance to the imaging standards. The TMD and Radiologist will define cases appropriate for trauma case or trauma peer review.	
Level IV	O.6. Nursing Services. Nursing Administration shall:		
Level IV	O.6.A. ensure the trauma nursing positions, including the TPM and Trauma Registrar, have adequate time dedicated to the trauma program to ensure compliance to TAC 157.125. The TPM must be dedicated to one facility.	Level IV trauma facilities are required to maintain a concurrent trauma program. The TPM is responsible for the trauma PI process and "rounding" on all admitted patients to ensure compliance to the trauma standards of care. "Rounding" occurs when the patient is admitted and during the hospital stay. The registry data extraction begins within the 24-48 hours of activation and is completed after discharge for those patients that are admitted. Patients who are transferred or discharged will have their reviews started within 24 to 48 hours. The TPM is responsible for the planning and organization for the trauma operations and trauma peer review committee as well as RAC participation. There must be a written job description for the TPM that defines their role and authority in the oversight of trauma patients from pre-hospital to trauma activation and	(Language may align with the ACS criteria.)

		admission / transfer / discharge through to discharge. The TPM must be organizationally positioned to make recommendations to improve care from prehospital, to all hospital areas that provide trauma care. The TPM must have experience in trauma care, current certification in TNCC or ATCN, ENPC or PALS, ACLS, and education and training in IC 700, 100, 200. The TPM must be a full-time RN in the hospital and must be dedicated to the hospital. The TPM must complete a course designed to provide clarification on the TPM role such as TETAF/TTCF designation course within twelve months of beginning the role of TPM. The TPM must attend a performance improvement course specific to their role within this same twelve-month time of beginning the TPM position. (TPM cannot be the TPM at multiple hospitals.)	
Level IV	O.6.B. commit to advancing the education and understanding of trauma standards of care for all nursing staff caring for the trauma patient;	All nursing staff in the hospital whose unit provides care or services to the trauma patient must have documented trauma education, training, and skills competencies to include all age groups and standards for pain management, the transfer process, trauma-informed care, and screening for human trafficking.	
Level IV	O.6.C. approve and utilize an acuity-based classification system to define workload and number of nursing staff to provide safe patient care for all trauma patients throughout their hospitalization; and	The CNO and Nursing Leaders are responsible for resource management and the integration of staff RNs into the “shared decision-making” for staffing and an acuity-based staffing model.	
Level IV	O.6.D. Develop a written facility plan for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, volume, multiple emergency procedures, and admissions.	The CEO and CNO are responsible for the facility plan for increasing staffing levels and resources to address volume and high acuity, high risk situations. This may be managed through a staffing plan, disaster plan, or on-call systems, but the staff must be educated, trained, and	

		demonstrate an understanding of the process.	
Level IV	O.7.A. All registered nurses responding to the full and limited trauma activations shall have current credentials in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses. Two registered nurses must respond to the highest level of activation and documentation must reflect their response times;	Registered nurses in the emergency department shall complete TNCC/ATCN, ENPC or PALS courses defined equivalent by the department.	
Level IV	O.7.B. Documentation that 100% of emergency department nursing staff responding to trauma activations or caring for trauma patients, have current education, training, skills credentialing, and certifications in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses, within 12 months of date assigned to the emergency department.	All emergency department nurses responding to full and limited activation have current education, training, skills credentialing, and certifications. 100% of registered nurses have current TNCC or ATCHNENPC or PALS, and ACLS status within twelve months of date hired. All nursing staff in the emergency department have a documented orientation, education, training, and skills check list for their role in disaster response. Education, training, and skills competencies include trauma-informed care practices, and abuse/neglect/trafficking screening.	
Level IV	O.7.C. emergency nursing documentation for trauma patients is systematic, meets the trauma registry guidelines, and includes at a minimum pre-hospital care summary, trauma activation times, response times of all team members, primary and secondary survey findings, vital signs and temperature, interventions, sequencing of care, diagnostic evaluations, serial vital signs and neurologic assessments, consult times and response times, decisions to admit or transfer, outcomes, who received the report at the receiving area.	All the staff assigned to the resuscitation area will have education, training, and skills competency checks for documentation of the identified key elements identified as necessary in the completion of the trauma flow sheet. The emergency department manager is responsible for monitoring the compliance to documentation of the trauma actions and providing action plans to address documentation when needed and reporting findings to the trauma operations committee meeting.	
Level IV	O.8. Nursing Staff who participate in care of all trauma patients		

	throughout the continuum of care shall:		
Level IV	O.8.A. have ongoing documented knowledge and skills in trauma nursing for patients of all ages including trauma specific orientation, education, training and skills competencies specific to their area of practice, and access to trauma continuing education.	The trauma unit orientation process, trauma education, training, and skills are documented, and there is evidence that all nurses have completed these processes in their on-boarding. All nursing caring for trauma patients have documented training and education in trauma-informed care practices, and screening and referrals for abuse/neglect/trafficking.	
Level IV	O.8.B. have written standards of trauma nursing care for all units (i.e. ED, ICU, OR, PACU, Surgery areas, and general inpatient units) with evidence of appropriate implementation with education, training, and skills competencies.	The TMD and TPM assist in the development of these trauma nursing standards of care and assist in identifying key elements to monitor to ensure compliance to the standards. These standards of care include trauma-informed practices, and screening for abuse/neglect/trafficking, and how to report these findings, and to who it is reported.	
Level IV	O.8.C. document nursing care for trauma patients that is systematic, meets the trauma registry guidelines, and includes at a minimum: patient assessments and interventions, sequencing of care, diagnostic evaluation, serial vital signs, neurologic assessments, neurovascular assessments if fractures are present, wound care if wounds are present, consultants, response times and "rounding" times of physicians, outcomes, and plan of care with disposition. Specific issues such as "returning to the OR", "returning to the ICU" should have detailed documentation regarding the patient's status and the times requested to transfer the patient to the OR or ICU, and the actual time transferred. Documentation standards for the units are	The trauma nursing documentation should be included in each of the unit's written trauma standards of care. This is monitored by the unit's manager for compliance to the defined expectations and reported to the trauma operations committee.	

	monitored by the supervising manager.		
Level IV	O.9. Trauma Registrar. There shall be an identified Trauma Registrar who has:	If the Level IV trauma facility has a centralized registry through their system or the registry is outsourced, there must be an identified registrar who works with the facility. In these situations, the Level IV facility does not need a specific trauma registrar, but they must have documentation from the central registry or outsourced agency that the registry data abstraction for each case is completed within 60 days of the patient's discharge, and validation reports for submission the State Trauma Registry. The facility must have access to the data and receive monthly dashboard reports defined by the TMD and TPM. The facility must have documented evidence of the central staffing and outsourced agency's staff completion of the AAAM ISS Scoring Class and the ICD-10 Coding class.	
Level IV	O.9.A. completed appropriate education and training within 18 months of in-hire to the position of trauma registrar which includes	The individual in the trauma registrar position must complete the Data Management Course within twelve months of assignment as a trauma registrar. Staffing resources must ensure that concurrent practices for data abstraction and registry entry are maintained. Registry profiles must be completed within 60 days of the patient's discharge. Recommended trauma registrar staffing is one registrar for every 500 trauma registry admissions; a .8 registrar FTE for 300 up to 450 trauma registry admissions; and .5 registrar FTE for up to 299 trauma registry admissions to ensure a concurrent, accurate, and complete process. (NOTE: these trauma registrar staffing recommendations	

		focus only on the data abstraction and data entry. If the registrar has other job functions other than the abstraction and data entry, these volume numbers will need to decrease.)	
Level IV	O.9.B. a department recognized injury scoring, and/or coding course; and	The TPM and registrar must complete the AAAM Injury Scoring Course and ICD-10 Coding Course within eighteen months of in-hire. If the Level IV facility is utilizing a centralized system registry or outsourcing the registry, this element is not required.	
Level IV	0.9.C. four hours of continuing education annually specific to trauma data quality.	The trauma registrar is responsible for the trauma data validation and correction of the data. The registrar is responsible for the registry data submission to the State Trauma Registry quarterly. The registrar and the TPM are responsible to keep and track all submission and validation reports for inclusion in the trauma designation application packet. The registrar's continuing education and skills development are essential to the trauma center and must be supported. Resources to attend programs to assist with registrar certification are provided by the facility. This is not required if the registry is managed through a central registry or it is outsourced.	
Level IV	O.10. Emergency Services. Equipment and services for critically or seriously injured patients, complex neurosurgical patients, orthopedic management, for all ages shall be available for evaluation of: • Processes to address communication with EMS • Resuscitation and life support • Potential traumatic brain injuries • Hemodynamic monitoring • Temperature management	The TMD and TPM assist in developing and approve the written trauma standards of care. They assist the emergency department medical director and manager with defining the correct equipment, resources, and processes to manage the trauma patient population.	

	• Hemorrhage control, to include resources for massive transfusion as needed • Orthopedic management • Burn care • Processes to address suspicion of abuse, neglect, or trafficking • Processes to expedite transfers • Processes to address pain management		
Level IV	O.11. Clinical Support Services		
	O.11.A. Respiratory Services. Respiratory services shall be available 24 hours a day onsite and appropriate for the trauma patient population served.	There is documented evidence of the education, training, and skills specific to the trauma patient population for the respiratory therapist. The respiratory therapist has education and training specific to the trauma standards of care.	
Level IV	O.11.B. Clinical Laboratory Services		
Level IV	O.11.B.i. Laboratory services shall be available 24 hours a day onsite, with the emergency release of blood products, and plan to obtain additional blood products.	Laboratory staff who respond to the trauma activations must have documented evidence of education, training, and their specific function. This includes the processes of STAT or emergency release of blood products. Emergency blood release events should be monitored and evaluated for compliance to established procedures and reported to the trauma operations committee.	
Level IV	O.11.B.ii. Laboratory personnel shall be available onsite or on-call 24 hours a day, and promptly arrive on-site within 30 minutes of request. On-call response times will be documented and monitored through the trauma performance improvement program.	The response time of the laboratory personnel shall be tracked by the lab and through the trauma performance improvement process and reported at the trauma operations committee.	
Level IV	O.11.C. Standard Radiological Services. Services with educated and trained personnel shall be available onsite or on-call 24 hours a day, and promptly arrive onsite within 30 minutes of request. On-	Radiology is responsible for the documented call-back response time monitoring and reporting the response compliance to the trauma operations committee.	

	call response times will be documented and monitored through the trauma performance improvement program.		
Level IV	O.11.D. Special Radiological Services. Computerized tomography scanner (CT) abilities appropriate for the trauma patient population served shall be available onsite 24 hours a day. Appropriately educated and trained personnel shall be available onsite or on-call 24 hours a day, and promptly arrive onsite within 30 minutes of request. On-call personnel response times will be documented and monitored through the trauma performance improvement program.	The Radiology leaders are responsible for the documented response times of the personnel and monitoring times for compliance to the 30 minute on-call response. This information is reported to the trauma operations committee.	
Level IV	O.12. Social Services and Pastoral Care shall be available 24 hours a day to assist with crisis management, trauma-informed care practices, and screening for abuse, neglect, trafficking and referrals.	Social Services and Pastoral Care personnel are educated and trained on their role in trauma care for the facility to include assisting with crisis management, trauma-informed care practices, and screening for abuse, neglect, and trafficking, and reporting findings.	
Level IV	O.13. If the facility performs surgery and/or provides inpatient trauma care, the facility shall provide the same level of care and resources that the patient would receive at a higher level of designated trauma facility and shall review the care provided through the trauma PI program.	The TMD and TPM are responsible for monitoring this and to ensure the patient received the national standard of trauma care. If this is a frequent event, and the facility has this higher level of capabilities routinely, the facility is considered “under-designating”, and (should/shall) seek a higher level of designation.	