Num.	Level	Standard
STANDARD I -- ADMINISTRATIVE		
INTRODUCTION: From an institutional perspective, the willingness of the hospital's board of directors and administration to commit to allocating adequate resources and personnel to accept and care for trauma patients is essential for the successful operation of a trauma center.		
1	ALL	There shall be demonstrated commitment to trauma care by the hospital's board of directors, administration, medical staff, and nursing staff to treat any trauma patient presented to the facility for care. Methods of demonstrating commitment to the trauma center and system by the hospital shall include, but not be limited to, the following:
	ALL	A board of directors' resolution of commitment of hospital financial, human, and physical resources to treat all trauma patients at the level of hospital's approval, regardless of color creed, sex, nationality, place of residence, or financial class.
	ALL	A board of directors' resolution of commitment to participate in the state regional trauma system and the local or regional trauma system, if one exists.
	ALL	Institution of procedures to document and review all transfers with neighboring hospitals and trauma centers for transfers into and out of the hospital.
	ALL	Providing patient care data as requested by the department or its agent and participate in a national performance improvement and/or risk adjusted benchmarking program(s) as prescribed by the department in Rule 64-2.011 or 64J-2.006 F.A.C.
	ALL	Establishment of formal written patient transfer agreements with neighboring hospitals and trauma centers.
2	ALL	The hospital's chief executive officer (CEO) has overall responsibility for compliance with all trauma center standards. The CEO or his or her designee shall ensure that all staff involved with the care of the trauma patient are aware of their responsibilities as required by the trauma center standards.
3	ALL	The hospital shall ensure that the trauma medical director is responsible and accountable for administering all aspects of trauma care. Therefore, the trauma medical director shall be empowered to enforce the trauma center standards with other medical and clinical departments in the hospital. The trauma program manager shall perform under the direction of the trauma medical director and shall interact with all departments on behalf of the medical director.
4	ALL	When there are issues that the trauma medical director has been unable to resolve through the hospital's organizational structure, the hospital shall provide a specific mechanism to ensure that the medical staff or CEO address such unresolved issues. This mechanism shall include direct consultation with the affected services, including, but not limited to, trauma and emergency services.
5	ALL	The trauma medical director shall have written job description that outlines that the Trauma Medical Director shall have the following authority and responsibilities:
	ALL	Reviews and verifies the qualifications and attests to the medical ability of all personnel who provide trauma services.
	ALL	Authorize trauma service privileges.
	ALL	Work in cooperation with the nursing administration to support the nursing needs of trauma patients.
	ALL	Develop treatment protocols, and coordinates the performance improvement and peer review processes.
	ALL	The trauma medical director shall have the authority to correct deficiencies in trauma care and exclude from trauma service personnel who do not meet performance and quality criteria. Specifically, as part of the trauma medical director's responsibility to verify qualifications and clinical competency, the trauma medical director shall verify that each general surgeon on the on call panel is capable of providing initial stabilization measures

		and instituting diagnostic procedures for patients, both adult and pediatric, with neural trauma.
	ALL	The hospital shall ensure that the procedures, policies, or bylaws address circumstances in which the trauma medical director determines that an attending physician's actions compromise the health, safety, or welfare of trauma patients. In such case, procedures, policies, or bylaws shall address options such as temporary or permanent removal of the physician from the trauma service, or other appropriate remedial measure.
	ALL	The trauma medical director shall have oversight responsibility for trauma patient care and shall monitor trauma patient care on an ongoing basis as delineated in Standard XVIII.
	ALL	When the trauma medical director is unavailable to the trauma service the medical director shall delegate authority to another trauma surgeon to carry out the above administrative functions.

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STANDARD II -- TRAUMA SERVICE		
INTRODUCTION: From a personal leadership perspective, the qualifications of the trauma medical director and the trauma program manager should reflect leadership, planning, performance improvement, and trauma care expertise. These individuals lead the trauma care team and are responsible for the organizational integrity of the program. As such, it is desirable that these individuals obtain greater than 50 percent of their continuing education credits outside the hospital through participation in regional, state and national meetings. It is also desirable that they participate in the development or operation of a local, regional, and statewide and/or national trauma care system and be involved in local or regional EMS services and local or regional trauma agency activities. The hospital might consider providing additional resources, such as a quality improvement staff member and clerical support, to assist with these activities.		
1	ALL	Organizational Requirements -- The trauma service shall be a dedicated and defined service within the organizational structure of the hospital as evidenced by the following:
	ALL	A designated medical director contracted to direct and oversee the operation of the trauma service. The medical director position for the trauma service shall be paid by the hospital and documented by a written job description and organizational chart.
	ALL	A designated trauma program manager for the trauma service. The trauma program manager position for the trauma service shall be staffed by the hospital and documented by a written job description and organizational chart. The trauma program manager's responsibilities as outlined in their job description shall be solely dedicated to the trauma service.
	ALL	A trauma registrar for the trauma service. The trauma registrar position(s) for the trauma service shall be effectively staffed by the hospital and documented by a written job description and organizational chart. There shall be one full time equivalent trauma registrar will be required to process more than per 500 annually that meet the trauma registry inclusion criteria
	ALL	A trauma performance improvement support person. The performance improvement position(s) for trauma service shall be funded by the hospital and documented by a written job description and organizational chart. There shall be one full time equivalent performance improvement personnel per 750 admitted patients annually that meet the trauma registry inclusion criteria.
	I	At least one qualified trauma surgeon (as described in Standard III.A) to be in-hospital and on primary trauma call at all times to provide trauma service care.
	II,PED	At least one qualified trauma surgeon (as described in Standard III.A) to be on primary trauma call at all times to provide trauma service care.
	ALL	At least one qualified trauma surgeon (as described in Standard III.A) to be on backup trauma call at all times to provide trauma service care.
	I, PED	At least one qualified pediatric trauma surgeon for the trauma service (as described in Standard III.A.3.b).
	PED	At least one qualified pediatric trauma surgeon for the trauma service (as described in Standard III.A.3.b).
2	ALL	Administrative Requirements -- The trauma medical director shall ensure that:
	ALL	The following physicians participating on the trauma service meet and maintain the qualifications, board certifications (including maintenance of board certification), and trauma-related continuing medical education (CME) as required in Standards III.A and B and Standard V.B: • Pediatric and general trauma surgeons. • Emergency physicians. • Liaisons to the peer review committee as outlined in Standard XVIII.D

	ALL	Evidence of participation and leadership by the trauma medical director and trauma program manager (or designee) in their region or community relating to trauma care. This shall include involvement in a local or regional trauma agency if such group exists in their location.
	ALL	A written plan is on file that describes the hospital's interaction with the local or regional trauma agency, if one exists, and other county and regional medical response or treatment resources during disaster and mass casualty situations.
	ALL	The hospital submits trauma data to the state Bureau of Emergency Medical Oversight, Trauma Section, trauma registry program in accordance with by Rule 64J-2.006, Florida Administrative Code.
	ALL	The trauma service maintains up-to-date documentation demonstrating proof of compliance with all standards. This documentation shall be available for review by the Department of Health at any time.
	I, PED	The trauma center shall provide, within the facility, pediatric trauma patient care services, from emergency department admission through rehabilitation, that are separate and distinct from adult trauma patient care services.
3	ALL	Medical and Patient Care Requirements -- The trauma medical director shall maintain oversight responsibility for the development, implementation, and ongoing compliance of hospital policies and clinical protocols for trauma care.
	ALL	The trauma medical director shall ensure that policies and protocols are developed for a minimum of the following: • Priority admission status for trauma patients. • Patient transfers into and out of the hospital. • The trauma medical director shall approve all trauma-related patient care protocols before implementation. • The trauma medical director, in coordination with the trauma program manager, shall monitor compliance with trauma-related protocols through the trauma quality management process.
4	ALL	Qualifications of Leadership Staff -- The trauma service shall have evidence on file that describes the qualifications of the trauma medical director and the trauma program manager to provide medical and organizational leadership to the trauma service. At a minimum, this evidence shall include the following:
A	ALL	Trauma Medical Director
	I,II	Proof of current board certification in general surgery.
	PED	Proof of current board certification in general surgery or pediatric surgery.
	I	Documentation that the hospital granted the medical director full and unrestricted privileges to provide general surgical and trauma care surgical services for adult and pediatric patients.
	II	Documentation that the hospital granted the medical director full and unrestricted privileges to provide general surgical and trauma care surgical services for adult patients.
	PED	Documentation that the hospital granted the medical director full and unrestricted privileges to provide general surgical and trauma care surgical services for pediatric patients.
	I	Documentation that the medical director manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), at least eight of which are pediatric, if the medical director manages pediatric trauma patients. These cases may include operative and non- operative interventions.
	II	Documentation that the medical director manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), These cases may include operative and non- operative interventions.

	PED	Documentation that the medical director manages a minimum of 12 pediatric trauma cases per year (average of three trauma cases per quarter), These cases may include operative and non- operative interventions.
	I, II	The trauma medical director shall demonstrate proof of maintenance of board certification or must have 16 hours of trauma-related medical education annually or 48 hours in 3 years.
	PED	The trauma medical director shall demonstrate proof of maintenance of board certification or must have 16 hours of trauma-related medical education annually, 8 which shall be in pediatric trauma, or 48 hours in 3 years.
	ALL	Current ATLS instructor certification.
B	ALL	Trauma Program Manager
	ALL	Documentation of current Florida Registered Nurse licensure.
	ALL	Documentation of current Emergency Nurses Association Trauma Nursing Core Course (TNCC) training or equivalent.
	ALL	The trauma program manager's responsibilities as outlined in their job description shall be solely dedicated to the trauma service.
	I,II	Documentation of a minimum 16 hours of trauma related continuing education per year.
	PED	Documentation of a minimum 16 hours of trauma related continuing education per year, 8 hours shall be in pediatric trauma.

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STANDARD III -- SURGICAL SERVICES		
INTRODUCTION: The background of surgeons involved in the provision of trauma patient care should reflect an interest in and a commitment to trauma. Formal trauma fellowships, training in surgery with an active trauma service, or combat experience as a surgeon constitutes examples of such interest. Each trauma surgeon participating on the trauma service should also maintain his or her skills and expertise through continuing trauma-related education. It is desirable that these individuals obtain greater than 50 percent of their continuing education credits outside the hospital. Active trauma surgeon involvement in not only the care of injured patients, but also in the development of trauma protocols, coordination of trauma call schedules, and involvement in trauma rounds is imperative for the successful operation of a trauma center. Each of those elements indicates a commitment to excellence in trauma patient care.		
1	ALL	General or Pediatric Surgery
	I	There shall be a minimum of five qualified trauma surgeons, assigned to the trauma service, with at least two trauma surgeons available to provide primary (in-hospital) and backup trauma coverage 24 hours a day at the trauma center when summoned. Pursuant to Standard II.A.6, there shall be at least one qualified pediatric trauma surgeon for the trauma service.
	II	There shall be a minimum of five qualified trauma surgeons, assigned to the trauma service, with at least two trauma surgeons available to provide primary and backup trauma coverage 24 hours a day at the trauma center when summoned.
	PED	There shall be a minimum of five qualified trauma surgeons, assigned to the trauma service, with at least two trauma surgeons available to provide primary and backup trauma coverage 24 hours a day at the trauma center when summoned. If the trauma medical director is not a pediatric surgeon, then at least one of the five must be a pediatric surgeon.
2	ALL	Primary Call
	I	To be physically present in-hospital to meet all trauma alert patients in the trauma resuscitation area at the time of the trauma alert patient's arrival.
	II,PED	To be on call and approve promptly at the trauma center when summoned.
	ALL	To perform no non-emergent surgery or procedures, during the on-call period, that would render the trauma surgeon unavailable to arrive promptly to a trauma alert patient.
	ALL	To refrain from taking general surgery emergency calls or trauma calls at any other facility while on trauma call at the primary facility.
3	ALL	Backup trauma call
	ALL	When the trauma surgeon on primary call takes a trauma patient to surgery, the trauma surgeon on backup trauma call shall become the primary trauma surgeon and shall arrive promptly when summoned. Note: This standard does not prevent the backup on-call trauma surgeon from preforming elective or other surgical procedures; however, the back up on-call trauma surgeon must be able to arrive promptly to a trauma alert patient.
	ALL	To refrain from taking general surgery emergency calls or trauma calls at any other facility while on trauma call at the primary facility.
4	ALL	Evidence shall be on file that clearly describes the qualifications of each trauma surgeon to be a member of the trauma service and to take trauma calls. At a minimum, this evidence shall include the following:
A	ALL	For a general surgeon:
	ALL	Proof of current board certification or actively participating in the certification process with a time period set by each specialty board in general surgery, or proof of meeting the following definition of alternate criteria: Alternate Criteria for the Non-Board-Certified General Surgeon in a trauma center. In rare cases, a non-board-certified general surgeon who meets all of the following criteria or has been evaluated and approved through the American College of Surgeons (ACS),

		Committee on Trauma, Verification Review Committee (VRC), alternate pathway criteria process may be included on the trauma call panel: Note: Successful completion of the criteria below or approval through the ACS-VRC shall be demonstrated prior to the physician being added to the call panel. • Licensed to practice medicine in the state of Florida and is approved for full and unrestricted surgical privileges by the hospital's credentialing committee. • The surgeon has successfully completed a residency training program in general surgery, with the time period being consistent with the years of training in the United States. This completion must be certified by a letter from the program director. • Completed 36 hours of trauma related continuing medical education (CME) during the past 3 years. • Documentation of membership or attendance at local and regional or national trauma meetings during the previous 12 months. • Performance improvement assessment by the trauma medical director demonstrating that the morbidity and mortality results. • Documentation that the surgeon was present at least 50% of the trauma performance improvement meetings during the previous 12 months. • Completion of an assessment, accompanied by a letter attesting to the demonstration of clinical competence and performance of quality of trauma care, by third party vendor contacted by the hospital that is a board-certified general surgeon. The contractor shall at a minimum review a list of patients treated during the past year with accompanying Injury Severity Score and outcome data.
	I	Documentation that the hospital granted the general surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services for adult and pediatric patients.
	II	Documentation that the hospital granted the general surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services for adult patients.
	PED	Documentation that the hospital granted the general surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services for pediatric patients.
	I	Documentation that the general surgeon manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), at least eight of which are pediatric if the general surgeon manages pediatric trauma patients. These cases may include operative and non-operative interventions.
	II	Documentation that the medical director manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), These cases may include operative and non- operative interventions.
	PED	Documentation that the medical director manages a minimum of 12 pediatric trauma cases per year (average of three trauma cases per quarter), These cases may include operative and non- operative interventions.
	I,II	Each general surgeon shall demonstrate proof of maintenance of board certification or must have 16 hours of trauma-related medical education annually (or 48 hours in 3 years) or demonstrate participation in an internal education process (IEP) conducted by the trauma program based on the principles of practice-based learning and the trauma performance improvement program.
	PED	The trauma medical director shall demonstrate proof of maintenance of board certification or must have 16 hours of trauma-related medical education annually, 8 which shall be in pediatric trauma, (or 48 hours in 3 years) or demonstrate participation in an internal education process (IEP) conducted by the trauma program based on the principles of practice-based learning and the trauma performance improvement program

	ALL	Current ATLS provider certification.
B	I, PED	For a pediatric surgeon:
	I, PED	Proof of current board certification or actively participating in the certification process with a time period set by each specialty board in general surgery, or proof of meeting the following definition of alternate criteria. Alternate Criteria for the Non-Board-Certified Pediatric Surgeon. In rare cases, a non-board-certified general surgeon who meets all of the following criteria or has been evaluated and approved through the American College of Surgeons (ACS), Committee on Trauma, Verification Review Committee (VRC), alternate pathway criteria process may be included on the trauma call panel: Note: Successful completion of the criteria below or approval through the ACS-VRC shall be demonstrated prior to the physician being added to the call panel. • Licensed to practice medicine in the state of Florida and is approved for full and unrestricted surgical privileges by the hospital's credentialing committee. • The surgeon has successfully completed a residency training program in general surgery, with the time period being consistent with the years of training in the United States. This completion must be certified by a letter from the program director. • Completed 36 hours of trauma related continuing medical education (CME) during the past 3 years. • Documentation of membership or attendance at local and regional or national trauma meetings during the previous 12 months. • Performance improvement assessment by the trauma medical director demonstrating that the morbidity and mortality results. • Documentation that the surgeon was present at least 50% of the trauma performance improvement meetings during the previous 12 months. • Completion of an assessment, accompanied by a letter attesting to the demonstration of clinical competence and performance of quality of trauma care, by third party vendor contacted by the hospital that is a board-certified general surgeon. The contractor shall at a minimum review a list of patients treated during the past year with accompanying Injury Severity Score and outcome data.
	I, PED	When the number of pediatric surgeons on staff is too few to sustain the pediatric trauma panel, general surgeons who are currently board-certified or actively participating in the certification process with a time period set by each specialty board may serve on the trauma team.
	I, PED	Documentation that the hospital granted the pediatric surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services specific to pediatric patients.
	I, PED	Documentation that the pediatric surgeon manages a minimum of 12 pediatric trauma cases per year (average of three trauma cases per quarter). These cases may include operative and non- operative interventions.
	I, PED	Each pediatric surgeon shall demonstrate proof of maintenance of board certification; or must have 16 hours of trauma-related medical education annually (or 48 hours in 3 years); or demonstrate participation in an internal education process (IEP) conducted by the trauma program based on the principles of practice-based learning and the trauma performance improvement program.
	I, PED	Current ATLS provider certification.
C	I, PED	Senior surgical residents (PGY-4 or above) may fill the in-hospital general surgical requirement if the trauma medical director ensures the following:

	I, PED	A qualified general surgeon (or pediatric surgeon for pediatric patients) is on trauma call and shall arrive promptly at the trauma center when summoned.
	I, PED	The trauma medical director attests in writing that each resident is capable of the following: • Providing appropriate assessment and responses to emergent changes in patient condition. • Instituting initial diagnostic procedures. • Initiating surgical procedures. This statement shall be on file and available for Department of Health review for each general surgical resident that fills this requirement.
	I, PED	When a trauma alert patient is identified, the attending trauma surgeon shall be summoned and take an active role by participating in patient care during the resuscitation.
	I, PED	The attending trauma surgeon shall also accompany the senior surgical resident to the operating room.
	I, PED	Each general surgical resident has current ATLS provider certification.
D	ALL	Neurological Surgery
	I	There shall be a minimum of one qualified neurosurgeon to provide in-hospital trauma coverage 24 hours a day at the trauma center.
	II, PED	There shall be a minimum of one qualified neurosurgeon to be on-call and arrive promptly when summoned to provide trauma coverage 24 hours a day at the trauma center.
	ALL	Proof of current board certification or actively participating in the certification process with a time period set by each specialty board in neurosurgery, or proof of meeting the following definition of alternate criteria: Alternate Criteria for Non-Board-Certified Neurosurgeon in a trauma center. In rare cases, a non-board- certified specialist who meets all of the following criteria or has been evaluated and approved through the American College of Surgeons (ACS), Committee on Trauma, Verification Review Committee (VRC), alternate pathway criteria process may be included on the trauma call panel: Note: Successful completion of the criteria below or approval through the ACS-VRC shall be demonstrated prior to the physician being added to the call panel. • Licensed to practice medicine in the state of Florida and is approved for full and unrestricted surgical privileges by the hospital's credentialing committee. • The surgeon has successfully completed a residency training program in general surgery, with the time period being consistent with the years of training in the United States. This completion must be certified by a letter from the program director. • Completed 36 hours of trauma related continuing medical education (CME) during the past 3 years. • Documentation of membership or attendance at local and regional or national trauma meetings during the previous 12 months. • Performance improvement assessment by the trauma medical director demonstrating that the morbidity and mortality results. • Documentation that the surgeon was present at least 50% of the trauma performance improvement meetings during the previous 12 months. • Completion of an assessment, accompanied by a letter attesting to the demonstration of clinical competence and performance of quality of trauma care, by

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		third party vendor contacted by the hospital that is a board-certified general surgeon. The contractor shall at a minimum review a list of patients treated during the past year with accompanying Injury Severity Score and outcome data.
	I, PED	Documentation that the hospital has granted the neurosurgeon privileges to provide neurosurgical and trauma care services for adult and pediatric patients.
	II	Documentation that the hospital has granted the neurosurgeon privileges to provide neurosurgical and trauma care services for adult patients.

	I, PED	Senior neurosurgical residents, PGY-4 or above, may fill the in-hospital neurosurgeon requirement only if the trauma medical director and the Chief of Neurosurgery ensure the following:
		
		• An attending neurosurgeon is on trauma call and available to arrive promptly at the trauma center to provide stabilization, diagnostic procedures, or definitive operative care.
		• The trauma medical director and the Chief of Neurosurgery attest in writing that the senior neurosurgical resident is capable of the following:
		  o Providing appropriate assessment and responses to emergent changes in patient condition.
		  o Instituting initial diagnostic procedures.
		  This statement shall be on file and available for department review for each senior neurosurgical resident that fills the neurosurgeon requirement.
		• There is evidence on file that each resident has completed at least two years of neurosurgical training.

	ALL	General trauma surgeons on trauma call may fill the in-hospital neurosurgeon requirement only if the trauma medical director and the Chief of Neurosurgery ensure the following: The trauma medical director and the Chief of Neurosurgery attest in writing that the senior neurosurgical resident is capable of the following: • Providing appropriate assessment and responses to emergent changes in patient condition. • Instituting initial diagnostic procedures. This statement shall be on file and available for department review for each senior neurosurgical resident that fills the neurosurgeon requirement.
5	ALL	Surgeons in the following specialties shall be available to respond promptly to the trauma center when summoned:
	I, PED	Cardiac surgery
	I, PED	Hand surgery
	I, PED	Microsurgery
	I, II	Obstetric/gynecologic surgery
	ALL	Ophthalmic surgery
	ALL	Oral/maxillofacial surgery
	ALL	Orthopedic surgery
	ALL	Otorhinolaryngologic surgery
	II	Pediatric surgery
	ALL	Plastic surgery
	ALL	Thoracic surgery
	ALL	Urologic surgery
	I,II	All surgeons staffing the services listed in items C.1-11 above shall be currently board

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		certified in their respective specialties, or deemed comparably competent by the trauma medical director and granted privileges by the hospital to care for adult and pediatric patients.
	PED	All surgeons staffing the services listed in items C.1-11 above shall be currently board certified in their respective specialties, or deemed comparably competent by the trauma medical director and granted privileges by the hospital to care for pediatric patients.

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STANDARD IV -- NON-SURGICAL SERVICES		
INTRODUCTION: A trauma center should use a coordinated team approach for the optimal care of trauma patients because the complex problems of trauma patients can require the involvement of several specialty areas. However, trauma surgeons should not relinquish the overall responsibility for the trauma patient.		
1	ALL	Anesthesia -- An anesthesiologist shall be in-hospital and promptly available for trauma patient care 24 hours a day. The anesthesiologist shall be board certified or actively participating in the certification process with a time period set by each specialty board and have privileges from the hospital to provide anesthesia and trauma care services for adult and pediatric patients. A certified registered nurse anesthetist (C.R.N.A.) or; Certified Anesthesiologist's Assistants (C-AA) a senior anesthesia resident (CA-3 or above) may, however, fill the in-hospital anesthesiologist requirement only if the trauma medical director ensures the following: • A staff anesthesiologist is on trauma call and available to arrive promptly at the trauma center when summoned. • The trauma medical director and the Chief of Anesthesiology attest in writing that each C.R.N.A., C-AA or resident is capable of the following: 1. Providing appropriate assessment and responses to emergent changes in patient condition. 2. Starting anesthesia for any trauma patients that the attending trauma surgeon determines are in need of operative care (pending the arrival of the anesthesiologist on trauma call). This statement shall be on file and available for Department of Health review for each C.R.N.A., C-AA or senior anesthesia resident that fills the anesthesiologist requirement • Evidence is on file that each resident has completed at least 24 months of clinical anesthesiology.
2	ALL	The following non-surgical specialties shall be available 24 hours a day to arrive respond promptly at the trauma center when summoned:
	ALL	Cardiology
	ALL	Gastroenterology
	ALL	Hematology
	ALL	Infectious disease
	ALL	Internal medicine
	ALL	Nephrology
	ALL	Pathology
	ALL	Pediatrics
	I, II	Psychiatry
	ALL	Pulmonary medicine
	ALL	Radiology
	I, II	All specialists staffing the services listed in B.1-11 above shall be currently board certified in their respective specialties or deemed comparably competent by the Trauma Medical Director, and granted medical staff privileges by the hospital to care for adult and pediatric patients.
	PED	All specialists staffing the services listed in B.1-11 above shall be currently board certified in their respective specialties or deemed comparably competent by the Trauma Medical Director, and granted medical staff privileges by the hospital to care for pediatric patients.

STANDARD V -- EMERGENCY DEPARTMENT		
INTRODUCTION: Resuscitation is a vital component of trauma care that requires appropriate organization, personnel, and resources to ensure an effective multidisciplinary approach. Since the trauma team initially comes together during this stressful and fast-paced time, members must maintain the knowledge and skills necessary to quickly assess and manage patients with traumatic injuries. It is desirable that the emergency department medical director and other emergency physicians obtain at least half of their trauma-related continuing education outside the hospital. It is also desirable that emergency nurses assigned to the trauma resuscitation obtain their initial trauma education through a comprehensive trauma core course. The resuscitation, if well planned and organized, should optimize the patient's chances of survival, minimize morbidity, and ensure both efficiency and proficiency of the trauma team. Once organized, resuscitations should undergo constant study, constructive evaluation, and continuous quality improvement.		
1	ALL	Emergency Department Facility Requirements
	ALL	There shall be an easily accessible and identifiable resuscitation area designated for trauma alert patients. This area shall be large enough to allow assembly of the full trauma team.
	I, PED	There shall be resources, staff, and equipment necessary to treat the pediatric trauma patient.
	ALL	The trauma resuscitation area shall be of adequate size and contain adequate trauma care equipment and supplies to simultaneously perform at least two multisystem trauma alert patient resuscitations.
	ALL	There shall be evidence of security measures in place in the resuscitation area designed to protect the life and well-being of assigned trauma center staff, patients, and families (for example, a silent or overt alarm system or an assigned security guard).
	ALL	There shall be facilities to accommodate the simultaneous unloading of two EMS ground units.
	ALL	There shall be a helicopter-landing site in close proximity to the resuscitation area. Close proximity means that the interval of time between the landing of the helicopter and the transfer of the patient into the resuscitation area will be such that no harmful effect on the patient's outcome results. All helicopter landing sites shall also meet the following requirements: • The site shall be licensed by the Florida Department of Transportation. • Use of the air space shall be approved by the Federal Aviation Administration. • Documentation shall be on file with the trauma service indicating that the trauma center develops and maintains protocols and provides training during employee orientation regarding the safe loading and unloading of patients from a helicopter, as well as precautions to ensure the safety of staff or bystanders while in the vicinity of the aircraft.
2	ALL	Physician Requirements
	ALL	Emergency Department Medical Director -- Evidence shall be on file indicating that the trauma center has designated a medical director for the emergency department. Evidence shall also be on file that describes the qualifications of the medical director to provide trauma-related medical and organizational leadership to physician, nursing, and hospital support staffs. At a minimum, this evidence shall include the following:
	I, II	Proof of current board certification in emergency medicine.
	PED	Proof of current board certification in emergency medicine or pediatric emergency medicine.
	I, II	Documentation that the hospital granted privileges to the emergency department medical director to provide trauma and other emergency care services for adult and pediatric patients.
	PED	Documentation that the hospital granted privileges to the emergency department medical director to provide trauma and other emergency care services for pediatric patients.

	I, II	The Emergency Department Medical Director shall demonstrate proof of maintenance of board certification; or must have 16 hours of trauma-related medical education annually (or 48 hours in 3 years); or demonstrate participation in an internal education process (IEP) conducted by the trauma program based on the principles of practice based learning and the trauma performance improvement program.
	PED	The Emergency Department Medical Director shall demonstrate proof of maintenance of board certification; or must have 16 hours of trauma-related medical education annually, 8 hours of which are in pediatric trauma (or 48 hours in 3 years); or demonstrate participation in an internal education process (IEP) conducted by the trauma program based on the principles of practice based learning and the trauma performance improvement program.
	ALL	Documentation of a full-time practice in emergency medicine (may include both administrative and patient care hours).
	ALL	Current ATLS provider certification.
3	ALL	Emergency Physicians -- Evidence shall be on file indicating that at least one emergency physician is on duty in the emergency department 24 hours a day to cover adult and pediatric trauma patient care services. The emergency department medical director shall ensure that the emergency physicians, during their assigned shifts, comply with the following conditions:
	ALL	To be physically present in-hospital to and available to respond if needed to meet all trauma alert patients in the trauma resuscitation area at the time of the trauma alert patient's arrival.
	ALL	To assume trauma team leadership if the trauma surgeon on trauma call is not physically present at the time of the trauma alert patient's arrival in the trauma resuscitation area.
	ALL	To transfer the care of the trauma patient to the attending trauma surgeon upon his or her arrival in the resuscitation area.
A	ALL	Evidence shall also be on file that clearly describes the qualifications of the emergency physicians working in the resuscitation area. At a minimum, this evidence shall include the following:
	ALL	Proof of current board certification or actively participating in the certification process with a time period set by each specialty board in emergency medicine, or proof of meeting the following definition of alternate criteria: • Has provided exceptional care of trauma patients Licensed to practice medicine in the state of Florida and is approved for full and unrestricted surgical privileges by the hospital's credentialing committee • Has numerous publications and presentations The Emergency Physician has successfully completed a residency training program in emergency medicine, with the time period being consistent with the years of training in the United States. This completion must be certified by a letter from the program director. • Has published excellent research 36 hours of trauma related continuing medical education (CME) during the past 3 years. • Is documented to provide excellent teaching. Documentation of membership or attendance at local and regional or national trauma meetings during the previous 12 months. • Performance improvement assessment by the trauma medical director demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with the morbidity and mortality results for comparable patients treated by other members of the trauma call panel. • Documentation that the surgeon was present at least 50% of the trauma performance improvement meetings during the previous 12 months.

		• Completion of an assessment, accompanied by a letter attesting to the demonstration of clinical competence and performance of quality of trauma care, by third party vendor contacted by the hospital that is a board-certified neurosurgeon. The contractor shall at a minimum review a list of patients treated during the past year with accompanying Injury Severity Score and outcome data. • Has worked as a full-time emergency physician for at least three out of the last five years.
	ALL	The Emergency Department physician shall demonstrate proof of maintenance of board certification; or must have 16 hours of trauma-related medical education annually (or 48 hours in 3 years); or demonstrate participation in an internal education process (IEP) conducted by the trauma program based on the principles of practice-based learning and the trauma performance improvement program.
	ALL	Documentation that the hospital granted privileges to the emergency physician to provide trauma and other emergency care services for adult and pediatric patients.
	ALL	Current ATLS provider certification.
B	I, PED	For emergency physicians who care for only pediatric trauma patients, the evidence shall include the following:
	I, PED	Proof of current board certification or actively participating in the certification process with a time period set by each specialty board in pediatric emergency medicine, or proof of meeting the following definition of alternate criteria: • The non-board-certified physician must have completed an approved residency program. • The physician must be licensed to practice medicine and approved for emergency medicine privileges by the hospital's credentialing committee. • The physician must meet all criteria established by the trauma director and emergency medicine director. • The physician must have experience in caring for trauma patients, which must be tracked by the PI program. • The trauma director [and] emergency medicine director must attest to this physician's experience and quality of patient care as a part of the recurring granting of trauma team privileges consistent with the hospital's policy. • This individual is expected to meet all other qualifications for members of the trauma team.
	I, PED	Board certification in a primary care specialty or emergency medicine and a written attestation by the emergency department medical director that the physician has worked as a full-time emergency physician for at least three out of the last five years.
	I, PED	The Emergency Department Medical Director shall demonstrate proof of maintenance of board certification; or must have 16 hours of trauma-related medical education annually, 8 hours of which are in pediatric trauma (or 48 hours in 3 years); or demonstrate participation in an internal education process (IEP) conducted by the trauma program based on the principles of practice based learning and the trauma performance improvement program.
	I, PED	Documentation that the hospital granted privileges to the emergency physician to provide trauma and other emergency care services for pediatric patients.
	I, PED	Current ATLS provider certification.
C	I, PED	A PGY-3 emergency medicine chief resident or emergency medicine fellow may fill the requirements of meeting trauma alert patients in the resuscitation area only if the emergency department medical director ensures the following:
	I, PED	An attending emergency physician, who meets the qualifications delineated in items B.2 and 3, is in the emergency department 24 hours per day.

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	I, PED	The trauma medical director and the emergency department medical director attest in writing that each participating resident or fellow is capable of the following: • Providing appropriate assessment and responses to emergent changes in patient condition. • Instituting initial diagnostic procedures. • Providing definitive emergent care.
	I, PED	There is documentation on file indicating that each PGY-3 resident or fellow has completed at least 24 months of emergency medicine experience and has current ATLS provider certification.
4	ALL	Resuscitation Area Nursing and Support Personnel Staffing Requirements
	ALL	At a minimum, two nurses (R.N.s) per shift shall be in-hospital and taking primary assignment for the resuscitation area.
	ALL	All resuscitation area nurses shall fulfill all initial and recurring training requirements as delineated in Standard VIII within the time frames provided.
	ALL	The number of nursing personnel and technical staff members assigned to provide patient care in the resuscitation area (in excess of the minimum requirement provided in item C.1.a above) shall be established by each trauma center and shall ensure adequate care of the trauma patient.
	ALL	The trauma center shall have a designated and trained staff member to record pertinent patient information on a trauma flow sheet during each trauma alert (may be one of the nurses specified in item C.1.a above).
5	ALL	Resuscitation Area Documentation Requirements
	ALL	The trauma team shall document patient care in the resuscitation area.
	ALL	At a minimum, documentation of patient care in the resuscitation area shall include: • The time EMS called trauma alert. • The time of the trauma alert patient's arrival in the resuscitation area. • The prehospital or hospital reason for the trauma alert being called. • The time of arrival for each trauma team member and physician consultant. • Serial physiological measurements and neurological status. • All invasive procedures performed and results. • Laboratory tests. • Radiological procedures. • The time of disposition and the patient's destination from the resuscitation area. • Complete nursing assessment. • Weight for pediatric trauma patients. • Immobilization measures. • Total burn surface area and fluid resuscitation calculations for burn patients.
6	ALL	Emergency Department Responsibilities
	ALL	The emergency department shall summon the trauma team when the facility is notified of a trauma alert en route that meets state/local trauma alert criteria.
	ALL	The emergency department physician shall evaluate all trauma patients not identified as a trauma alert utilizing trauma scorecard methodology. (See Rules 64J-2.004 and 64J-2.005, Florida Administrative Code.) Once the emergency department physician identifies the patient as a trauma alert patient, he or she shall call an in-hospital trauma alert and summon the trauma team.
	ALL	The trauma team, physician consultants, and other support personnel shall arrive promptly when notified of a trauma alert and summoned. The trauma team, physician

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		consultants, and other support personnel shall ensure that their response times are documented in each patient's record on the trauma flow sheet.
	ALL	The trauma team shall include, at a minimum, the following: • A trauma surgeon (as team leader). • An emergency physician. • At least two trauma resuscitation area registered nurses. Notes: The emergency physician shall at a minimum be physically present in-hospital and available to participate in the trauma team in accordance with Standard V.B.2 (a-c) The trauma medical director may also require other disciplines to participate on this team.

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STANDARD VI -- OPERATING ROOM AND POST-ANESTHESIA RECOVERY AREA		
INTRODUCTION: Another key component in the provision of definitive trauma care is the timely availability of surgical facilities. Availability also means that operating rooms and post- anesthesia recovery areas are appropriately staffed with trained nurses and technicians.		
1	ALL	Operating Room
	ALL	The trauma center shall have at least one adequately staffed operating room available within 15 minutes for adult and pediatric trauma patients 24 hours a day. A separate operating room for adult and pediatric patients is not required.
	ALL	The trauma center shall have a second adequately staffed operating room available within 30 minutes after the primary operating room is occupied with an adult or pediatric trauma patient.
	ALL	The operating team shall consist minimally of the following: • One scrub nurse or technician. • One circulating registered nurse. • One anesthesiologist immediately available. (See Standard IV.A.)
2	ALL	Post-Anesthesia Recovery Unit (PACU)
	ALL	The trauma center shall have a PACU area (the surgical intensive care unit is acceptable) adequately staffed with registered nurses and other essential personnel 24 hours a day.
	ALL	A physician credentialed by the hospital to provide care in the ICU or emergency department shall be in-hospital and available to respond immediately to the PACU for care of adult and pediatric trauma patients 24 hours a day.

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STANDARD VII -- INTENSIVE CARE UNIT (ICU) AND PEDIATRIC INTENSIVE CARE UNIT (PICU)		
INTRODUCTION: The critically ill trauma patient requires continuous and intensive multidisciplinary assessment and intervention to restore stability, prevent complications, and achieve and maintain optimal outcomes. The trauma service assumes initial responsibility for the care of an injured patient and should maintain that responsibility as long as the patient remains critically ill.		
1	I,II	The adult ICU must be separate and distinct from the PICU. Note: The ICU and PICU may collocated the same physical space; however, pediatric patients must have a designated area with dedicated pediatric resources as outlined in Standard VI.C.
2	I, II	Adult ICU Physician Requirements
	I, II	The trauma medical director or trauma surgeon designee is responsible for adult trauma patient care in the ICU. Part of these responsibilities includes ensuring that an attending trauma surgeon remains in charge of the patient's care to coordinate all therapeutic decisions. The attending trauma surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise.
	I, II	An attending trauma surgeon may transfer primary responsibility for a stable adult patient with a single-system injury (for example, neurosurgical) from the trauma service if it is mutually acceptable to the attending trauma surgeon and the surgical specialist of the accepting service.
	I, II	The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement, (See Standard III.A.4), or a Surgical Critical Care Fellow shall be available from within the hospital to arrive promptly for adult trauma patients in the ICU for emergent situations when the trauma medical director or trauma surgeon designee is not available. This coverage is not intended to replace the primary admitting trauma surgeon in caring for the patient in the ICU; it is to ensure that the patient's immediate needs will be met while the primary surgeon is being contacted.
	I, II	The trauma center shall track by way of the trauma registry all adult trauma patients, whether under the primary responsibility of the trauma service or of another surgical or non-surgical service, through the quality management process to evaluate the care provided by all health care disciplines.
3	I, II	Adult ICU Nursing Requirements
	I, II	The ratio of nurses to trauma patients in the ICU shall be a minimum of 1:2
4	I, PED	Pediatric ICU (PICU) Physician Requirements
	I, PED	The trauma medical director or trauma surgeon designee is responsible for pediatric trauma patient care in the PICU. Part of these responsibilities include ensuring that an attending trauma surgeon or pediatric surgeon remains in charge of the pediatric patient's care to coordinate all therapeutic decisions. The attending trauma surgeon or pediatric surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise.
	I, PED	An attending trauma surgeon or pediatric surgeon may transfer primary responsibility for a stable pediatric patient with a single-system injury (for example, neurosurgical) from the trauma service if it is mutually acceptable to the attending trauma surgeon or pediatric surgeon and the surgical specialist of the accepting service.
	I, PED	The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), or a Surgical Critical Care Fellow shall be available from within the hospital to arrive promptly for pediatric trauma patients in the PICU for emergent situations when the trauma medical director or trauma surgeon designee is not available. This coverage is not intended to replace the primary admitting trauma surgeon

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		in caring for the patient in the PICU; it is to ensure that the patient's immediate needs will be met while the primary surgeon is being contacted.
	I, PED	The trauma center shall track by way of the trauma registry all pediatric trauma patients, whether under the primary responsibility of the trauma service or of another surgical or non-surgical service, through the quality management process to evaluate the care provided by all health care disciplines.
5	I, PED	Pediatric ICU (PICU) Nursing Requirements
	I, PED	The ratio of nurses to trauma patients in the PICU shall be a minimum of 1:2
6	ALL	Nursing documentation- All trauma patient care provided in the ICU and PICU shall be documented such that information about the patient is easily tracked.
7	ALL	Laboratory services shall be available 24 hours per day for the standard analysis of blood, urine, body fluids, including micro sampling when appropriate.

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STANDARD IX -- EQUIPMENT		
INTRODUCTION: The rapid resuscitation, emergency management, and subsequent care of trauma patients require specialized equipment and supplies. This equipment may be expensive and unique to the care of trauma patients, so personnel should have appropriate training and orientation in the use, care, and maintenance of this equipment.		
1	ALL	Trauma Resuscitation Area
	ALL	Two-way radio communication with prehospital transport vehicles (radio communications shall conform to the State EMS Communications Plan).
2	ALL	Operating Room
	ALL	Thermal control equipment for patients and resuscitation fluids.
	ALL	Intraoperative radiologic capabilities
	ALL	Cardiopulmonary bypass capability and cardiothoracic surgery capabilities available 24 hours per day. (Level II must have a transfer agreement)
	ALL	Equipment for fracture fixation.
	ALL	Equipment to perform a craniotomy
	ALL	Equipment for bronchoscopy and gastrointestinal endoscopy.
	ALL	Operating microscope available 24 hours per day. (Level I Only)
3	ALL	Post-Anesthesia Recovery Unit (PACU)
	ALL	The PACU must have the necessary equipment to monitor and resuscitate patients, consistent with the process of care designated by the institution.
	ALL	Pulse oximetry.
	ALL	End-tidal carbon dioxide detection.
	ALL	Pulmonary artery catheterization
	ALL	Arterial pressure monitoring
	ALL	Patient rewarming
4	ALL	Intensive Care Unit and Pediatric Intensive Care Unit
	ALL	The ICU and/or PICU must have the necessary equipment to monitor and resuscitate patients.
	ALL	Capability for continuous cardiac rhythm monitoring.
	ALL	Capnography
	ALL	Pulmonary artery catheterization
	ALL	Rapid transfusion
	ALL	Patient rewarming

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STANDARD X -- LABORATORY SERVICES		
1	ALL	Service Capabilities -- The trauma center shall have the following laboratory capabilities for adult and pediatric trauma alert patients available in-hospital 24 hours per day:
	ALL	Services for the prompt analysis of the following: • Blood, urine, and other body fluids. • Blood gases and pH determination within five minutes 90 percent of the time. • Coagulation studies. • Microbiology. • Serum and urine osmolality.
	ALL	An appropriately staffed blood bank. The blood bank shall, at a minimum, be capable of providing the following: • Blood typing, screening, and cross matching. • Blood bank must have an adequate in-house supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients. • Red blood cells and fresh frozen plasma must be available within 15 minutes • There shall be massive transfusion protocol developed collaboratively between the trauma service and the blood bank.
2	ALL	The trauma center shall have written protocols available ensuring that trauma patients receive priority over routine laboratory tests.

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STANDARD XI -- ACUTE HEMODIALYSIS CAPABILITY		
1	ALL	Acute hemodialysis capability shall be available for trauma patients 24 hours a day.

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STANDARD XII -- RADIOLOGICAL SERVICES		
1	ALL	Service Capabilities -- The following radiological service capabilities for trauma alert patients shall be available in-hospital 24 hours per day:
	ALL	Qualified radiologists must be available promptly (30 minutes, from page or call) to perform complex imaging studies, or interventional procedures. Qualified radiologists are defined as interventional radiologist for interventional procedures. In addition, vascular surgeons are also acceptable.
	ALL	Computerized tomography (CT).
	ALL	Magnetic Resonance Imaging (MRI).
	ALL	Routine radiological studies.
2	ALL	Staffing Requirements -- Radiological staff needed to perform radiological services for trauma alert patients shall be available 24 hours a day. At a minimum, this includes the following: A radiologist, board certified (maintenance of board certification) or actively participating in the certification process with a time period set by each specialty board and granted privileges by the hospital to provide radiological services for adult and pediatric patients, shall be in-hospital and promptly available 24 hours a day. (See Note #5.) A chief radiology resident may fill the in-hospital requirement only if the trauma medical director ensures the following:
	ALL	A staff radiologist (item B.1. above) is on trauma call and available to arrive promptly at the trauma center when summoned.
	ALL	The trauma medical director and the Chief of Radiology attest in writing that each participating resident is capable of the following: • Authorizing any radiological studies required for adult and pediatric trauma alert patients. • Providing appropriate evaluation of adult and pediatric trauma alert patient radiological studies.
	ALL	A CT technician shall be in-hospital 24 hours a day.
	ALL	A radiological technician shall be available in-hospital 24 hours per day.
3	ALL	CT Scanner Requirements
	ALL	At least one CT scanner shall be available for trauma alert patients and be located in the same building as the resuscitation area. CT scanners located in remote areas of the hospital campus (that requires moving the patient from one building to another), in mobile vans, or in other institutions do not meet this requirement.
	ALL	If the trauma center has only one CT scanner, a written plan shall be in place describing the steps to be taken if the apparatus is in use or becomes temporarily inoperable. The plan must include trauma patient transfer agreements.

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STANDARD XIII -- ORGANIZED BURN CARE		
INTRODUCTION: Most burn injuries are relatively minor and patients are discharged following outpatient treatment at the facility where they are first seen. Some burns, however, are serious enough to require hospitalization, either through direct admission or by referral to hospitals with special burn treatment capabilities.		
1	ALL	The trauma center shall have written policies and procedures for triage, assessment, stabilization, emergency treatment, and transfer (either into or out of the facility) of burn patients. Policies and procedures shall also be written regarding in-hospital management, including rehabilitation, of burn patients.
2	ALL	The trauma center is capable of providing specialized care, dedicated beds, and supplies or equipment appropriate for the care of a patient with major or significant burns (See Note #6) when the facility meets one of the following criteria: • Is verified by the American Burn Association Committee on Burn Center Verification of the American College of Surgeons. **OR** • If the trauma center is not capable of providing specialized care, dedicated beds, and supplies or equipment appropriate for the care of a patient with major or significant burns (See Note #6), the facility shall have a written transfer agreement with such a facility. The trauma center shall also have written medical transfer policies and protocols to ensure the timely and safe transfer of the burn patient.

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STANDARD XIV -- ACUTE SPINAL CORD AND BRAIN INJURY MANAGEMENT CAPABILITY		
1	ALL	The trauma center shall have written policies and procedures for triage, assessment, stabilization, emergency treatment, and transfer (either into or out of the facility) for brain or spinal cord injured patients. Policies and procedures shall also be written regarding in-hospital management, including rehabilitation, and the implementation of the preventive ulcer program, for brain or spinal cord injured patients.

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STANDARD XV -- ACUTE REHABILITATIVE SERVICES		
INTRODUCTION: A trauma service should provide for the rehabilitation of its patients, with the goal of returning to society an individual who functions at the highest possible level consistent with his or her injuries. Early rehabilitation minimizes the risk of secondary complications that may interfere with or limit functional recovery. Members of the trauma service should also work with colleagues to prepare the patient and family physically, psychosocially, and emotionally for the transition to rehabilitation and ultimately for return to the community.		
1	ALL	The trauma medical director and trauma program manager shall ensure that all trauma patients have an appropriately timed evaluation by any or all of the following (as appropriate to the patient's injury):
	ALL	Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon.
		Neuropyschologist.
	ALL	Nursing personnel may include the following: • Trauma program manager or designee. • Clinical nurse specialist. • Rehabilitation nurse.
	ALL	Occupational therapist.
	ALL	Physiatrist or medical director of the rehabilitation services department.
	ALL	Physical therapist.
	ALL	Speech therapist.
2	ALL	The consultant shall document this evaluation in the patient's medical record. Documentation shall include any short- or long-term rehabilitation goals and plan.
3	ALL	The physician with primary responsibility for the patient shall review the assessment and recommendations within 48 hours and document the review in the patient's medical record.
4	ALL	The trauma center shall have one of the following for long-term rehabilitative services: • A designated rehabilitation unit that is accredited by the Commission on Accreditation of Rehabilitative Facilities. • A written transfer agreement in place with, a designated rehabilitation unit that is accredited by the Commission on Accreditation of Rehabilitative Facilities and written medical transfer policies and protocols for when to initiate a transfer to ensure the timely and safe transfer of the trauma patient.
5	ALL	The trauma center shall have dedicated service-based case managers who are knowledgeable in the specific needs of severely injured persons and the resources/services available for them statewide. The number of case managers assigned to the trauma service, at minimum, shall be equal to ratio of patients to case managers in the rest of the hospital.

STANDARD XVI -- PSYCHOSOCIAL SUPPORT SYSTEMS		
INTRODUCTION: Such factors as age and developmental phase, previous and current health problems, family and social support systems, economic status, level of education, and the meaning given to the injury by the patient and family all affect human responses to injury. The trauma center should assure that qualified personnel are available to assess and support the patient and the patient's family or significant others. This should include crisis intervention, acceptance and adaptation to the repercussions of the injury, and facilitation of the transition from the hospital.		
1	ALL	The trauma center shall have written policies and protocols to provide mental health services, child protective services, and emotional support to trauma patients or their families. At a minimum, the policies and protocols shall include qualified personnel to provide the services and require that the personnel shall arrive promptly at the trauma center when summoned.
2	ALL	Qualified personnel may include, but are not be limited to, the following:
	ALL	Nurses (in addition to resuscitation area personnel).
	ALL	Pastoral or spiritual care representatives.
	ALL	Patient advocates or representatives.
	ALL	Physician consultants.
	ALL	Psychologists or psychiatrists.
	ALL	Social service workers.
3		Drug and alcohol counseling and referral services shall be available for patients and their families.
4		The personnel listed in B.1-6 shall document these interventions in the patient's medical record.

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STANDARD XVII -- OUTREACH PROGRAMS		
INTRODUCTION: Although the trauma center is a key component of acute care for the critically injured trauma patient, an effective trauma system encompasses all phases of care, from prehospital to reintegration into society. By providing multidisciplinary educational opportunities and becoming actively involved in the formulation of community approaches to trauma care, the trauma center will aid in attaining the goal of optimal care for all injured patients. It is desirable that the trauma center coordinate their outreach activities with the local or regional trauma agency, if one exists. Finally, the trauma center should consider developing these programs in response to identified, targeted local problems. Use of national injury prevention programs are recommended to avoid replication and eliminate the need to spend resources to develop a quality program when one has already been developed and tested.		
1	ALL	The trauma service shall have written evidence documenting active involvement in at least two public education programs (one general and one pediatric) and two public trauma prevention programs (one general and one pediatric) per calendar year.
	ALL	Injury prevention programs shall be chosen based upon the epidemiologic needs of the community served by the trauma center.
2		The trauma service shall provide 24-hour availability of telephone consultation with members of the hospital's trauma team and physicians of the community and outlying areas. Scheduled on-site consultations with members of the hospital's trauma team shall be available with physicians of the community and outlying areas. Evidence of these consultations shall be documented.
3		Evidence of contact with referring physicians regarding patient transfers shall be documented in all cases.

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STANDARD XVIII -- QUALITY MANAGEMENT		
INTRODUCTION: The goals of a trauma quality improvement program are to monitor the process and outcome of patient care, to ensure the quality and timely provision of such care, to improve the knowledge and skills of the trauma care providers, and to provide institutional structure and organization to promote quality improvement. The plan should contain these essential elements for successful implementation: authority and accountability for the program, a well-defined organizational structure for the committee composition and member responsibilities, defined standards to determine quality of care, and explicit definitions for outcomes required by the facility's prescribed standards.		
1	ALL	Trauma centers must have a Performance Improvement Patient Safety (PIPS) program that is documented through a comprehensive written plan. The PIPS plan shall document the use of the following requirements:
	ALL	The hospital shall ensure adequate administrative support and staff to ensure evaluation of all aspects of trauma care as referenced in Standard II.
	ALL	The trauma PIPS program shall be integrated with the hospital's quality and patient safety efforts and shall have a clearly defined reporting structure and method for provision of two communication. The hospital shall provide documented feedback to the PIPS program on all issues that require action beyond the scope of the trauma program.
	ALL	There shall be a reliable method of data collection. At a minimum, the data collection process shall include all patients that meet trauma registry inclusion criteria outlined in Rule 64J-2.006 F.A.C
	ALL	There shall be processes for event identification including mechanisms for event verification and validation.
	ALL	There shall be evidence of effective methods of problem resolution, outcome improvements, and assurance of safety ("loop closure"). • When an opportunity for improvement is identified, appropriate corrective actions to mitigate or prevent similar future adverse events must be developed, implemented, and clearly documented by the trauma PIPS program. • Methods of problem resolution shall describe the use of documented corrective action plans, and methods of monitoring, reevaluation, and benchmarking.
	ALL	There shall be a peer review committee established. (See Standard XVIII. D)
	ALL	There shall be a trauma systems committee established. (See Standard XVIII.E)
		All trauma centers shall use a national risk adjusted benchmarking system to measure performance and outcomes. The trauma center shall participate in, and document the utilization of, any national or state risk adjusted benchmarking program required in Rule 64J-2.006 F.A.C. The trauma center shall participate in any trauma agency or Department sponsored regional/state performance improvement activities. All process and outcome measures must be documented within the trauma PIPS program's written plan and reviewed and updated at least annually
2	II	Pediatric PIPS program (15 years or younger).
	II	Trauma centers admitting at least 100 pediatric trauma patients annually shall have a separate pediatric-specific trauma PIPS program plan.
	II	Trauma centers admitting less than 100 pediatric trauma patients annually must review each case for timeliness and appropriateness of care.
3	ALL	PIPS Administrative Responsibilities

	ALL	The trauma center shall demonstrate the PIPS program operates in alignment of its comprehensive PIPS plan.
	ALL	The hospital shall ensure adequate administrative and staff support to ensure evaluation of all aspects of trauma care as outlined in Standard II.A.
	ALL	The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program in accordance with Standard II.
4	ALL	Peer Review Committee
	ALL	The peer review committee must be chaired by the Trauma Medical Director.
	ALL	The peer review committee must meet at least 10 times annually.
	ALL	The peer review committee meeting shall be documented (minutes). Documentation shall reflect the review of cases and proposed corrective actions.
	ALL	The peer review committee shall have named representation (Liaison), including a named alternate, from the following: • General surgery • Emergency medicine • Orthopedics • Anesthesiology • Critical care • Neurosurgery • Radiology
	ALL	The total of the representative and alternate’s combined attendance must add up to 50 percent or greater.
	ALL	Note: This standard shall not be interpreted to mean that each peer review committee meeting shall have a set number of attendees to count towards the 10 required meeting referenced in Standard XVIII.D.2.
5	ALL	Trauma Systems Committee
	ALL	The trauma systems committee must be chaired by the Trauma Medical Director.
	ALL	The trauma systems committee shall be empowered to address events that involve multiple disciplines and is endorsed by the hospital governing body as part of its commitment to optimal care of injured patients.
	ALL	The trauma systems committee shall meet at least 10 times annually.
	ALL	The trauma systems committee meetings shall be documented (minutes). Documentation shall reflect the review of operational events and, when appropriate, the analysis and proposed corrective actions.
	ALL	The trauma systems committee shall at a minimum have a named representative (Liaison), including a named alternate, from the following: • Trauma Program Manager • Emergency Department Medical Director • Trauma surgeon, other than the Trauma Medical Director • Surgical specialist other than a trauma surgeon, such as neurosurgeon, orthopedic or pediatric surgeon. • Representative from the hospital’s administrative team. • Operating room nursing director or designee. • Emergency department nursing director or designee.

	ALL	Each representative and alternate's combined attendance must add up to 50 percent or greater. Note: This standard shall not be interpreted to mean that each trauma systems committee meeting shall have set number of attendees to count towards the 10 required meeting referenced in Standard XVIII.E.3.
	ALL	A representative from each emergency medical service (EMS) provider that routinely transports patients to the trauma center shall be invited to attend each trauma systems committee meeting. Note: This may be satisfied through the trauma center's participation in a local or regional trauma agency, if such agency exists in their location and the local or regional trauma agency's plan has an established process for trauma system performance improvement that includes EMS. In such circumstance, a representative from the local or regional trauma agency shall be invited to attend the trauma systems meeting. If such an agency does not exist, this standard may also be satisfied by the inclusion of an EMS Liaison (may be ex officio) from the primary EMS transporting agency to the trauma center in the trauma systems committee. The Trauma Medical Director shall request replacement of the EMS Liaison, or dissolve the position, if attendance drops below 50 percent of meetings annually.
	ALL	There shall be method to provide multidisciplinary educational opportunities to all staff that participate in care of an injured person.
6	ALL	Required Trauma Center PIPS Core Measures
		All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review. The PIPS from shall track the following measures for mortality. • Total trauma-related mortality rates. • Outcome measures for total, pediatric (younger than 15 years), and geriatric (older than 64 years) trauma encounters should be categorized as follows: • DOA (pronounced dead on arrival with no additional resuscitation efforts initiated in the emergency department). • Death in ED (died in the emergency department despite resuscitation efforts). • Death In-hospital (including operating room). • Mortality rates by Injury Severity Scale (ISS) subgroups. • Anticipated/Unanticipated mortality with or without opportunity for improvement.
	ALL	Trauma surgeon response to the emergency department.
	ALL	Response parameters for consultants addressing time-critical injuries (for example, epidural hematoma, open fractures, and hemodynamically unstable pelvic fractures) must be determined and monitored
	ALL	Rates of under triage and over triage must be monitored and reviewed quarterly
	ALL	Trauma patient admissions to a nonsurgical service.
	ALL	Acute transfers out. All trauma patients who are diverted or transferred during the acute phase of hospitalization to another trauma center, acute care hospital, or specialty hospital (for example, burn center, reimplantation center, or pediatric trauma center) or patients requiring cardiopulmonary bypass or when specialty personnel are unavailable must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review.

	ALL	Trauma center diversion-bypass hours must be routinely monitored, documented, and reported, including the reason for initiating the diversion policy.
	ALL	Availability of the anesthesia service • In-house anesthesia service (emergency department, intensive care unit, floor, and postanesthesia care unit) must be available for the care of trauma patients • Operating room delays involving trauma patients because of lack of anesthesia support services must be identified and reviewed to determine the reason for delay, adverse outcomes, and opportunities for improvement.
	ALL	Delay in operating room availability must be routinely monitored. Any case that is associated with a significant delay or adverse outcome must be reviewed for reasons for delay and opportunities for improvement.
	ALL	Response times of operating room and postanesthesia care unit personnel when responding from outside the trauma center must be routinely monitored.
	ALL	Rate of change in interpretation of radiologic studies should be categorized by RADPEER or similar criteria (describe process/scoring metric used).
	ALL	Response times of computed tomography technologist (30 minutes)/magnetic resonance imaging (60 minutes) technologist/interventional radiology team (30 minutes) when responding from outside the trauma center.
	ALL	Unanticipated transfers to a higher level of care within the institution
	ALL	Adverse events and problem trends, selected cases involving multiple specialties must undergo multidisciplinary trauma peer review.
	ALL	When an opportunity for improvement is identified, appropriate corrective actions to mitigate or prevent similar future adverse events must be developed, implemented, and clearly documented by the trauma PIPS program.
7	ALL	The trauma center shall have formal documented process for communicating with EMS providers, for the purposes of providing feedback, evaluating patient care protocols, evaluate prehospital triage effectiveness, resolving operational issues and the exchange of agreed upon data elements necessary to support prehospital performance improvement activities. Note: This may be satisfied through the trauma center's participation in a local or regional trauma agency, if such agency exists in their location and the local or regional trauma agency's plan has an established process for trauma system performance improvement that includes EMS

STANDARD XIX – DISASTER PLANNING AND MANAGEMENT		
1	ALL	The trauma center shall meet the disaster related requirements pursuant to s. 395.1055(1) c, F.S., and the Agency for Health Care Administration, Comprehensive Emergency Management Plan, Chapter 59A-3.078, Florida Administrative Code, and Joint Commission on the Accreditation of Healthcare Organizations' Standards.

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STANDARD XX -- TRAUMA RESEARCH		
INTRODUCTION: One of the major responsibilities of a = trauma center is to continually expand the body of knowledge in the field of trauma through clinical and basic research programs. It is incumbent on the full-time staff of the trauma center to apply this newly acquired knowledge to the treatment of the injured patient and to disseminate the knowledge throughout the medical community.		
		Note: Effective 5 years after the adoption of this publication, all Level I Trauma Centers shall meet the research requirements for Level I trauma centers outlined in Chapter 19 of the American College of Surgeons, Committee on Trauma publication Resources for the Optimal Care of the Injured Patient, 2014.
1	I, PED	The trauma service shall conduct ongoing clinical and research programs in trauma patient care and a trauma center program must have:
	I	Three articles published in a 3-year period. These articles must result from work related to the trauma center. Of the three articles, at least 1 must be authored or coauthored by members of the general surgery trauma team. Trauma-related articles co-authored by members of other disciplines or work done in collaboration with other trauma centers; sub-specialists involved in trauma care for examples: neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, and rehabilitation; and participation in multicenter investigations may be included in the remainder, and
	I	Of the 7 following trauma related scholarly activities, 4 must be demonstrated: • Leadership in major trauma organizations. There must be evidence of this leadership for a Level I organization. Evidence includes membership in trauma committees of any of the regional and national trauma organizations such as the American Association for the Surgery of Trauma (AAST), Western Trauma Association, Eastern Association for the Surgery of Trauma, and the ACS Committee on Trauma. • Peer-reviewed funding for trauma research. There should be demonstrated evidence of funding of the center from a recognized government or private agency or organization. • Evidence of dissemination of knowledge to include review articles, book chapters, technical documents, Web-based publications, editorial comments, training manuals, and trauma-related course material. • Display of scholarly application of knowledge as evidenced by case reports or reports of clinical series in journals included in MEDLINE. • Participation as a visiting professor or invited lecturer at national or regional trauma conferences. • Support of resident participation in institution-focused scholarly activity, including laboratory experiences, clinical trials, or resident trauma paper competitions at the state, regional, or national level. • Mentorship of residents and fellows, as evidenced by the development of a trauma fellowship program or successful matriculation of graduating residents into trauma fellowship programs.
2	I	The institution will have a designated trauma research director and demonstrate current involvement in and commitment to research in adult and pediatric trauma care.
2	PED	The institution will demonstrate current involvement in and commitment to research in pediatric trauma care.
	I, PED	Methods of demonstrating the trauma center involvement and commitment will include, but not be limited to, the following: • Commitment of resources

		• Outcome, mechanism, or process-related studies • Regular meetings of research group • Funded studies • Effort (publications in peer review journal or regional or national presentation) • Multidisciplinary studies • Concluded studies • Proposals reviewed by Institutional Review Board

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