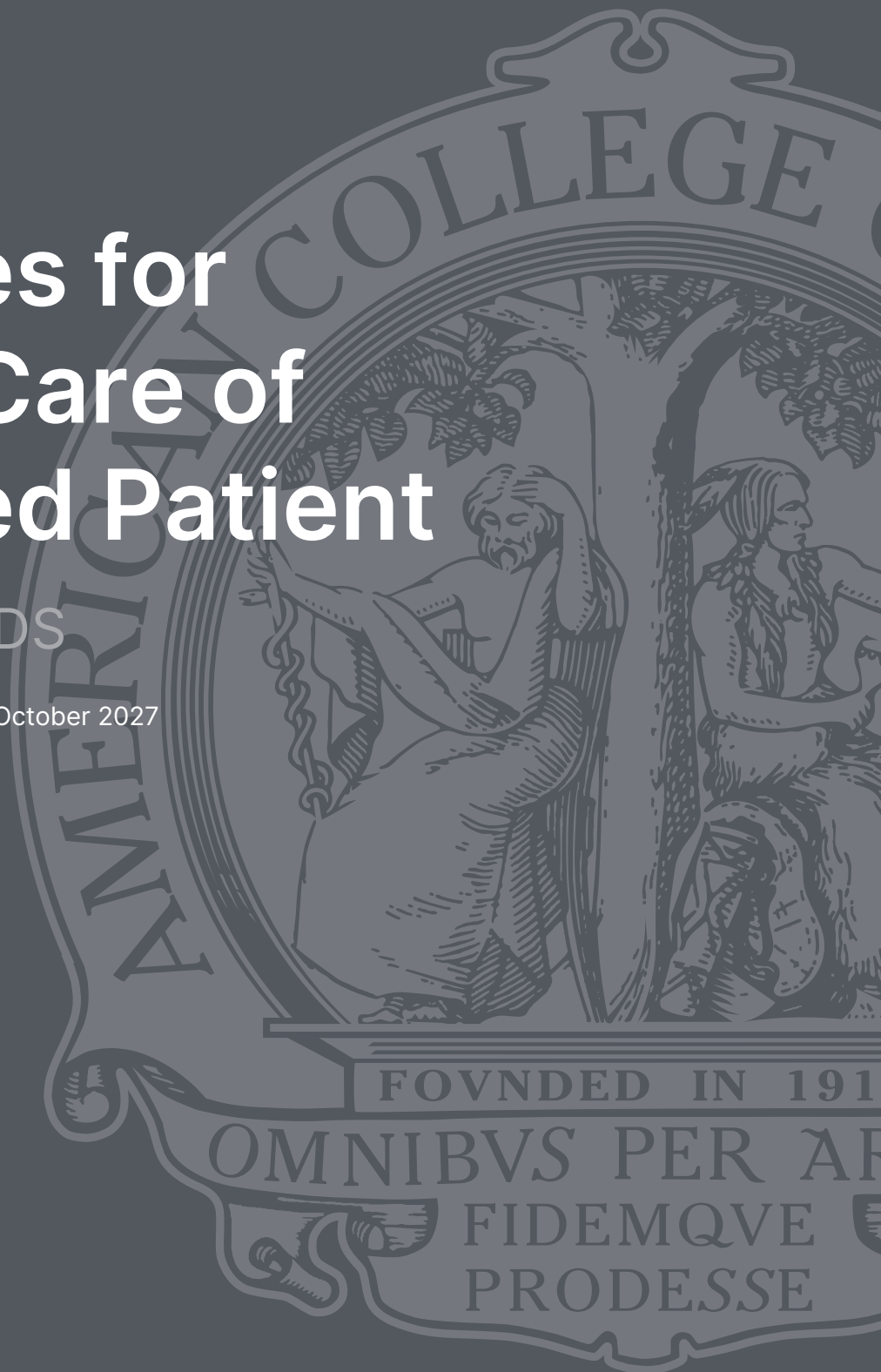
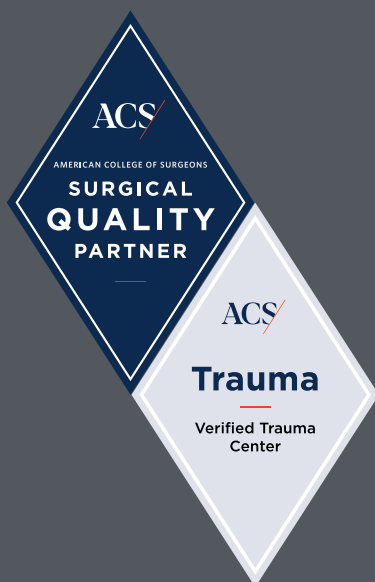




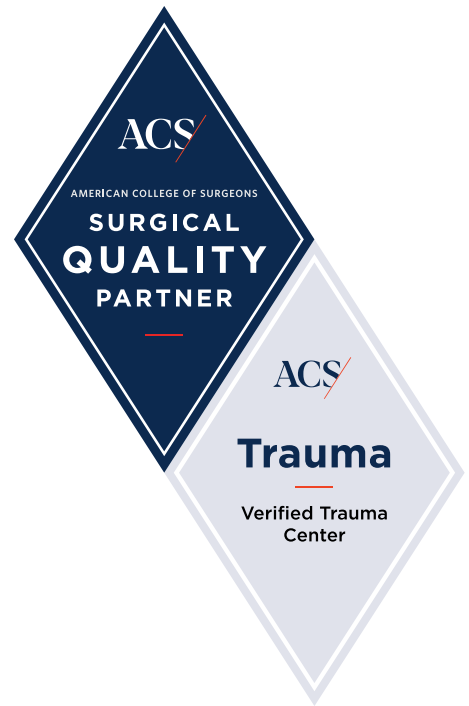
Resources for Optimal Care of the Injured Patient

2026 STANDARDS

Released October 2026 | Effective October 2027



facs.org/vrc



AMERICAN COLLEGE OF SURGEONS

Resources for Optimal Care of the Injured Patient

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This publication is not intended to be a comprehensive guide to all services, personnel, and processes needed to conduct surgery. The guidance herein does not constitute a standard of care and is not intended to replace the medical judgment of the physician or healthcare professional in individual circumstances.

Dedication

This edition of the standards is dedicated to all of the trauma clinicians, trauma program leaders, performance improvement, injury prevention, and trauma registry professionals who effectively “illuminate the way” with the data and insights they provide to reach the highest standard of care. The hard work done, day in and day out, ensures that each injured patient has the greatest opportunity for recovery.

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Important Notice about the Use of This Document

These standards are intended solely as qualification criteria for the Verification, Review, and Consultation (VRC) Program. They do not constitute a standard of care and are not intended to replace the medical judgment of the physician or health care professional in individual circumstances. “Standard,” as used in this manual, is defined as a “qualification for verification,” not “standard of care.”

In addition to verifying compliance with the standards as written in this manual, the VRC Program may consider other factors not stated herein when reviewing a program for verification and reserves the right to withhold verification on this basis.

Confidentiality Requirements

The American College of Surgeons and the VRC Program expect programs to follow local, state, and federal requirements related to patient privacy, risk management, and peer review in attempting to meet the standards outlined herein.

Acknowledgments

The Committee on Trauma (COT) is thankful to the representatives of the COT member organizations and the members of the workgroup, who were vital to the completion of this standards manual. The COT is further grateful to all stakeholders who provided thoughtful and essential comments during the public feedback period. Those participating in the development of these standards and this edition of *Resources for Optimal Care of the Injured Patient* are listed below.

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Background

About the American College of Surgeons

The American College of Surgeons (ACS) is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and improve the quality of care for all surgical patients. The ACS is dedicated to the ethical and competent practice of surgery. The contributions of the ACS have significantly influenced surgical care and have established the ACS as an important advocate for all surgical patients. The ACS has more than 82,000 members and is the largest organization of surgeons in the world.

ACS Quality Programs are developed according to a four-part framework used to evaluate and improve quality of care, consisting of (1) program-specific standards, (2) infrastructure needed to deliver high-quality, high-value care, (3) use of high-quality data, and (4) accreditation/verification to ensure proper implementation of components one through three. This model has been shown to improve both care and outcomes in specialties such as cancer, trauma, and metabolic/bariatric surgery, as well as in other surgical disciplines.

About the Committee on Trauma

The Committee on Trauma (COT) was founded in 1922 by Charles L. Scudder, MD, FACS, and is the oldest standing committee of the ACS. The COT focuses on a multidisciplinary approach to the care of the injured patient and recognizes that trauma is a surgical disease requiring surgical leadership. The mission of the COT is to develop and implement programs that support injury prevention and ensure optimal patient outcomes across the continuum of care. These programs incorporate advocacy, education, trauma center and trauma system development, best practice dissemination, outcome assessment, and performance improvement (PI).

About the Verification, Review, and Consultation Program

The VRC Program is an important component of the COT's Trauma Quality Program, which also includes the Trauma Quality Improvement Program (TQIP) and Performance Improvement and Patient Safety (PIPS) Program. The COT first published criteria for the resources and personnel needed for optimal care of the trauma patient in 1976. Since 1987, the VRC Program has **verified** trauma centers that meet the standards—the presence of the resources, structures, and processes—outlined in *Resources for Optimal Care of the Injured Patient*. The **designation** of trauma centers is a regulatory process performed by authorized regional governmental or other agencies.

Foreword

This is the eighth edition of *Resources for Optimal Care of the Injured Patient* (hereafter referred to as the Resources Manual) published by the ACS COT. The Resources Manual outlines the standards required for trauma center verification by the VRC Program. The Resources Manual is used for the assessment of commitment, readiness, resources, policies, patient care, PI, and other relevant features of the trauma program.

The standards manuals have the same layout across all ACS Quality Programs to ensure consistency for hospitals participating in multiple programs. Standards are organized based on the nine categories noted below, and each standard includes the following sections: **Definition and Requirements, Additional Information, Measures of Compliance, Resources, and References.**

Category	Description
1. Institutional Administrative Commitment	Resource allocation, commitment to patient safety, focus on continuous PI
2. Program Scope and Governance	Trauma center levels and the functions of trauma program leadership
3. Facilities and Equipment Resources	Required facilities and equipment for care of the injured patient
4. Personnel and Services	Availability of personnel and services
5. Patient Care: Expectations and Protocols	Use of comprehensive clinical pathways and practice guidelines
6. Data Surveillance and Systems	Collection and use of trauma registry data
7. Performance Improvement and Patient Safety (PIPS)	Problem identification, resolution, outcomes improvement, and assurances of patient safety
8. Education: Professional and Community Outreach	Programs designed to improve outcomes and prevent injury
9. Research	Research activities for Level I trauma centers

Overview of the Verification, Review, and Consultation Program

Levels of Trauma Care

The VRC Program's classification system for trauma centers is not intended as a ranking of medical care but instead represents the resources available to care for patients with differing needs—from the most complex multisystem trauma patient to those with mild or moderate single-system injuries. Each trauma center has an important role in its community and a critical function in the trauma system. The ACS COT expects trauma centers' commitment to quality care to be the same regardless of level. Trauma centers must adhere to the standards outlined in the Resources Manual based on their level of verification.

There are three levels of trauma center verification, each defined by specific standards. These standards denote the spectrum of care that must be available to the injured patient at the facility, along with other expectations related to research and educational contributions to advance the field and increase capacity. In most trauma systems, designated trauma centers of different levels coexist with other acute care facilities, which should also be formal members of the trauma system; these facilities assist in caring for patients whose injuries are less acute, provide data for research programs, and participate in PI.

In many areas, Level I trauma centers serve as the lead hospitals. In systems with lower population densities, Level II trauma centers may assume this role. In smaller communities and rural settings, Level III trauma centers often serve as the lead hospital.

Level I

Level I trauma centers must be capable of providing system leadership and comprehensive trauma care for all injuries. In its central role, a Level I trauma center must have adequate depth of resources and personnel. Most Level I trauma centers are university-based teaching hospitals due to the resources required for patient care, education, and research. In addition to providing acute trauma care, these centers have an important role in local trauma system development, regional disaster planning, increasing capacity, and advancing trauma care through research.

Level II

Level II trauma centers are expected to provide initial definitive trauma care for a wide range of injuries and injury severity and may take on additional responsibilities in the region related to education, system leadership, and disaster planning.

Level III

Level III trauma centers typically serve communities that may not have timely access to a Level I or II trauma center and fulfill a critical role in much of the United States by serving more remote and/or rural populations. Level III trauma centers provide definitive care to patients with mild to moderate injuries, allowing patients to be cared for closer to home. These centers also have processes in place for the prompt evaluation, initial management, and transfer of patients whose needs might exceed the resources available.

The Verification, Review, and Consultation Process

The VRC Program is designed to assist trauma centers in the evaluation and improvement of the trauma care they deliver and to provide objective, external review of institutional capabilities and performance. To this end, the trauma program is evaluated by a peer review team experienced in trauma care. The review team assesses commitment, readiness, resources, policies, patient care, PI, and other relevant features of the trauma program, as outlined in the Resources Manual.

To be found compliant with a VRC Standard, the program must be able to demonstrate compliance with the entire **Definition and Requirements** and **Measures of Compliance** sections for that standard. The **Measures of Compliance** section is intended to provide summary guidance on how compliance must be demonstrated but is not intended to stand alone or supersede the **Definition and Requirements**.

Reporting Period and Verification Cycle are terms used throughout the book. For all standards, compliance is based on the Reporting Period unless stated otherwise, such as with the Verification Cycle. The Reporting Period is defined as the twelve (12) month period ending with the calendar month preceding three (3) months prior to the site visit date. For verified trauma centers, the Verification Cycle is defined as the thirty-six (36) month period preceding the expiration date of the current verification status.

ACS COT will provide a trauma center consultation, verification, or reverification site visit at the request of the hospital or state/emergency medical service (EMS) designating authority.

Consultation Site Visits

Trauma centers may consider a **consultation** site visit to prepare for the initial verification site visit. This consultation site visit is optional but strongly recommended. It will provide recommendations to educate and aid the trauma center in preparing for and attaining verification. A consultation site visit may also be beneficial to programs seeking to change their current verification level.

Initial (Verification)/Renewal (Reverification) Site Visits

An **initial verification** site visit is for trauma centers seeking to be verified for the first time, to restore verification after a lapse in status, or to change their current verification level. During a verification site visit, reviewers will confirm whether the trauma center meets the standards outlined in the Resources Manual.

A **renewal reverification** site visit is for ACS-verified programs that are planning to maintain their current verification level status. After successful verification, a program must undergo reverification every three years to maintain its verification status.

Site Visit Process

Trauma centers are required to submit an online application to request a site visit. Once the application is processed, the trauma center will receive access to the online prereview questionnaire (PRQ). The information provided by the trauma center in the PRQ allows the review team to have a clear understanding of the existing trauma care capabilities and the performance of the trauma program and medical staff before the review.

Additionally, programs may apply as **combined** facilities, defined as Level I or Level II adult facilities with Level II pediatric program wherein an adult trauma center and pediatric trauma center within the same building or campus undergo a single site visit.

A Level I pediatric trauma center and a Level I adult trauma center must undergo separate site visits.

Review teams are composed of experts with substantial expertise in the areas of trauma care, trauma center operations, and trauma systems. A review team may include trauma surgeons, pediatric surgeons, nurses, and specialty physicians. The composition of a review team will vary depending on the type of site visit, hospital request, and/or state authority regulations.

The review encompasses all areas of the trauma center involved in trauma care. A typical site visit will include the following components:

- **Medical record review**—The review team will evaluate the care of trauma patients by reviewing medical records and evaluating the effectiveness of the center's PI program.
- **Risk-adjusted benchmark report review**—The trauma medical director (TMD) and review team will discuss specific efforts to address any issues arising from outcomes in one of the two most recent risk-adjusted benchmark reports (e.g., data drilldowns, PI projects).
- **Review of program documents**—The review team will examine supporting documentation such as call schedules, research, injury prevention efforts, and so forth utilized in providing care for trauma patients.

- **Review meeting**—The meeting is intended to include a discussion of the overall trauma program, clarification of the PRQ, specific concerns, unique features of the institution, discussion of the local trauma system, and clarification of the review process. It also provides an opportunity for the review team to highlight any program strengths to hospital administration. During this meeting, the review team will meet with the TMD, the trauma program manager (TPM), subspecialty liaisons, hospital and nursing administrators, the prehospital liaison, and the designating authority (if required). Other individuals may be invited if needed to clarify the PRQ and describe existing trauma center activities.
- **Hospital tour**—The tour will highlight all areas of the trauma center where trauma care is provided and will follow the path of a trauma patient through the facility. The review team will interview hospital staff and directors in those areas.
- **Exit interview**—The site visit concludes with an exit interview to share the preliminary findings of the review team with the trauma center leadership team. The review team will communicate the compliance with standards, strengths, opportunities for improvement, and recommendations they have identified. Final decisions regarding compliance with the standards will be made by the VRC Program and may differ from the findings stated at the exit interview.

The review team will prepare a preliminary report that supports the statements made at the exit interview. The VRC Program will review the report and issue the final approval. Trauma centers that are successfully verified will be added to the list of currently ACS-verified trauma centers on the VRC website (<https://www.facs.org/search/trauma-centers>).

Note that the information presented in this section is subject to change, as the site visit process is continually being improved. For additional details and the most up-to-date information, please refer to the VRC Program website.

Outcomes of Verification

Verification standards are divided into **Type I** and **Type II** standards. Type I standards are considered critical standards that directly impact patient care. The trauma program must be in compliance with all applicable standards at the time of the site visit. If noncompliance with any standard is identified, the trauma program must demonstrate compliance through a **Corrective Action Review** to achieve or extend verification. The type of Corrective Action Review will depend on the standard(s) in question and will be determined by the VRC Program. Figures 1–3 outline the various visit results and verification outcomes.

Figure 1. Verification Visit Results and Outcomes

Visit Results	Verification Outcomes
Compliant with all standards	Verified, 3-year certificate
Noncompliant with up to 3 Type II standards	Verified, 1-year certificate
Noncompliant with any Type I standard OR Noncompliant with more than 3 Type II standards	Not verified

Figure 2. Pathways for Verification Outcomes

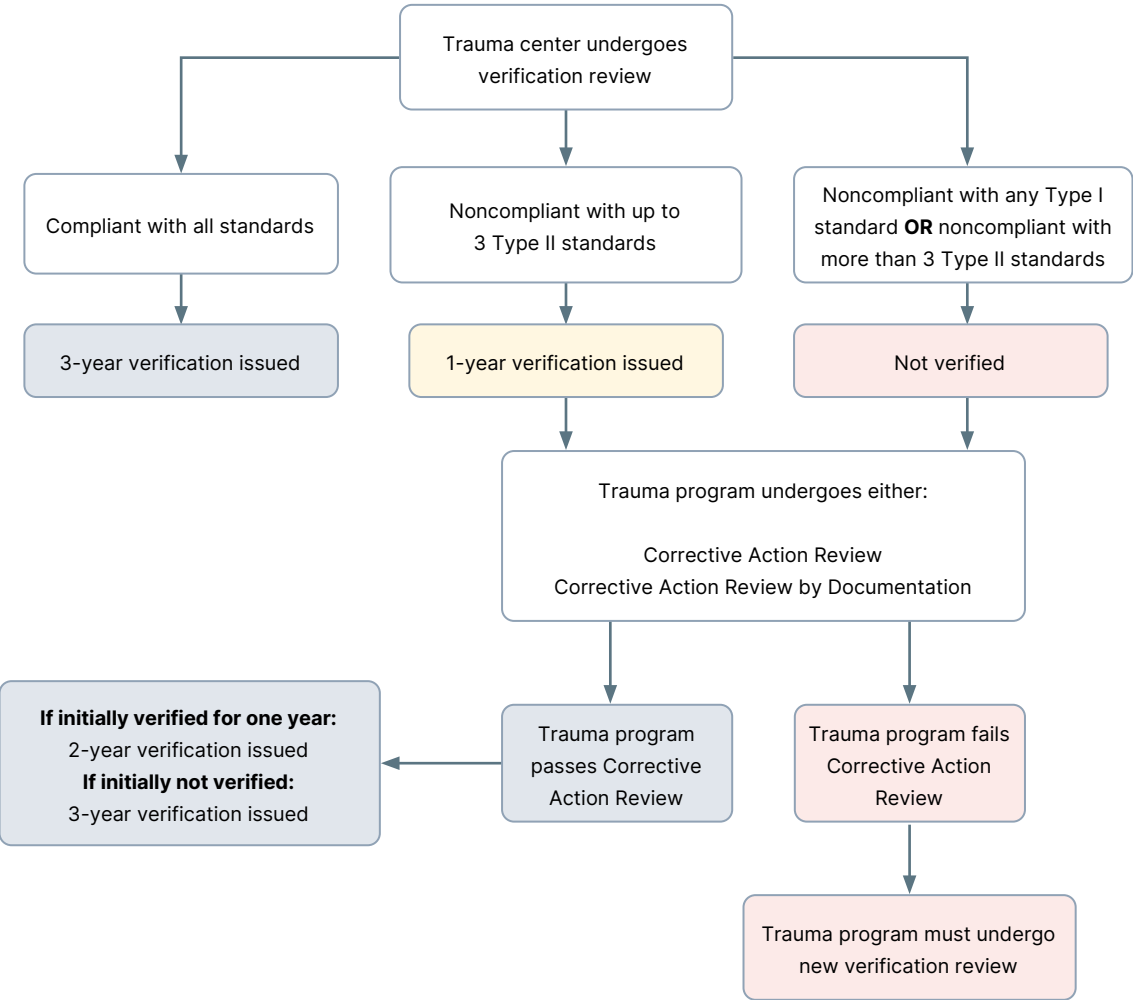
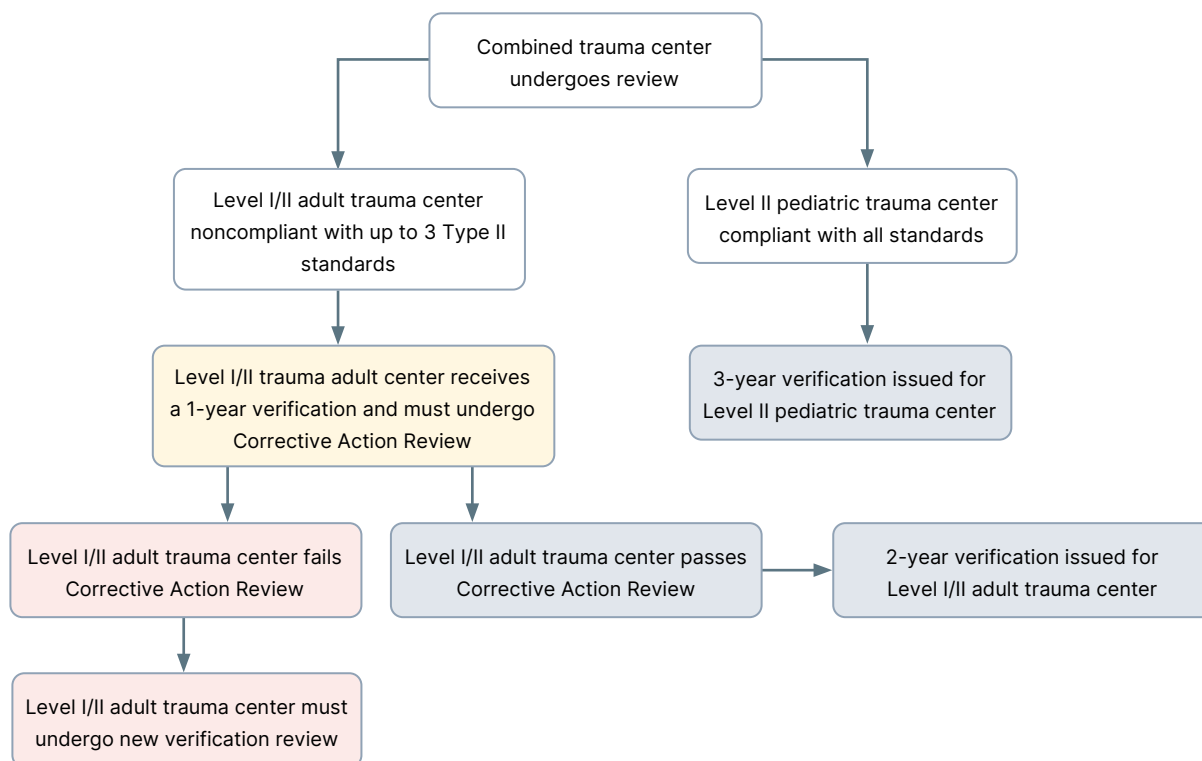


Figure 3. Example Pathways for Verification Outcomes for Combined Trauma Centers



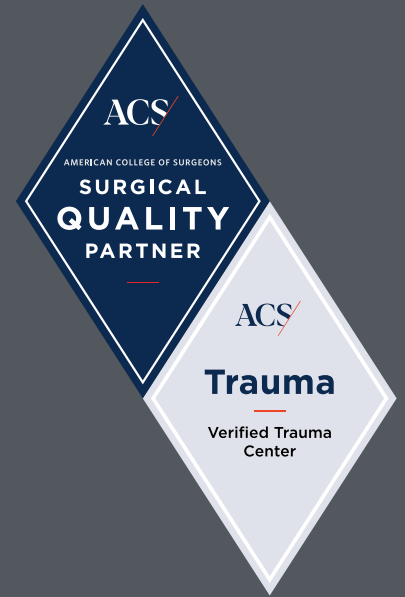
Types of Corrective Action Reviews include:

- **Corrective Action Review**—A one-day review conducted by at least one member of the original review team in which the scope of review is narrowed to the corrective action implemented to resolve the previously identified noncompliant standard(s). This review type is most common with standards related to PI and, as such, requires medical record review.
 - **Corrective Action Review by Documentation**—The trauma center will provide specific documentation requested by the VRC Program within a predetermined time period. The original review team and VRC Program will review all submitted documentation. If the documentation satisfactorily resolves the noncompliant standard(s), verification will be extended.
6. The site visit report is written in a standardized format.
 7. A final review is performed by the VRC Program to ensure accurate interpretation of the findings, well-documented conclusions, and consistency and professionalism in the final report. Confidentiality of the entire review process ensures that the series of steps will be a constructive process in which a hospital can place its trust.
 8. Finally, to ensure the quality and integrity of the VRC Program, the trauma center undergoing review will be asked to complete an extensive survey that includes the conduct of the review team and an overall assessment of the VRC Program.

Consistency in the Review Process

The ACS strives for consistency in the review process to ensure that it is equitable across trauma centers. The following steps ensure consistency of the review process:

1. A hospital PRQ allows the review team to have a preliminary understanding of the trauma care capability and performance of the hospital and medical staff before the review. This questionnaire is completed online by the trauma program and hospital staff.
2. An organized agenda is prepared for the review so that all site reviews are performed in an efficient and standardized manner.
3. All reviewers are approved and vetted by the COT and VRC. Reviewers are also provided online training courses to ensure that all facets of the review process are conducted appropriately.
4. Every site visit team has an assigned lead reviewer. These reviewers are experienced in trauma care and have been promoted to this position by the VRC.
5. All reviewers undergo routine performance appraisals, with feedback solicited from trauma center personnel, site review team members, and VRC Program staff.



1

Institutional Administrative Commitment

Rationale

Full support and continuous commitment from institutional leadership is vital to achieving and maintaining trauma center verification. Resource allocation (such as equipment, personnel, and administrative support), a commitment to patient safety, and an enduring focus on continuous PI are the hallmarks of strong institutional administrative support that ensures compliance with standards and the highest quality of care for trauma patients.

1.1 Administrative Commitment—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.

References

None

Additional Information

Human resources include physicians, registered nurses, advanced practice providers (APPs), physician assistants, coordinators, and so forth.

This standard fully encompasses all staffing needs, physical structures, space allotments, and equipment needed for a trauma center to function optimally.

Measures of Compliance

Documentation that demonstrates compliance, including:

- Hospital Board of Directors (or other administrative governing authority) approval of the establishment of the trauma center at the level specified and of the application for verification
- Commitment to adherence to the standards required for the level of verification
- Commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to the standards

1.2 Research Support—TYPE II

Applicable Levels

LI, PTCI

Resources

None

Definition and Requirements

The hospital administration of a Level I trauma center must demonstrate support for the research program.

References

None

Additional Information

Level I trauma centers have an important role in advancing the knowledge and science relevant to care for the injured patient. Advancements in the field might fall within many different domains including, but not limited to, the biological sciences, translational research, comparative effectiveness research, or implementation science.

Measures of Compliance

Narrative description of support of the research program, such as the following:

- Basic laboratory space
- Sophisticated research equipment
- Advanced information systems
- Biostatistical support
- Salary support for basic and translational scientists, or seed grants for junior investigators



2

Program Scope and Governance

Rationale

The trauma program and its medical staff provide the structures, processes, and personnel to comply with trauma center verification standards in order to ensure optimal care of the injured patient. This staff includes the program leadership (TPM and TMD) to oversee key functions of the trauma program. There must also be ongoing commitment from the trauma multidisciplinary PIPS committee.

2.1 State and Regional Involvement—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must participate in the regional and/or statewide trauma system.

Additional Information

Examples of participation may include the following:

- Participation in state and regional trauma advisory committees
- Leadership in state and regional medical audit committees
- Collaboration with regional trauma advisory committees, EMS, or other agencies to promote the development of state and regional systems
- Participation in media and legislative education to promote and develop trauma systems
- Participation in state and regional trauma needs assessment or injury surveillance
- Participation in the development of a state or regional trauma plan or state trauma registry
- Provision of technical assistance and education to hospitals and their providers within the region to improve system performance

Measures of Compliance

- Narrative description of participation in a regional and/or statewide trauma system
- Written documentation that demonstrates participation, such as meeting agendas

Resources

None

References

None

2.2 Hospital Regional Disaster Committee—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must participate in regional disaster/emergency management committees, health care coalitions, and regional mass casualty exercises.

Additional Information

None

Measures of Compliance

Narrative description of participation in regional disaster/emergency management committee meetings, health care coalition meetings, and regional mass casualty exercises

Resources

Hospitals and Health Care Coalitions, Office of the Assistant Secretary for Preparedness and Response:
<https://www.aspr.gov/>

References

None

2.3 Disaster Management Planning—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

All trauma programs must be integrated into the hospital's disaster plan to ensure a robust surgical response:

- A trauma surgeon from the trauma panel must be included as a member of the hospital's disaster committee and be responsible for the development of a surgical response to a mass casualty event.
- The surgical response must outline the critical personnel, means of contact, initial surgical triage (including subspecialty triage when appropriate), and coordination of secondary procedures.
- The trauma program must participate in two hospital drills or disaster plan activations per year that include a trauma response and are designed to refine the hospital's response to mass casualty events.

Level I trauma centers must also include an orthopaedic surgeon from the orthopaedic trauma call panel as a member of the hospital's disaster committee.

References

None

Additional Information

Tabletop exercises are acceptable for the two annual hospital drills.

Measures of Compliance

- Attendance records demonstrating trauma surgeon and orthopaedic surgeon (LI, PTCI) participation in disaster committee meetings
- Hospital disaster plan that includes a surgical response
- Dates and nature of drills or activations

2.4 Level I Adult Trauma Patient Volume Criteria—TYPE I

Applicable Levels

LI

Definition and Requirements

A Level I adult trauma center must care for at least 1,200 trauma patients per year or at least 240 trauma patients with Injury Severity Score (ISS) greater than 15 per year.

Additional Information

For the purposes of this standard, a patient counts toward this volume criteria if they meet the National Trauma Data Standard (NTDS) inclusion criteria, which includes patients who meet the definition for observation status or are dead on arrival (DOA).

Measures of Compliance

Data that demonstrate patient volume according to the NTDS inclusion criteria by ISS

Resources

American College of Surgeons NTDS Data Dictionary:
<https://www.facs.org/quality-programs/trauma/tqp/center-programs/ntdb/ntds/data-dictionary>

References

None

2.5 Level I Pediatric Trauma Patient Volume Criteria— TYPE I

Applicable Levels

PTCI

Definition and Requirements

A Level I pediatric trauma center must care for 200 or more injured patients under 15 years of age per year.

Additional Information

For the purposes of this standard, a patient counts toward this volume criteria if they meet the NTDS inclusion criteria, which includes patients who meet the definition for observation status or are DOA.

Measures of Compliance

Data that demonstrate patient volume according to the NTDS inclusion criteria by ISS

Resources

American College of Surgeons NTDS Data Dictionary:
<https://www.facs.org/quality-programs/trauma/tqp/center-programs/ntdb/ntds/data-dictionary>

References

None

2.6 Adult Trauma Centers Admitting Pediatric Patients— TYPE I

Applicable Levels

LI, LII, LIII

Definition and Requirements

Adult trauma centers that care for 100 or more injured children under 15 years of age must have the following:

- Pediatric emergency department area
- Pediatric intensive care area
- Appropriate resuscitation equipment, as outlined in the pediatric readiness toolkit

Additional Information

This standard is applicable to programs that admit injured children but are not seeking pediatric verification. For the purposes of this standard, a patient counts toward the volume criteria if they meet the NTDS inclusion criteria, which includes patients who meet the definition for observation status or are DOA.

Measures of Compliance

- Admission data for the reporting period
- Evaluated during the site visit process

Resources

Pediatric readiness toolkit, Emergency Medical Services for Children Innovation and Improvement Center: <https://emscimprovement.center/projects/pediatricreadiness/readiness-toolkit/>

American College of Surgeons NTDS Data Dictionary: <https://www.facs.org/quality-programs/trauma/tqp/center-programs/ntdb/ntds/data-dictionary>

References

None

2.7 Trauma Multidisciplinary PIPS Committee—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

All trauma centers must have a trauma multidisciplinary PIPS committee chaired by the TMD or an associate TMD.

Combined adult and pediatric programs (Level I/II adult trauma center with Level II pediatric trauma center) must hold separate adult and pediatric trauma multidisciplinary PIPS meetings with distinct minutes.

References

None

Additional Information

An associate TMD is not a requirement but may be helpful for large programs or succession planning.

Measures of Compliance

- Terms of Reference that define the committee's scope, membership, frequency of meetings, and decision-making process

2.8 Trauma Medical Director Requirements—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, the TMD must fulfill the following requirements:

- Hold current board certification or board eligibility in general surgery or pediatric surgery
- Serve as the director of a single trauma program
- Hold current Advanced Trauma Life Support (ATLS®) certification
- Participate on the trauma call panel
- Provide evidence of 36 hours of trauma-related continuing medical education (CME) during the verification cycle. For pediatric TMD, at least 9 of 36 hours must be pediatric-specific CME
- The TMD must hold active membership in at least one national trauma organization and have attended at least one meeting during the verification cycle (LI, PTCI)
- The TMD must hold active membership in at least one regional, state, or national trauma organization and have attended at least one meeting during the verification cycle (LII, LIII, PTCII)

If a board-certified general surgeon who is not board-certified or board-eligible in pediatric surgery serves as the pediatric TMD, the following are required:

- The pediatric TMD must meet all applicable TMD requirements listed above
- The pediatric TMD must complete 36 hours of trauma-related CME during the verification cycle, with at least 12 hours specifically focused on pediatric trauma care
- The center must designate a board-certified or board-eligible pediatric surgeon to serve as the pediatric surgeon liaison to the trauma program
- The pediatric surgeon liaison must meet the criteria in Standard 4.1

- The pediatric surgeon liaison must facilitate collaboration between pediatric surgery and the trauma program and at minimum, include the following responsibilities:
 - Assist with process improvement, guideline development, and complex case discussions
 - Develop pediatric surgical response criteria, including that a pediatric surgeon must be directly involved in patient care
 - Attend at least 50% of trauma multidisciplinary PIPS committee meetings (refer to Standard 7.6)
 - Complete 12 hours of pediatric trauma-related CME
 - Attend the VRC site visit at the time of verification

Additional Information

Refer to Appendix A for details on board certification and board eligibility.

Membership in an ACS state COT is not equivalent to membership in a national trauma organization.

A total of 30 hours of trauma-related CME obtained from board certification or recertification may be applied once to the CME criteria during the verification cycle.

In trauma centers undergoing a consultation or initial verification review, the TMD must have at least 12 hours of trauma-related CME during the reporting period.

Measures of Compliance

- Evidence of current board certification or board eligibility
- Roles and responsibilities of the TMD
- Evidence of ATLS certification
- Call schedules
- Evidence of trauma-related CMEs
- Proof of membership and attendance record in a national trauma organization (LI, PTCI)
- Proof of membership and attendance record in a regional, state, or national trauma organization (LII, LIII, PTCII)

For trauma centers that have a pediatric TMD who is not board-certified or board-eligible in pediatric surgery, the following additional Measures of Compliance are required:

- Evidence of 36 hours of trauma-related CME, with at least 12 hours focused on pediatric trauma care for the pediatric TMD
- Designation of pediatric surgeon liaison
- Description of roles and responsibilities of the designated pediatric surgeon liaison
- Pediatric surgical response criteria, including that a pediatric surgeon must be directly involved in patient care
- Evidence of 12 hours of pediatric trauma-related CME for the pediatric surgeon liaison

Resources

None

References

None

2.9

Trauma Medical Director Responsibility and Authority—
TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, the TMD must be responsible for and have the authority to: • Develop and enforce policies and procedures relevant to care of the injured patient • Ensure providers meet all requirements and adhere to institutional standards of practice • Work across departments and/or other administrative units to address deficiencies in care • Determine (with their liaisons) provider participation in trauma care, which might be guided by findings from the PIPS process or an Ongoing Professional Practice Evaluation (OPPE) • Oversee the structure and process of the trauma PIPS program	None
Additional Information	
None	
Measures of Compliance	
Roles and responsibilities of the TMD	

2.10 Trauma Program Manager Requirements—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, the TPM must fulfill the following requirements:

- Have 1.0 full-time equivalent (FTE) commitment to the trauma program
- Provide evidence of 36 hours of trauma-related continuing education (CE) during the verification cycle
- Have completed the Trauma Outcomes and Performance Improvement Course (TOPIC) at least once

In Level I Trauma Programs (LI, PTCI):

- TPMs hired for the first time in a TPM role on or after October 1, 2027, must have a minimum of three years caring for trauma patients.
- Hold current membership in a national trauma organization and have attended at least one meeting during the verification cycle.

In Level II Trauma Programs (LII, PTCII):

- TPMs hired for the first time in a TPM role on or after October 1, 2027, must have a minimum of three years caring for trauma patients.
- The TPM must have attended at least one national or regional trauma conference during the verification cycle.
- At least 0.5 FTE of the TPM's time must be spent on TPM-related activities. The remaining time must be dedicated to other roles within the trauma program.
- In combined adult and pediatric programs (Level I/II adult trauma center with Level II pediatric trauma center), the pediatric TPM may serve at least 0.5 FTE in that role, with the remaining time dedicated to other responsibilities within the adult or pediatric trauma program.

In Level III Trauma Programs (LIII):

- Have attended at least one national or regional trauma conference during the verification cycle.

- At least 0.5 FTE of the TPM's time must be spent on TPM-related activities. The remaining time must be dedicated to other roles within the trauma program.

Additional Information

The TPM assumes day-to-day responsibility for process and PI activities. The TPM's role also includes partnering with the TMD in the development of policies and oversight of the program.

In trauma centers undergoing a consultation or initial verification review, the TPM must have at least 12 hours of trauma-related CE during the reporting period.

Measures of Compliance

- Roles and responsibilities of the TPM
- Trauma-related CEs
- TOPIC certificate
- Narrative description of clinical experience (LI, LII, PTCI, PTCII)
- Proof of membership in national trauma organizations (LI, PTCI)
- Attendance records from a national or regional trauma conference

Resources

Society of Trauma Nurses, <https://www.traumanurses.org/education/topic>

References

None

2.11 Trauma Program Manager Responsibilities and Reporting Structure—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, the TPM must have a reporting structure that includes the TMD and they are to assume at minimum, the following leadership responsibilities in conjunction with the TMD and/or hospital administration

- Oversight of the trauma program
- Assist with the budgetary process for the trauma program
- Develop and implement clinical protocols and practice management guidelines
- Provide educational opportunities for staff development
- Monitor performance improvement activities in conjunction with a PI coordinator (where applicable)
- Serve as a liaison to administration and represent the trauma program on hospital and regional committees to enhance trauma care
- Have oversight of the trauma registry

References

None

Additional Information

The reporting structure must, at minimum, include a “dotted line” to the TMD to ensure that the TMD and TPM are aligned in setting goals for the benefit of the trauma program and its patients.

Measures of Compliance

- Relevant organizational chart
- Role profile/description that highlights the responsibilities of the trauma program manager

2.12 Injury Prevention Program—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have an injury prevention program that:

- Has a designated injury prevention professional
- Prioritizes injury prevention work based on trends identified in the trauma registry and local epidemiological data
- Implements at least two activities over the course of the verification cycle with specific objectives and deliverables that address separate major causes of injury in the community
- Demonstrates evidence of partnerships with community organizations to support their injury prevention efforts

In Level I trauma centers, the injury prevention professional must be someone other than the TPM or PI personnel.

Additional Information

While there are no specific certification requirements for an injury prevention professional, this individual would have the skills to lead trauma center efforts to develop and maintain an organized, interdisciplinary, public health approach to injury prevention. Examples of injury prevention areas of focus include:

- Motor vehicle occupant safety
 - Child passenger safety seat education
 - Distracted driving
- Motorcycle and bicycle safety/helmet initiatives
- Pedestrian safety
- Fall prevention
- Firearm injury prevention programs
- Violence intervention and screening programs
- STOP THE BLEED® program as a community engagement strategy

Specific objectives and deliverables for each of the prevention initiatives should be documented in advance of implementation so that centers can describe their successes relative to their stated goals.

In trauma centers undergoing a consultation or initial verification review, the injury prevention program must implement at least one activity over the course of the reporting period with specific objectives and deliverables that address separate major causes of injury in the community.

Measures of Compliance

- Job description for relevant staff
- Graphs/tables highlighting recent injury mechanism trends from registry
- Report of injury prevention activities including the following:
 - Activity name
 - Activity date
 - Participation data
 - Evaluation of outcomes (where feasible)
- Program objectives and deliverables for each injury prevention activity
- Any materials (including posters, flyers, press releases, etc.) relevant to the injury prevention initiatives

Resources

Below are suggestions for planning optimal injury prevention and violence intervention strategies with the greatest impact.

- **Utilize available data:** Identify high rates of injury and the populations in which these injuries occur. Analyze data to determine the mechanisms of injury, injury severity, and contributing factors. Utilize multiple injury and death data sources to reflect the true burden of injury.
- **Target at-risk populations:** Identify, understand, and target efforts toward at-risk populations while being sensitive to generational differences, as well as cultural, religious, and other established customs. Engage target population as a key stakeholder in development, implementation, and evaluation of the intervention.¹
- **Leverage partnerships:** Make use of other trauma centers, prehospital organizations, public health and violence prevention organizations, law enforcement agencies, schools, churches, and others interested and involved in community injury prevention efforts.
- **Choose effective or well-informed intervention strategies:** New intervention program development, assessment, and implementation are complex and time-consuming. Not all proven interventions work in every population. Evidence-informed interventions may still require adaptation for demographic and risk factor differences.²⁻⁶
- **Develop a plan:** Logic models are a best-practice method to plan intervention strategies and should be utilized to outline the intervention effort, including delineating risk and protective factors.⁷
- **Evaluate:** Develop surveillance and monitoring tools to assess not only the available performance indicators of the trauma center's prevention efforts but also the prevention effectiveness. Evaluation efforts should start at program inception with a feasibility assessment and include intermediate and long-term outcomes.
- **Communicate:** Partner with local print and broadcast media, and be prepared for many opportunities for trauma center leaders to serve as a reliable source of injury prevention information. Understand your stakeholders and the at-risk populations, and articulate your prevention message based upon their vantage point.⁷
- **Advocate:** Elected and appointed leaders can help implement prevention efforts if the trauma center understands their goals and ways to work with them to create effective laws promoting prevention.

The list below includes ways in which trauma centers might track and report their prevention activities:

- Description of the mechanism of injury or root causes and risk factors of injury targeted by prevention programs
- Dates and locations of intervention events
- Trauma center resources
- Personnel hours (paid and volunteered)
- Trauma center expenses
- Community partners and their personnel hours
- Other sources of financial support
- Media exposure
- Involvement of elected and appointed officials
- Public policy initiatives or legislation
- Number of community members reached with prevention message or service
- Available outcome data related to the prevention activity and its target
- Strategic evaluation program, from inception to long-term outcomes

The Safe States Alliance provides direction on the core elements of injury prevention programs. The guidance offers programs ideas on how they might be expanded or strengthened and provides a description of what constitutes a model program: <https://www.safestates.org/page/traumaivp>.

The American Trauma Society, in partnership with the Trauma Prevention Coalition, has a training program for injury prevention professionals: <https://amtrauma.org>.

Centers with high rates of trauma due to interpersonal violence might find this primer on developing a hospital-based violence intervention program helpful: <https://www.facs.org/quality-programs/trauma/advocacy-and-injury-prevention/firearm-injury-prevention-activities/violence-intervention-programs/> and can also find helpful information from the Health Alliance for Violence Intervention at <https://www.thehavi.org/>.

Helpful injury prevention resources for intentional and unintentional injury prevention can be found on the ACS COT's website, <https://www.facs.org/quality-programs/trauma/advocacy/ipc>.

References

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2.13 Organ Procurement Program—TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, an organ procurement program must be available and consist of at least the following: • An affiliation with an organ procurement organization (OPO) • A written policy for notification of the regional OPO • Protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death	None
Additional Information	
This standard pertains to solid organ procurement from trauma patients only.	
Measures of Compliance	
• OPO affiliation agreement • Regional OPO notification policy • Protocol for brain deaths	

2.14 Child Life Program—TYPE II

Applicable Levels

PTCI, PTCII

Resources

None

Definition and Requirements

All pediatric trauma centers must have a child life program.

References

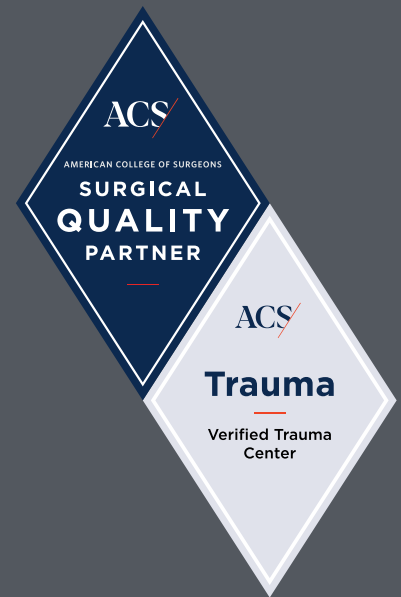
None

Additional Information

Child life programs promote emotional safety, reduce distress, increase adaptive coping, and protect and enhance developmental integrity by offering opportunities for therapeutic play, preparation, education, and interaction with others in an emotionally and physically safe environment.

Measures of Compliance

- Narrative description of the scope of the child life program
- Roles and responsibilities of the position responsible for administering child life program



3

Facilities and Equipment Resources

Rationale

The trauma program must maintain and provide the required facilities, services, and equipment for the care of the injured patient.

3.1 Operating Room Availability—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In Level I and II trauma centers, an operating room (OR) must be staffed and available within 15 minutes of notification, and in Level III trauma centers, within 30 minutes of notification.

References

None

Additional Information

A “staffed” OR is one where nursing and anesthesia personnel are available to prepare the room and patient for an emergency surgical intervention.

The expectation is that the OR team is notified when a trauma patient is going to be sent to the OR. The initial call and the team members’ response must be tracked. This can be documented with a logbook, an electronic medical record, or a badge swipe.

Measures of Compliance

- OR staffing policy
- Documentation of time of notification to time of patient arrival in the OR
- Evaluated during the site visit process

3.2 Additional Operating Room—TYPE II

Applicable Levels

LI, LII, PTCI, PTCII

Definition and Requirements

In Level I and II trauma centers, if the first OR is occupied, an additional OR must be staffed and available.

Additional Information

A staffed OR is one where nursing and anesthesia personnel are available to prepare the room and patient for an emergency surgical intervention.

Timely access to surgical care is critical for patient safety. Trauma centers are required to have the capacity to respond to small surges in surgical activity without compromising patient care.

Measures of Compliance

OR policies or related materials outlining process, staffing, and expectations related to preparing a second OR, both during regular working hours and after hours

Resources

None

References

None

3.3 Operating Room for Orthopaedic Trauma Care— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have a dedicated OR prioritized for fracture care in nonemergent orthopaedic trauma.

In a Level III trauma center, access to the OR must be made available for nonemergent orthopaedic trauma.

Additional Information

Skeletal fixation is often secondary to immediate and life-saving resuscitative intervention; might be staged and often requires unique expertise. Predictable access to an OR assures that orthopaedic trauma care can be planned and that the right expertise will be available to provide optimal care.

Operational details related to staffing, frequency of availability, and use by other services should be collaboratively determined and approved by the TMD and the orthopaedic trauma leader. The frequency of availability should be sufficient to provide timely fracture care for patients.

Measures of Compliance

- Narrative description of how an OR is prioritized for fracture care in nonemergent orthopaedic trauma
- Schedule for dedicated orthopaedic OR (LI, LII, PTCI, PTCII)
- Schedule for access to OR (LIII)
- Evaluated during the site visit process

Resources

None

References

None

3.4 Blood Products—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have an adequate supply of blood products available.

Level III trauma centers must have an adequate supply of red blood cells and plasma available.

Additional Information

An “adequate supply” is based on the needs of the trauma center.

Measures of Compliance

Evaluated during the site visit process

Resources

None

References

None

3.5 Medical Imaging—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In Level I and II trauma centers, the following services must be available 24 hours per day and be accessible for patient care within the time interval specified:

- Conventional radiography—15 minutes
- Computed tomography (CT)—15 minutes
- Point-of-care ultrasound—15 minutes
- Interventional radiologic procedures—1 hour
- Magnetic resonance imaging (MRI)—2 hours

In Level III trauma centers, the following services must be available 24 hours per day and be accessible for patient care within the time interval specified:

- Conventional radiography—30 minutes
- CT—30 minutes
- Point-of-care ultrasound—15 minutes

Additional Information

“Accessible for patient care” implies that the necessary human resources and equipment are available within the time specified. The “time interval” refers to the time between initial request and initiation of the test/procedure. This does not mean that every test must be completed within the interval specified. Timeliness depends on patient need. Review of perceived delays in imaging that might have affected patient care are a component of the PIPS program.

Measures of Compliance

- Evaluated during the site visit process
- Policies and procedures ensuring availability of services

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

3.6 Remote Access to Radiographic Imaging—TYPE II

Applicable Levels	Resources
LI, LII, PTCI, PTCII	None
Definition and Requirements	References
Level I and II trauma centers must have a mechanism to remotely view radiographic images from referring hospitals within their catchment area.	None
Additional Information	
Viewing mechanisms may include email, a phone app, a picture archiving and communications system (PACS), etc.	
Measures of Compliance	
Narrative description of the mechanism for remote access to imaging from referring hospitals	

3.7 Cardiopulmonary Bypass Equipment—TYPE II

Applicable Levels

LI, LII, PTCI, PTCII

Resources

None

Definition and Requirements

In Level I and II trauma centers, cardiopulmonary bypass equipment must be immediately available when required, or a contingency plan must exist to provide emergency cardiac surgical care.

References

None

Additional Information

The contingency plan must address the need for immediate transfer of patients with time-sensitive cardiovascular injuries.

Measures of Compliance

Evaluated during the site visit process or through the contingency plan



4

Personnel and Services

Rationale

The trauma program must have access to a wide variety of personnel and services to provide timely care to the injured patient.

4.1 Trauma Surgeon Requirements—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

Trauma surgeons must have direct patient care responsibilities at the institution and must meet the following qualifications:

- Complete the ATLS course at least once
- Have privileges in general and/or pediatric surgery
- Hold current board certification or board eligibility in general surgery, or have been approved through the Alternate Pathway
 - Level I pediatric trauma centers must have at least two surgeons board-certified or board-eligible in pediatric surgery.
 - Level II pediatric trauma centers must have at least one surgeon board-certified or board-eligible in pediatric surgery.

Additional Information

Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.

Measures of Compliance

- Evidence of ATLS certification
- Evidence of board certification, board eligibility, or Alternate Pathway approval
- Narrative description of the pediatric surgeon(s) active involvement in the provision of direct (bedside) trauma patient care (PTCI, PTCII)

Resources

None

References

None

4.2 Trauma Surgeon Coverage—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, trauma surgery coverage must be continuously available.

In Level I and II trauma centers, the trauma surgeon must be dedicated to a single trauma center while on call.

References

None

Additional Information

“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage

Measures of Compliance

- Call schedules
- Evaluated during the site visit process

4.3 Trauma Surgery Backup Call Schedule—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

Level I and II trauma centers must have a published backup call schedule for trauma surgery.

Level III trauma centers must have a documented backup call schedule or a backup plan for trauma surgery.

References

None

Additional Information

Trauma surgeons who serve as a backup are not required to be dedicated to one hospital.

Measures of Compliance

- Backup trauma call schedules (LI, LII)
- Backup trauma call schedules or backup plan (LIII)

4.4 Specialty Liaisons to the Trauma Service—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

The trauma program must have the following designated liaisons:

LI, LII, PTCI, PTCII:

- Board-certified or board-eligible emergency medicine physician
- Board-certified or board-eligible orthopaedic surgeon
- Board-certified or board-eligible anesthesiologist
- Board-certified or board-eligible neurosurgeon
- Board-certified or board-eligible radiologist
- Board-certified or board-eligible intensive care unit (ICU) physician
- Geriatric provider (applies only to LI and LII)
- Board-certified or board-eligible pediatric surgeon liaison (applies only to PTCI and PTCII and only if the pediatric TMD is not board-certified or board-eligible in pediatric surgery, refer to Standard 2.8)

LIII:

- Board-certified or board-eligible emergency medicine physician
- Board-certified or board-eligible orthopaedic surgeon
- Board-certified or board-eligible anesthesiologist
- Board-certified or board-eligible neurosurgeon (applies only to LIII-N)
- Board-certified or board-eligible ICU physician

In Level I trauma centers, the orthopaedic trauma surgeon liaison must have completed an orthopaedic traumatology fellowship approved by the Orthopaedic Trauma Association (OTA). In Level I pediatric trauma centers, this requirement may be met by having a pediatric fellowship-trained orthopaedic surgeon.

Additional Information

Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.

Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.

Orthopaedic Surgeon Liaison

A Level I pediatric trauma center and an adult trauma center may share the adult orthopaedic trauma surgeon liaison provided they are credentialed to care for pediatric patients at the pediatric trauma center.

Alternate Training Criteria

In Level I trauma centers, orthopaedic trauma surgeons who have not completed an OTA-approved orthopaedic traumatology fellowship may serve as the liaison by meeting the following criteria, subject to approval after review of credentials and training:

- At least 50% of the physician's practice is dedicated to providing care to orthopaedic trauma patients
- Active trauma committee membership in a regional, national, or international organization (outside of parent hospital or institution) and attendance of at least one meeting during the reporting period
- Evidence of peer-reviewed publications/research in orthopaedic trauma over the past three years
- Participation in trauma-related educational activities as an instructor or educator (outside of parent hospital or institution) in the past three years

Anesthesia Liaison

For Level III trauma centers:

- In states where certified registered nurse anesthetists (CRNAs) are licensed to practice independently, they may serve as the anesthesia liaison.

- In states where CRNAs are not licensed to practice independently, they may serve as the anesthesia liaison only if there is not a board-certified or board-eligible anesthesiologist on staff.

Geriatric Provider Liaison

In Level I and II trauma centers, the geriatric liaison may be a geriatrician, or a physician with expertise and a focus in geriatrics, or an APP with certification, expertise, and a focus in geriatrics. The role of the liaison is to assist in the development and implementation of geriatric protocols and to be available for patient consultation.

Measures of Compliance

- Documentation of clinician assigned to specific liaison roles and evidence of board certification, board eligibility, or Alternate Pathway approval
- Documentation of orthopaedic trauma fellowship requirements (LI, PTCI)
- Narrative description of the geriatric liaison qualifications (LI, LII)

Resources

None

References

None

4.5 Emergency Department Director—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In Level I and II trauma centers, the emergency department director must be board-certified or board-eligible, or have been approved through the Alternate Pathway, in emergency medicine or pediatric emergency medicine.

In Level I and II trauma centers, physicians who completed primary training prior to 2016 and are board-certified in a specialty other than emergency medicine or pediatric emergency medicine may serve as the emergency department director.

In Level III trauma centers, the emergency department director must be board-certified or board-eligible.

References

None

Additional Information

Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.

Measures of Compliance

- Roles and responsibilities of the emergency department director
- Evidence of board certification, board eligibility, or Alternate Pathway approval

4.6 Emergency Department Physician Requirements— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, emergency medicine physicians involved in the care of trauma patients must be currently board-certified or board-eligible, or have been approved through the Alternate Pathway.

- In Level I and II trauma centers, physicians must be board-certified or board-eligible in emergency medicine or pediatric emergency medicine.
 - Physicians who completed primary training in a specialty other than emergency medicine or pediatric emergency medicine prior to 2016 may participate in trauma care.
- In Level I pediatric trauma centers, at least one physician must be board-certified or board-eligible in pediatric emergency medicine.
- In Level III trauma centers, physicians must be board-certified or board-eligible in emergency medicine, pediatric emergency medicine, or a specialty other than emergency medicine.

All emergency medicine physicians must have completed the ATLS course at least once. Physicians who are board-certified or board-eligible, or have been approved through the Alternate Pathway, in a specialty other than emergency medicine or pediatrics with subspecialty in pediatric emergency medicine must hold current ATLS certification.

Additional Information

Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.

Measures of Compliance

- Evidence of board certification, board eligibility, or Alternate Pathway approval
- Evidence of ATLS certification

Resources

None

References

None

4.7 Emergency Department Physician Coverage—TYPE I

Applicable Levels	Resources
LI, LII, PTCI, PTCII	None
Definition and Requirements	References
In Level I and II trauma centers, a board-certified or board-eligible emergency medicine physician must be present in the emergency department at all times. This requirement may also be met with a board-certified or board-eligible physician who completed primary training prior to 2016 in a specialty other than emergency medicine or pediatric emergency medicine.	None
Additional Information	
“At all times” is defined as 24/7/365 and implies there are no gaps in coverage. Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.	
Measures of Compliance	
• Emergency medicine physician call schedules demonstrating trauma coverage • Evidence of board certification, board eligibility, or Alternate Pathway approval	

4.8 Pediatric Critical Care Staffing—TYPE II

Applicable Levels

PTCI

Resources

None

Definition and Requirements

In Level I pediatric trauma centers, there must be at least two physicians who are board-certified or board-eligible in pediatric critical care medicine or in both pediatric surgery and surgical critical care.

These two physicians must practice at least part of their time in the ICU where the majority of pediatric trauma patients are cared for.

References

None

Additional Information

Refer to Appendix A for details on board certification and board eligibility.

Measures of Compliance

- Evidence of board certification or board eligibility
- ICU call schedules

4.9 Neurosurgeon Requirements—TYPE II

Applicable Levels

LI, LII, LIII-N, PTCI, PTCII

Definition and Requirements

Level I, Level II, and Level III-N trauma centers must have neurosurgeons who are board-certified or board-eligible or have been approved through the Alternate Pathway.

In Level I pediatric trauma centers, there must be at least one board-certified or board-eligible neurosurgeon who has completed a pediatric neurosurgery fellowship.

Additional Information

Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.

Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.

Measures of Compliance

- Evidence of current board certification, board eligibility, or Alternate Pathway approval
- Level I pediatric center: CV of board-certified or board-eligible neurosurgeon who completed a pediatric neurosurgery fellowship

Resources

None

References

None

4.10 Neurosurgical Trauma Coverage—TYPE I

Applicable Levels

LI, LII, LIII-N, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have neurosurgeons continuously available for the care of neurotrauma patients and must have a contingency plan for when neurotrauma capabilities become encumbered or overwhelmed.

Level III-N trauma centers must have neurosurgeons available, must have a neurotrauma contingency plan that includes the potential for diversion, and must implement the plan when neurosurgery capabilities are encumbered, overwhelmed, or unavailable.

The contingency plan must meet the following criteria:

- A thorough review of each instance by the PIPS program
- Monitoring of the effectiveness of the process by the PIPS program

Additional Information

“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.

Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.

Since LIII-N are not required to have continuous availability of neurosurgery, it is expected that there be an established plan for diversion of patients who might require time-sensitive neurotrauma care to lessen the need for secondary transfers.

Neurosurgery capabilities are encumbered or overwhelmed when there is an inability to meet standards of care for patients with time-sensitive injuries.

Measures of Compliance

- Trauma neurosurgery call schedules
- Neurotrauma contingency plan

Resources

None

References

None

4.11 Orthopaedic Surgeon Requirements—TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, orthopaedic surgeons must be board-certified or board-eligible or have been approved through the Alternate Pathway. In Level I pediatric trauma centers, at least one board-certified or board-eligible orthopaedic surgeon must have completed a pediatric orthopaedic fellowship.	None
Additional Information	
Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.	
Measures of Compliance	
• Evidence of current board certification, board eligibility, or Alternate Pathway approval • Level I pediatric center: CV of a board-certified or board-eligible orthopaedic surgeon who completed a pediatric orthopaedic fellowship	

4.12 Orthopaedic Trauma Coverage—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

Trauma centers must have orthopaedic surgeons continuously available for the care of orthopaedic trauma patients and must have a contingency plan for when orthopaedic trauma capabilities become encumbered or overwhelmed.

References

None

Additional Information

“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.

Refer to Appendix A for details on board certification, board eligibility, and the Alternate Pathway.

Measures of Compliance

- Orthopaedic trauma surgery call schedules
- Orthopaedic surgery contingency plan

4.13 Specialized Orthopaedic Trauma Care—TYPE II

Applicable Levels	Resources
LII, PTCI, PTCII	None
Definition and Requirements	References
Trauma centers must have an orthopaedic surgeon who has completed an OTA-approved fellowship or has met the alternate training criteria. This requirement may also be met by having transfer protocols specifying the type of patients/ injuries that will be transferred to a center with an orthopaedic surgeon who has completed an OTA-approved fellowship or meets the alternate training criteria.	None
Additional Information	
Alternate training criteria are outlined in Standard 4.4 and are subject to approval after review of credentials and training.	
Measures of Compliance	
• CV of the orthopaedic surgeon with OTA-approved fellowship or credentials for alternate training • Transfer protocols	

4.14 Anesthesia Services—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In Level I and II trauma centers, anesthesia services must be available within 15 minutes of request. Furthermore, the attending anesthesiologist must be present within 30 minutes of request for all operations.

In Level III trauma centers, anesthesia services must be available within 30 minutes of request.

References

None

Additional Information

Anesthesia services may be composed of anesthesiologists, CA-3 and CA-4 residents, CRNAs, or CAAs.

These providers must be able to begin an emergency operation per hospital policy or credentialing.

For Level III trauma centers in states where CRNAs are licensed to practice independently, CRNAs should follow local or institutional practices and may not require physician supervision.

Measures of Compliance

- Hospital or trauma policy on anesthesia services pertaining to availability and response time
- Evaluated during the site visit process

4.15 Radiologist Access—TYPE I

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, a radiologist must have access to patient images and be available for imaging interpretation, in person or by phone, within 30 minutes of request.	None
Additional Information	
The expectation is that the radiologist must be able to provide a preliminary interpretation of the imaging. The time is measured from time of request to time of interpretation.	
Measures of Compliance	
• Radiology policy or guidelines • Evaluated during the site visit process	

4.16 Interventional Radiology Response for Hemorrhage Control—TYPE II

Applicable Levels

LI, LII, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have the necessary human (physicians, nurses, and technologists) and facility resources (angiography suite or hybrid operating room) continuously available so that an endovascular or interventional radiology procedure for hemorrhage control can begin within 60 minutes of request.

Additional Information

“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.

The response time is tracked from request to arterial puncture.

Patients requiring a rapid response for hemorrhage control as defined above are those where blood transfusion has been initiated and there is a confirmed blood pressure less than 90 mm Hg at any time prior to angioembolization in adults, or age-specific hypotension in children.

It is not expected that every case undergoing intervention must be initiated within 60 minutes. The expectation is that if the clinical situation dictates the need for rapid intervention, that it can be initiated within 60 minutes.

Physician resources could include interventional radiologist, a neurosurgeon/neurologist, or a vascular surgeon credentialed to perform angiography and embolization or stent placement.

Measures of Compliance

- Report of time interval between request and arterial puncture for patients undergoing emergency angioembolization for hemorrhage control
- Call schedules
- Describe the process to mobilize interventional personnel (physicians, nurses, and technologists) to ensure procedures can begin within 60 minutes of request

Resources

None

References

None

4.17 ICU Director and Surgical Critical Care Staffing— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have an ICU surgical director who actively participates in unit administration.

In Level I adult trauma centers, the ICU surgical director must be board-certified or board-eligible in surgical critical care.

In Level I pediatric trauma centers, the ICU surgical director must be board-certified or board-eligible in pediatric surgery.

In Level II adult trauma centers, the ICU surgical director or co-director must be board-certified or board-eligible in general surgery. In addition, there must be at least one surgeon who is board-certified or board-eligible in surgical critical care and who participates in the trauma program to guide care of critically injured patients.

In Level II pediatric trauma centers, the ICU surgical director or co-director must be board-certified or board-eligible in general or pediatric surgery.

In Level III trauma centers, the ICU surgical director or co-director must be board-certified or board-eligible in general surgery.

Additional Information

“Active participation in unit administration” is defined as participating in the development of pathways and protocols for the care of trauma patients and in unit-based PI activities. It is expected that the ICU surgical director participate in the care of patients in the ICU where the majority of trauma patients are cared for.

Refer to Appendix A for details on board certification and board eligibility.

Measures of Compliance

- Role and responsibilities of the ICU surgical director and/or co-director
- Evidence of board certification or board eligibility

Resources

None

References

None

4.18 ICU Clinician Coverage—TYPE I

Applicable Levels

LI, LII, PTCI, PTCII

Resources

None

Definition and Requirements

In Level I and II trauma centers, the ICU must be staffed with clinicians who are continuously available to respond at bedside within 15 minutes of request.

References

None

Additional Information

Coverage may be provided by physicians (residents, fellows, or attendings) or APPs.

“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.

Measures of Compliance

- ICU/PICU call schedules
- Evaluated during the site visit process

4.19 ICU Clinician Coverage for Level III Trauma Centers— TYPE I

Applicable Levels	Resources
LIII	None
Definition and Requirements	References
In Level III trauma centers, clinician coverage of the ICU must be available within 30 minutes of request, with a formal plan in place for emergency coverage.	None
Additional Information	
Coverage may include an intensivist, hospitalist, resident, or APP. The formal plan for emergency coverage should allow for patients' immediate needs to be met until the attending surgeon is available.	
Measures of Compliance	
• ICU call schedules • ICU emergency coverage plan • Evaluated during the site visit process	

4.20 ICU Nursing Staffing Requirement—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, the patient-to-nurse ratio in the ICU must be 1:1 or 2:1, depending on patient acuity as defined by the hospital policy for ICU nursing staffing.

References

None

Additional Information

None

Measures of Compliance

Hospital policy for ICU nursing staffing

4.21 Surgical Specialists Availability—TYPE II

Applicable Levels

LI, LII, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have continuous availability of the surgical expertise listed below:

- Cardiothoracic surgery
- Vascular surgery
- Endovascular surgery
- Hand surgery
- Plastic surgery
- Obstetrics/Gynecology surgery
- Otolaryngology
- Urology

Additional Information

Expertise implies that there is a physician and/or a surgeon credentialled by the hospital to provide acute trauma care for the services listed above.

“Continuous” is defined as 24/7/365. Sporadic gaps in coverage due to vacation/conference attendance, etc. must be addressed with a contingency plan.

Measures of Compliance

- Specialty trauma call schedules
- Contingency plan for sporadic gaps in coverage

Resources

None

References

None

4.22 Ophthalmology Services—TYPE II

Applicable Levels

LI, LII, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have continuous availability of ophthalmology services or must have a contingency plan to ensure ophthalmic trauma care.

Additional Information

“Continuous” is defined as 24/7/365.

Ophthalmology services include an ophthalmologist, the necessary equipment, and personnel to provide surgical care to patients with ophthalmic injuries.

A contingency plan should ensure optimal and timely care.

The contingency plan must include an ophthalmologist capable of providing timely surgical care. Access to ophthalmologists may be met either through on-site coverage or via a transfer agreement for patients requiring urgent surgical intervention. While tele-ophthalmology can support initial triage and evaluation, it cannot replace the availability of an ophthalmologist to perform surgical care.

Measures of Compliance

Narrative description of ophthalmic capabilities (call schedules or contingency plan and report of transfers out for patients with ophthalmic injuries).

Resources

American Society of Ophthalmic Trauma,
<https://www.theasot.com/on-call-preparedness/>

References

None

4.23 Soft Tissue Coverage Expertise—TYPE II

Applicable Levels

LI, PTCI

Resources

None

Definition and Requirements

Level I trauma centers must have the capability for comprehensive soft tissue coverage of wounds, including microvascular expertise for free flaps.

References

None

Additional Information

Comprehensive soft tissue coverage capability includes coverage of all open fractures, soft tissue coverage of a mangled extremity, and soft tissue defects of the head and neck.

Measures of Compliance

- Narrative description of availability and expertise for complex soft tissue reconstruction
- Specialty surgeon trauma call schedules

4.24 Craniofacial Expertise—TYPE II

Applicable Levels

LI, PTCI

Resources

None

Definition and Requirements

Level I trauma centers must have the capability to diagnose and manage acute facial fractures of the entire craniomaxillofacial skeleton, including the skull, cranial base, orbit, midface, and occlusal skeleton, with expertise contributed by any of the following specialists: otolaryngology, oral maxillofacial surgery, or plastic surgery.

References

None

Additional Information

Trauma centers may have a variety of different models of care for patients with craniofacial injuries, including a single specialty covering all injuries, a rotating schedule, or involvement of specific expertise depending on the nature of the injuries. All are acceptable models of care.

Measures of Compliance

- Narrative description of availability and expertise for craniofacial reconstruction
- Specialty surgeon trauma call schedules

4.25 Replantation Services—TYPE II

Applicable Levels

LI, LII, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have replantation capability continuously available or must have in place a triage and transfer process with a replant center.

Additional Information

“Replantation capability” in this context refers to the replantation of a severed limb, digit, or other body part (e.g., ear, scalp, or penis). It may also include critical revascularization or care of a mangled extremity.

A triage and transfer process should ensure optimal care with a view toward minimizing time to replantation. The triage process might include diverting selected patients directly to a replant center if replantation is unavailable at the trauma center.

“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.

Measures of Compliance

- Narrative description of availability and expertise for replantation
- Specialty surgeon trauma call schedules
- Documentation of a regional and/or state triage and transfer process (for centers without capability or continuous coverage)

Resources

Trauma centers reporting that they provide 24/7/365 coverage for severe hand injuries—including replantation, revascularization, and care of the mutilated hand—are listed as part of the National Hand Trauma Center Network, an initiative of the American Society for Surgery of the Hand: <https://www.assh.org/s/hand-trauma-center-network>.

References

None

4.26 Medical Specialists—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

Level I and II trauma centers must have all of the following medical specialists:

- Cardiology*
- Gastroenterology*
- Internal medicine or pediatrics*
- Infectious disease*
- Nephrology*
- Pain management (with expertise to perform regional nerve blocks)
- Physiatry
- Psychiatry
- Pulmonary medicine*

An asterisk denotes services that must be continuously available.

Level III trauma centers must have internal medicine continuously available.

Additional Information

“Continuously” is defined as 24/7/365 and implies there are no gaps in coverage.

Other listed services must be available 7 days per week.

Measures of Compliance

Evaluated during the site visit process

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

4.27 Child Abuse (Nonaccidental Trauma) Physician— TYPE II

Applicable Levels

PTCI, PTCII

Definition and Requirements

Level I and II pediatric trauma centers must have either a physician on the medical staff who is board-certified or board-eligible in child abuse pediatrics or a board-certified or board-eligible physician with special interest in child abuse (nonaccidental trauma) who provides expertise to the trauma center.

Additional Information

The purpose of this role is to provide leadership in addressing the needs of children with nonaccidental trauma. This leadership includes the development of relevant policies and procedures and, where necessary, inpatient assessment and care.

Refer to Appendix A for details on board certification and board eligibility.

Measures of Compliance

- Roles and responsibilities of the child abuse physician
- Evidence of board certification, board eligibility, or qualifications of the child abuse physician

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

4.28 Allied Health Services—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

Trauma centers must have the following allied health services available:

- LI, LII, PTCI, PTCII
 - Respiratory therapy (24/7/365)
 - Nutrition support
 - Speech therapy
 - Social worker (7 days per week)
 - Occupational therapy (7 days per week)
 - Physical therapy (7 days per week)
- LIII
 - Respiratory therapy (24/7/365)
 - Nutrition support
 - Speech therapy
 - Social worker
 - Occupational therapy
 - Physical therapy

References

None

Additional Information

None

Measures of Compliance

Narrative description of the model of coverage for each service

4.29 Renal Replacement Therapy Services—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

Level I and Level II trauma centers must have renal replacement therapy services available to support patients with acute renal failure.

Level III trauma centers and Level II pediatric trauma centers must have renal replacement therapy services available to support patients with acute renal failure or a contingency plan in place if this service is not available.

Additional Information

Renal replacement therapy might include intermittent hemodialysis or any form of continuous renal replacement therapy (CRRT) to support patients with acute renal failure.

Measures of Compliance

- Evaluated during the site visit process
- Contingency plan, if applicable (LIII, PTCII)

Resources

None

References

None

4.30 Advanced Practice Providers—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, trauma and/or emergency department APPs who are clinically involved in the initial evaluation and resuscitation of trauma patients during the activation phase must have current ATLS certification.

References

None

Additional Information

This standard is not applicable to the following:

- APPs for neurosurgery and orthopaedic surgery
- CRNAs
- CAAs
- Scribes

Measures of Compliance

- List of trauma/emergency department APPs
- Evidence of ATLS certification for each trauma/emergency department APP listed

4.31 Trauma Registry Staffing Requirements—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, there must be at least 0.5 FTE (either on- or off-site) dedicated to the trauma registry per 200–300 annual patient entries.

All staff who have a registry role in data abstraction and entry, injury coding, data reporting, or data validation for the trauma registry must fulfill all the following registry training and certification requirements:

- Completed and passed the AAAM Abbreviated Injury Scale (AIS) course for the version used at the center
- Completed an ICD-10 course or refresher every five years
- Participate in a trauma registry course that includes all the following content:
 - Abstraction
 - Data management
 - Reports/report analysis
 - Data validation
 - HIPAA
- Have completed at least 24 hours of internal and/or external trauma-related CE during the verification cycle.
- At least one registry professional must be a current Certified Abbreviated Injury Scale Specialist (CAISS).

Combined adult and pediatric programs (Level I/II adult trauma center with Level II pediatric trauma center) may share the CAISS-certified FTE and other resources to meet this requirement; however, a lead pediatric registry professional must be clearly identified.

Additional Information

For purposes of this standard, the count of annual patient entries is defined as all patients who meet NTDS inclusion criteria plus all patients who meet inclusion criteria for hospital, local, regional, and state purposes.

Trauma centers must consider the additional tasks, beyond the abstraction and entry of patient data, that are assigned to the registry professional. Processes such as report generation, data analysis, research assistance, and meeting various submission requirements will decrease the amount of time dedicated to the meticulous collection of patient data.

Data collection might be outsourced to off-site personnel with the expectation that i) data are readily available for local performance improvement; ii) the center has oversight on data quality and opportunities for data quality improvement are identified and actioned.

Continuing education

For centers undergoing a consultation or initial verification review, 8 hours of CE must be obtained during the reporting period.

Staff hired during the verification cycle, 2 hours of trauma-related CE is required per quarter, based on the month of hire.

Registry Course for New Hires

Staff hired within the reporting period will have 12 months from the date of hire to complete all the registry training and certification requirements noted above.

Evolving Assistive Technology for Data Extraction

The ACS recognizes that evolving technologies, including AI-assisted data extraction tools, may support trauma registry operations. The organization is actively evaluating opportunities to leverage these technologies to enhance efficiency, data quality, and registry performance while ensuring appropriate human oversight, validation, and decision-making throughout the data abstraction process. Updates and additional guidance will be provided by the ACS as they become available and will be posted at <http://www.facs.org>

Measures of Compliance

- Number of trauma registry personnel
- Trauma registry report that shows annual patient entries
- Provide list of staff with dates of hire
- For staff, include:
 - CAISS Certification (at least one staff member)
 - AAAM AIS Course Certificate (all staff)
 - Certificate from trauma registry course (all staff)
 - ICD-10 course certificate within the last 5 years (all staff)
 - CE certificates or transcripts (all staff)

Resources

CAISS is a certification offered by the Association for the Advancement of Automotive Medicine (AAAM),
<https://www.aisinjuryscale.org/ais/certification>

References

None

4.32 Performance Improvement Staffing Requirements— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, there must be at least 0.5 FTE dedicated performance improvement (PI) personnel when the annual volume of registry patient entries exceeds 500 patients. The count of entries is defined as all patients that meet NTDS inclusion criteria, and those patients who meet inclusion criteria for hospital, local, regional, and state purposes.

When the annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1 FTE PI personnel.

References

None

Additional Information

Trauma centers are expected to have the necessary human resources to comply with the standards in Category 7—Performance Improvement and Patient Safety. Greater trauma center volumes might necessitate additional personnel.

Measures of Compliance

- Annual trauma registry report that shows the total volume of entries
- Roles and responsibilities of the PI personnel
- Number of PI personnel

4.33 Disaster Management and Emergency Preparedness Course—TYPE II

Applicable Levels

LI, PTCI

Definition and Requirements

In Level I adult and pediatric trauma centers, the trauma surgeon liaison to the disaster committee must successfully complete the Disaster Management and Emergency Preparedness (DMEP™) course at least once.

Additional Information

Completion of DMEP or eDMEP meets this standard.

Measures of Compliance

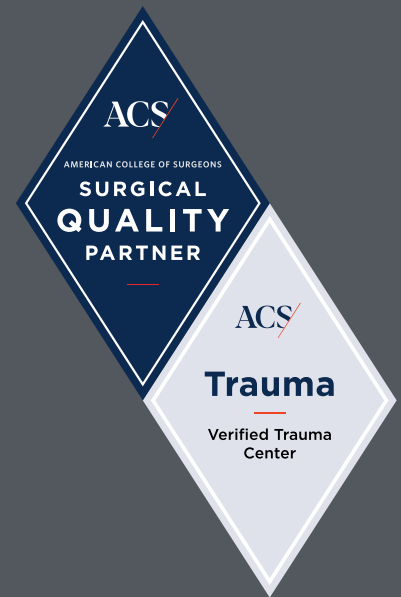
Evidence of DMEP or eDMEP Certificate

Resources

DMEP and eDMEP are courses offered by the American College of Surgeons (ACS).

References

None



5

Patient Care: Expectations and Protocols

Rationale

The trauma program must utilize comprehensive clinical pathways and clinical practice guidelines that facilitate the standardization of patient care for the injured patient. This standardization improves the quality of care and enables the training of personnel.

5.1 Clinical Practice Guidelines—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have evidence-based clinical practice guidelines, protocols, or algorithms that are reviewed during the verification cycle.

Level I and II pediatric trauma centers must have pediatric-specific evidence-based guidelines.

Additional Information

Clinical practice guidelines, protocols, or algorithms may be developed or revised in response to new evidence or opportunities for improvement.

Clinical practice guidelines provide an opportunity to standardize practice, which facilitates training, allows for auditing of practices, and tends to improve the quality of care.

Measures of Compliance

Clinical practice guidelines, protocols, or algorithms with date of last revision

Resources

Guidelines and best practices are available through the following (this is not an exhaustive list):

Eastern Association for the Surgery of Trauma: <https://www.east.org/education-career-development/practice-management-guidelines>

American College of Surgeons, Best Practices Guidelines: <https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

American Association for the Surgery of Trauma: <https://www.aast.org/resources/guidelines>

Western Trauma Association: <https://www.westerntrauma.org/western-trauma-association-algorithms/>

Emergency Medical Services for Children Innovation and Improvement Center. Pediatric Education and Advocacy Kit—Multisystem Trauma: <https://emscimprovement.center/education-and-resources/peak/multisystem-trauma/>

ATOMAC+ Pediatric Trauma Pediatric Research Network: <https://aptrn.org/clinical-research/>

Pediatric Emergency Care Applied Research Network: <https://pecarn.org>

References

None

5.2

Trauma Surgeon and Emergency Medicine Physician
Shared Responsibilities—TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, the shared roles and responsibilities of trauma surgeons and emergency medicine physicians for trauma resuscitation must be defined and approved by the TMD.	None
Additional Information	
None	
Measures of Compliance	
Documentation outlining shared roles and responsibilities of trauma surgeons and emergency medicine physicians for trauma resuscitation	

5.3 Levels of Trauma Activation—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, the criteria for tiered activations must be clearly defined. For the highest level of activation, the following eight criteria must be included:

1. Confirmed blood pressure less than 90 mm Hg at any time in adults, and age-specific hypotension in children
2. Gunshot wounds to the neck, chest, or abdomen
3. GCS less than 9 (with mechanism attributed to trauma)
4. Transfer patients from another hospital who require ongoing blood transfusion
5. Patients intubated in the field and directly transported to the trauma center
6. Patients who have respiratory compromise or are in need of an emergent airway
7. Transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint)
8. Emergency physician's discretion

References

None

Additional Information

The trauma program may include additional criteria.

Measures of Compliance

- Criteria for highest-level activation for which a trauma surgical evaluation is required
- Criteria for lower-level activation for which a trauma surgical evaluation is required

5.4 Trauma Surgeon Response to Highest Level of Activation—TYPE I

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
For the highest level of activation, at least 80% of the time, the trauma surgeon must be at the patient’s bedside within 15 minutes (Level I or II trauma centers) or 30 minutes (Level III trauma centers) of patient arrival.	None
Additional Information	
The trauma surgeons must meet this target in aggregate. While postgraduate trainees might initiate resuscitation, their presence does not count toward meeting this standard.	
Measures of Compliance	
Report that includes the number of highest-level trauma activations and the proportion for which the trauma surgeon was present within 15 minutes (Level I or II trauma centers) or 30 minutes (Level III trauma centers)	

5.5 Trauma Surgical Evaluation for Activations below the Highest Level—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

The trauma program must define and meet the acceptable response time to trauma surgical evaluation for activations other than the highest level.

References

None

Additional Information

The response time is measured from the initial trauma activation (or initial consultation) and trauma surgery team evaluation (as defined by the trauma program).

Measures of Compliance

- Criteria for lower-level activation where a trauma surgical evaluation is required
- Response report for time to trauma surgical evaluation for lower-level activations

5.6 Care Protocols for the Injured Older Adult—TYPE II

Applicable Levels

LI, LII

Definition and Requirements

Level I and II trauma centers must have the following protocols for care of the injured older adult:

- Identification of vulnerable geriatric patients
- Identification of patients who will benefit from the input of a health care provider with geriatric expertise
- Prevention, identification, and management of dementia, depression, and delirium
- Process to capture and document what matters to patients, including preferences and goals of care, code status, advanced directives, and identification of a proxy decision maker
- Medication reconciliation and avoidance of inappropriate medications
- Screening for mobility limitations and assurance of early, frequent, and safe mobility
- Implementation of safe transitions to home or other health care facility

Additional Information

None

Measures of Compliance

Patient care protocols for injured older adults, as listed above

Resources

Institute for Healthcare Improvement. Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults. July 2020. http://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

American College of Surgeons. Optimal Resources for Geriatric Surgery (2019). <https://www.facs.org/quality-programs/geriatric-surgery/standards>

American Geriatrics Society: <https://www.americangeriatrics.org>

Gerontological Society of America: <https://www.geron.org>

American College of Surgeons, Best Practices Guidelines: <https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.7 Assessment of Children for Nonaccidental Trauma— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have a process in place to assess children for nonaccidental trauma.

Additional Information

The process should demonstrate evidence of integration with child protective service, child advocacy center, etc.

Measures of Compliance

Nonaccidental trauma protocols/policies

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.8 Massive Transfusion Protocol—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have a massive transfusion protocol (MTP) that is developed collaboratively between the trauma service and the blood bank.

Level I and II pediatric trauma centers must have a pediatric-specific massive transfusion protocol.

Additional Information

An MTP includes a trigger for activation, a process for cessation, and strategies for preservation of unused blood. Appropriate clotting studies should be immediately available.

Measures of Compliance

Massive transfusion protocol

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.9 Anticoagulation Reversal Protocol—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

All trauma centers must have a rapid reversal protocol in place for patients on anticoagulants.

References

None

Additional Information

The protocol should include therapeutic options and indications for the use of each reversal agent.

Measures of Compliance

Rapid reversal protocol

5.10 Pediatric Readiness—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, each emergency department must perform a pediatric readiness assessment during the verification cycle and have a plan to address identified gaps.

Additional Information

“Pediatric readiness” refers to infrastructure, administration and coordination of care, personnel, pediatric-specific policies, equipment, and other resources that ensure the center is prepared to provide care to an injured child.

The components that define readiness are available in the Resources section below.

Measures of Compliance

- Pediatric Readiness Assessment Gap Report
- Plan to address gaps identified through the pediatric readiness assessment

Resources

Pediatric readiness assessment: <https://www.pedsready.org/>

Other resources to address deficiencies: <https://emscimprovement.center/domains/pediatric-readiness-project/readiness-toolkit/>

References

Remick K, Gausche-Hill M, Joseph MM, et al. Pediatric Readiness in the Emergency Department. *Pediatrics*. 2018;142(5):e20182459. doi:10.1542/peds.2018-2459.

5.11 Emergency Airway Management—TYPE I

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have a provider and equipment immediately available to establish an emergency airway.

Additional Information

The emergency airway provider must be capable of advanced airway techniques, including surgical airway.

Measures of Compliance

- Plan for emergency airway management that specifies provider and means of escalation
- Evaluated during the site visit process

Resources

None

References

None

5.12 Transfer Protocols—TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
All trauma centers must have clearly defined transfer protocols that include the types of patients, expected time frame for initiating and accepting a transfer, and predetermined referral centers for outgoing transfers.	None
Additional Information	
None	
Measures of Compliance	
Transfer protocols	

5.13 Decision to Transfer—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, the decision to transfer an injured patient must be based solely on the needs of the patient, without consideration of their health plan or payor status.

Additional Information

Subsequent decisions regarding transfer to a facility within a managed care network should be made only after stabilization of the patient's condition and in accordance with the ACS Statement on Managed Care and the Trauma System.

Measures of Compliance

- Evaluated during the site visit process
- Report of all transfers out, with reason for transfer

Resources

American College of Surgeons Statement on Managed Care and the Trauma System: <https://www.facs.org/about-acs/statements/21-managed-trauma>

References

None

5.14 Transfer Communication—TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, when trauma patients are transferred, the transferring provider must directly communicate with the receiving provider to ensure safe transition of care. This communication may occur through a transfer center.	None
Additional Information	
Examples of communication documentation may include call logs, emails, and patient summary reports.	
Measures of Compliance	
Transfer communication documentation evaluated during the site visit process	

5.15 Trauma Diversion Protocol, Hours, and Review— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must maintain a TMD-approved diversion protocol that includes the following:

- Trauma surgeon agreement for diversion
- A process for EMS and dispatch notification
- A diversion log documenting the reason and duration of each event
- Diversion hours not exceeding 400 hours during the reporting period
- Review of all diversion events by the trauma operations committee

Additional Information

Trauma center diversions may occur due to the following (this is not an exhaustive list):

- Equipment failure (e.g., CT scan down)
- Critical infrastructure failure (e.g., weather, electrical, IT)
- Lack of essential services (e.g., neurosurgeon, trauma surgeon, or encumbered)
- Bed availability

“Diversion” is defined as the time during which the trauma center is not accepting trauma patients from the scene or via interfacility transfer.

The name of the operations committee may vary. For example, it might be called the “trauma/hospital systems committee.”

Measures of Compliance

- Diversion protocols including, at minimum, the requirements above
- Trauma diversion report including total hours on diversion during the reporting period
- Minutes/documentation in which trauma diversions were discussed and reviewed

Resources

None

References

None

5.16 Neurosurgeon Response—TYPE II

Applicable Levels

LI, LII, LIII-N, PTCI, PTCII

Definition and Requirements

Neurosurgical evaluation must occur within 30 minutes of request for any of the following:

- Severe TBI (GCS less than 9) with head CT evidence of intracranial trauma
- Moderate TBI (GCS 9–12) with head CT evidence of potential intracranial mass lesion
- Neurologic deficit as a result of potential spinal cord injury (applicable to spine surgeon, whether a neurosurgeon or orthopaedic surgeon)
- Trauma surgeon discretion

In Level I, II, and III-N trauma centers, neurosurgical provider response times must be documented.

In all levels of trauma centers, the neurosurgery attending must be involved in clinical decision-making.

Additional Information

Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.

A neurosurgery resident or APP may act as a consultant as long as there is documented communication with the neurosurgery attending.

The time is measured from time of request until start of neurosurgical evaluation.

Patient evaluation may be done remotely or at bedside.

Measures of Compliance

- Report of neurosurgical response times for patients meeting the criteria in the standard
- Policy outlining the criteria and requirements for neurosurgery response time
- Evaluated during the site visit process

Resources

Brain Trauma Foundation Guidelines for the Management of Severe TBI: <https://braintrauma.org/coma/guidelines/severe-tbi>

American College of Surgeons, Best Practices Guidelines: <https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.17 Neurotrauma Plan of Care for Level III Trauma Centers—TYPE II

Applicable Levels

LIII

Definition and Requirements

All Level III trauma centers must have a written plan approved by the TMD that defines the types of neurotrauma injuries that may be treated at the center and which patients require neurosurgical consultation.

Additional Information

None

Measures of Compliance

Neurotrauma treatment plan

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/tqp/center-programs/tqip/best-practice>

References

None

5.18 Treatment Guidelines for Neurological and Spinal Cord Injuries—TYPE II

Applicable Levels

LI, LII, LIII-N, PTCI, PTCII

Definition and Requirements

All trauma centers must have treatment guidelines that cover the following:

- Which patients require neurosurgical consultation for traumatic brain injury (TBI)
- Management of severe TBI, including intracranial hypertension
- Management of spinal cord injury

Level I and II pediatric trauma centers must have pediatric-specific treatment guidelines.

Additional Information

Level III-N trauma centers are those that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival.

Measures of Compliance

Treatment guidelines for neurological and spinal cord injuries

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.19 Treatment Guidelines for Orthopaedic Injuries— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have treatment guidelines for, at minimum, the following orthopaedic injuries:

- Patients who are hemodynamically unstable attributable to pelvic ring injuries
- Long bone fractures in patients with multiple injuries (e.g., time to fixation, order of fixation, and damage control versus definitive fixation strategies)
- Open extremity fractures (e.g., time to antibiotics, time to OR for operative debridement, and time to wound coverage for open fractures)
- Hip fractures in geriatric patients (e.g., expected time to OR (LI, LII, LIII))

Additional Information

None

Measures of Compliance

Treatment guidelines for orthopaedic injuries

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.20 Orthopaedic Surgeon Response—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, an orthopaedic surgeon must be at bedside within 30 minutes of request for the following:

- hemodynamically unstable, secondary to pelvic fracture
- suspected extremity compartment syndrome
- fractures/dislocations with risk of avascular necrosis (e.g., femoral head or talus)
- vascular compromise related to a fracture or dislocation
- trauma surgeon discretion

The attending orthopaedic surgeon must be involved in the clinical decision-making for care of these patients.

Additional Information

An orthopaedic surgery resident or APP may act as a consultant as long as there is documented communication with the orthopaedic surgeon attending.

The time is measured from time of request until orthopaedic surgeon arrival at bedside.

Measures of Compliance

- Report of orthopaedic surgeon response times for patients meeting the criteria in the standard
- Policy outlining the criteria and requirements for orthopaedic surgeon response time
- Evaluated during the site visit process

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.21 Operating Room Scheduling Policy—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

All trauma centers must have an OR booking policy that specifies targets for timely access to the OR based on level of urgency and includes access targets for a range of clinical trauma priorities.

References

None

Additional Information

None

Measures of Compliance

OR scheduling policy

5.22 Surgical Evaluation of ICU Patients—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, trauma patients requiring ICU admission must be admitted to, or be evaluated by, a surgical service.

Additional Information

There must be a policy that defines the hospital's expectation of the time frame within which a trauma consult is performed for an ICU trauma patient. For example, a tertiary exam can be done before the trauma service signs off, or completed within 2 hours, 6 hours, or 24 hours, or as determined by the hospital policy.

The ICU policy includes notification of changes in care to the trauma service.

Measures of Compliance

- ICU policy
- Evaluated during the site visit process

Resources

None

References

None

5.23 Trauma Surgeon Responsibility for ICU Patients— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, the trauma surgeon must retain responsibility for the trauma patient in the ICU up to the point where the trauma surgeon documents transfer of primary responsibility to another service.

References

None

Additional Information

The trauma surgeon will retain responsibility while the trauma patient is under their care; this requires that they be kept informed of and concur with major therapeutic and management decisions when care is being provided by a dedicated ICU team.

Measures of Compliance

Evaluated during the site visit process

5.24 Communication of Critical Imaging Results—TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, documentation of preliminary diagnostic imaging must include evidence that critical findings were communicated to the trauma team. The final report must accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretations.	None
Additional Information	
None	
Measures of Compliance	
Evaluated during the site visit process	

5.25 Timely CT Scan Reporting—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, documentation of the final interpretation of CT scans must occur no later than 12 hours after completion of the scan.

Additional Information

None

Measures of Compliance

- Radiology reports evaluated during the site visit process
- Institutional policies that address timely CT scan reporting for trauma patients

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.26 Rehabilitation Services during Acute Phase of Care— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must meet the rehabilitation needs of trauma patients by:

- Developing protocols that identify which patients will require rehabilitation services during their acute inpatient stay
- Establishing processes that determine the rehabilitation care, needs, and services required during the acute inpatient stay
- Ensuring that the required services during acute inpatient stay are provided in a timely manner

Additional Information

Early multidisciplinary assessment of patients to determine their rehabilitation needs and provide the relevant services during the acute phase of care is critical to ensuring optimal functional recovery. Multidisciplinary assessment might include input from physicians (including physiatry, where applicable), physiotherapy, occupational therapy, speech language pathology, and mental health providers. These needs should be met as early as possible during the initial hospitalization.

Measures of Compliance

- Narrative description of how patients are assessed for acute rehab needs
- Protocols that outline the process for identifying patients in need of rehabilitation services
- Chart review showing evidence of an interdisciplinary plan of care established through input across rehabilitation providers
- Chart review demonstrating the assessment of rehabilitation needs and that these needs were met in a timely manner

Resources

None

References

None

5.27 Rehabilitation and Discharge Planning—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have a process to determine the level of care patients require after trauma center discharge, as well as the specific rehabilitation care services required at the next level of care. The level of care and services required must be documented in the medical record.

Additional Information

The level of care identifies the optimal disposition of the patient taking into account their needs; options include home with services, outpatient rehabilitation, an inpatient rehabilitation hospital, a skilled nursing facility, or a long-term acute care hospital. The specific services required might include rehabilitation expertise that focuses on spinal cord injury, TBI, musculoskeletal rehabilitation, or others relevant to the needs of the patient.

Discharge planning should also ensure a patient-centered approach. The core of a patient-centered approach is the acknowledgment that patients' perspectives can be integrated into all aspects of the planning, delivery, and evaluation of trauma center care.¹ A series of clinical trials conducted in US trauma care systems^{2–4} suggest that patient-centered care transition interventions can address patients' post-injury concerns, enhance patient self-efficacy, and are associated with clinically relevant reductions in post-injury inpatient and emergency department health service use.

Level I and II trauma centers should adopt a means of facilitating the transition of patients into the community using patient-centered strategies such as the following:

- Peer-to-peer mentoring
- A trauma survivors program
- Participation in the American Trauma Society's Trauma Survivors Network program⁵

- Continuous case management that elicits and addresses patient concerns and links trauma center services with community care

Patient-centered trauma care is an area that can benefit from ongoing integration of research findings and evolving expert opinion.

Measures of Compliance

- Evaluated during the site visit process
- Chart review

Resources

None

References

1. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm. Institute of Medicine; 2001.
2. Gassaway J, Jones ML, Sweatman WM, et al. Effects of Peer Mentoring on Self-Efficacy and Hospital Readmission after Inpatient Rehabilitation of Individuals with Spinal Cord Injury: A Randomized Controlled Trial. *Arch Phys Med Rehabil*. 2017;98(8):1526–1534.e2. doi:10.1016/j.apmr.2017.02.018.
3. Zatzick D, Russo J, Thomas P, et al. Patient-Centered Care Transitions after Injury Hospitalization: A Comparative Effectiveness Trial. *Psychiatry*. 2018;81(2):141–157. doi:10.1080/00332747.2017.1354621.
4. Major Extremity Trauma Rehabilitation Consortium. Early Effects of the Trauma Collaborative Care Intervention: Results from a Prospective Multicenter Cluster Clinical Trial. *J Orthop Trauma*. 2019;33(11):538–546. doi:10.1097/BOT.0000000000001581.
5. American Trauma Society. Available at: <https://www.amtrauma.org/>. Accessed February 5, 2022.

5.28 Mental Health Assessment Protocol—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must meet the mental health needs of trauma patients by having:

- A protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider (LI, LII, PTCI, PTCII)
- A process for referral to a mental health provider when required (LIII)

Additional Information

Level I and II trauma centers are required to have a structured approach to identify patients at high risk for mental health problems, while Level III trauma centers are required to have a means of referral should a problem or risk be identified during inpatient admission.

Measures of Compliance

- Mental health screening and referral protocol (LI, LII, PTCI, PTCII)
- Mental health referral process (LIII)

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None

5.29 Alcohol Misuse Screening and Intervention—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must screen all admitted trauma patients aged 12 years and older for alcohol misuse with a validated tool or routine blood alcohol content testing. Programs must achieve a screening rate of at least 80%.

In Level I and II trauma centers, at least 80% of patients who have screened positive for alcohol misuse must receive a brief intervention by appropriately trained staff prior to discharge. This intervention must be documented.

In Level III trauma centers, at least 80% of patients who have screened positive for alcohol misuse must receive a brief intervention by appropriately trained staff prior to discharge. This intervention must be documented. If brief intervention is not available for inpatients, there must be a mechanism for referral.

Additional Information

This standard applies to all admitted trauma patients with a length of stay greater than 24 hours, regardless of activation status.

Screening methods are at the discretion of the individual center. Examples of acceptable screening tools can be found in the Resources section.

“Intervention” is defined as providing screening results, exploring the individual’s view of their substance abuse and how it affects their health, and assisting the individual in navigating the available options for making a change. (Refer to the Resources section.)

Appropriately trained staff will be determined and credentialed by the institution. This may include nurses, social workers, etc.

Level III trauma centers that do not have brief intervention available must be able to track referrals for those screened positive.

Measures of Compliance

- Alcohol misuse report that includes criteria outlined in the standard
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol
- Alcohol misuse intervention report (numerator = number of patients [participatory and survived until discharge] who received an intervention; denominator = number of patients [participatory and survived until discharge] who screened positive for alcohol misuse)

Resources

American College of Surgeons, Best Practices Guidelines:
<https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

References

None



6

Data Surveillance and Systems

Rationale

High-quality data are critical to inform quality improvement and measure the performance of trauma programs. This is dependent on having well-trained registry personnel working closely with trauma leadership. High-quality data also allow for focused quality improvement activities and maximize the value of trauma benchmarking programs.

6.1 Data Quality Plan—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

All trauma centers must have a written data quality plan and demonstrate compliance with that plan. At minimum, the plan must require quarterly review of data quality.

References

None

Additional Information

The plan should allow for a continuous process that measures, monitors, identifies and corrects data quality issues and ensures the fitness of data for use.

Ensuring data validity is an important part of a data quality plan. Validation may be internal or external.

Examples of external data validation include the Trauma Quality Programs (TQP) Data Center Validation Summary Report and the TQP Data Center Submission Frequency Report.

High-quality data are necessary for focused quality improvement efforts.

Measures of Compliance

- Written data quality plan
- Narrative description of the following:
 - Results summarizing internal and/or external data validation
 - Evidence of a comprehensive review of the TQP Data Center Validation Summary Report
 - Evidence of a comprehensive review of the TQP Data Center Submission Frequency Report (if applicable)

6.2

Trauma Registry Patient Record Completion—
TYPE II

Applicable Levels	Resources
LI, LII, LIII, PTCI, PTCII	None
Definition and Requirements	References
In all trauma centers, the trauma registry must be concurrent, defined as having a minimum of 80% of patient records completed within 60 days of the patient discharge date.	None
Additional Information	
A completed record is one where all of the required data have been entered in the registry and the record has been closed. “Patient records” are defined as records for patients who meet inclusion criteria for NTDS, hospital, local, regional, and state purposes. Timeliness of data collection is necessary so that centers can validate their data and identify opportunities for improvement at the earliest possible time.	
Measures of Compliance	
Registry report covering the reporting period demonstrating that data for 80% of patient records are completed within 60 days of discharge date	

6.3 Trauma Registry Data Collection and Submission— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, trauma registry data must be collected in compliance with the NTDS inclusion criteria and data element definitions, and must have been submitted to the TQP Data Center in the most recent call for data.

Additional Information

The “most recent call for data” is defined as the most recent call for data that occurred more than 30 days prior to the site visit.

As an example: A TQP call for data closed on March 1st. The subsequent TQP call for data closed on June 1st. For a center with a visit on June 15th, they will have been required to collect the data in compliance with NTDS definitions and submitted their data by March 1st. For a center with a visit on August 15th, they will need to meet the standard for data submitted by June 1st.

Data collection using standardized definitions is necessary to allow centers to compare their processes and outcomes with other centers. Timeliness of data collection and submission is necessary to ensure that opportunities for improvement are readily identified.

Measures of Compliance

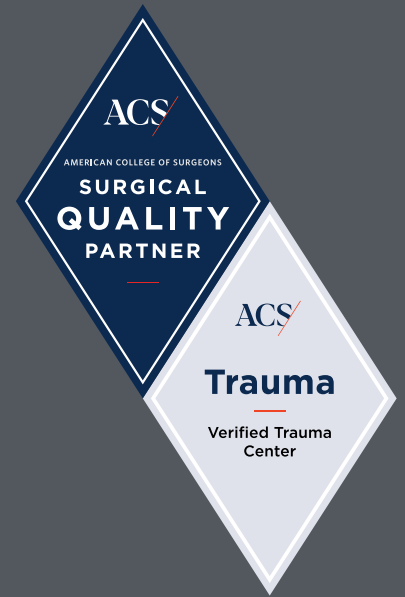
- Submission of all records meeting NTDS inclusion criteria
- All submitted records must pass the NTDS validation requirements (containing no level I or II flags)
- Submitted records must include at least 12 continuous and complete months of trauma registry data eligible for submission in the most recent call for data (defined above).

Resources

None

References

None



7

Performance Improvement and Patient Safety

Rationale

Processes for identifying adverse events and implementing subsequent corrective action plans—measurable through patient outcomes—are inherent cornerstones of continuous performance improvement and patient safety (PIPS).

Problem resolution, outcomes improvement, and assurances of patient safety (“loop closure”) must be readily identifiable through structured PI initiatives.

7.1 Trauma PIPS Program—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, the trauma PIPS program must be independent of the hospital quality program, but it must report PI activities through the hospital quality program.

Additional Information

The PIPS program must be empowered to identify opportunities for improvement and develop actions to reduce the risk of patient harm, irrespective of the department, service, or provider. The expected frequency and level of review require the PIPS program to function independently from the hospital quality program. However, the PIPS program must have a means to report events and actions to the hospital quality program so that events are aggregated across the organization.

The hospital quality program must provide feedback and loop closure to the trauma program.

Trauma care typically involves many providers across several disciplines and departments. The PIPS program is most effective when it brings the providers together to review and implement opportunities for improvement.

Measures of Compliance

Hospital organization chart reflecting the relationship of the PIPS program to the organizational PI program and demonstrating bidirectional flow of information

Resources

None

References

None

7.2 PIPS Plan—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have a written PIPS plan that:

- Outlines the organizational structure of the trauma PIPS process, with a clearly defined relationship to the hospital PI program
- Specifies the processes for event identification. As an example, these events may be brought forth by a variety of sources, including but not limited to: individual personnel reporting, morning report or daily sign-outs, case abstraction, registry surveillance, use of clinical guideline variances, patient relations, or risk management. The scope for event review must extend from prehospital care to hospital discharge.
- Includes a list of audit filters, event review, and report review that must include, at minimum, those listed in the Resources section
- Defines levels of review (primary, secondary, tertiary, and/or quaternary), with a listing for each level that clarifies:
 - Which cases are to be reviewed
 - Who performs the review
 - When cases can be closed or must be advanced to the next level
- Specifies the members and responsibilities of the trauma multidisciplinary PIPS committee
- Outlines an annual process for identification of priority areas for PI, based on audit filters, event reviews, and benchmarking reports

Additional Information

None

Measures of Compliance

PIPS plan that meets criteria outlined in this standard

Resources

Audit filters, event or report reviews:

- Surgeon arrival time for the highest level of activation
- Delay in response for urgent assessment by the neurosurgery and orthopaedic specialists
- Delayed recognition of or missed injuries
- Compliance with prehospital triage criteria, as dictated by regional protocols
- Delays or adverse events associated with prehospital trauma care
- Compliance of trauma team activation, as dictated by program protocols
- Accuracy of trauma team activation protocols (over and under triage rates)
- Delays in care due to the unavailability of emergency department physician (Level III)
- Unanticipated return to the OR
- Unanticipated transfer to the ICU or higher level of care
- Transfers out of the facility for appropriateness and safety
- All nonsurgical admissions (refer to Standard 7.8)
- Radiology interpretation errors or discrepancies between the preliminary and final reports
- Delays in access to time-sensitive diagnostic or therapeutic interventions, including any differences across populations identified in the TQIP report

- Compliance with policies related to timely access to the OR for urgent surgical intervention, including any differences across populations identified in the TQIP report
- Delays in response to the ICU for patients with critical needs
- Lack of availability of essential equipment for resuscitation or monitoring
- MTP activations
- Significant complications and adverse events
- Transfers to hospice
- All deaths: inpatient, died in emergency department (DIED), DOA
- Inadequate or delayed blood product availability
- Patient referral and organ procurement rates
- Screening of patients for psychological sequelae (LI/LII/PTCI/PTCII))
- Delays in providing rehab services
- Screening and intervention for alcohol misuse
- Pediatric admissions to nonpediatric trauma centers
- Neurotrauma care at Level III trauma centers
- Trauma and neurotrauma diversion
- Benchmarking reports

References

None

7.3 Documented Effectiveness of the PIPS Program— TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must have documented evidence of event identification; effective use of audit filters; demonstrated loop closure; attempts at corrective actions; and strategies for sustained improvement measured over time.

Additional Information

Utilize your PIPS plan as referenced in Standard 7.2.

Measures of Compliance

PIPS documentation including trauma multidisciplinary PIPS committee minutes, loop closure documentation, monitoring of event rates, OPPE, benchmarking reports, or other relevant data to inform and evaluate PI

Resources

Society of Trauma Nurses: <https://www.traumanurses.org/education/topic>

References

None

7.4 Participation in Risk-Adjusted Benchmarking Programs—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must participate in a risk-adjusted benchmarking program and use the results to determine whether there are opportunities for improvement in patient care and registry data quality.

Additional Information

TQIP meets the participation requirement for a risk-adjusted benchmarking program.

Risk-adjusted benchmarking programs other than TQIP must meet criteria listed on the TQP website, found on <https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/2022-resources-repository/>.

Participation in a risk-adjusted benchmarking program with regular review of data provides the best opportunities for centers to understand where there might be gaps in their quality of care.

Measures of Compliance

- During the site visit process, present the opportunities for improvement and actions taken to improve patient care and registry data quality from the evaluation of the risk-adjusted benchmarking report
- For trauma centers not participating in TQIP:
 - Documented proof of participation in a risk-adjusted benchmarking program that meets criteria listed for alternate programs
 - Copies of the two most recent risk-adjusted benchmark reports, at least one of which must have been received during the reporting period

Resources

None

References

None

7.5 Physician Participation in Prehospital Performance Improvement—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, a physician from the emergency department or trauma program must participate in the prehospital PI process, including assisting in the development of prehospital care protocols relevant to the care of trauma patients.

References

None

Additional Information

None

Measures of Compliance

- Attendance records from prehospital PI meetings
- Prehospital care protocols relevant to the care of trauma patients

7.6 Trauma Multidisciplinary PIPS Committee Attendance—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must meet the following trauma multidisciplinary PIPS committee meeting attendance thresholds:

- 60% of meetings for the TMD (cannot be delegated to the associate TMD)
- 50% of meetings for each trauma surgeon
- 50% of meetings for the liaisons (or one predetermined alternate) from emergency medicine, orthopaedic surgery, critical care medicine, and anesthesia
- 50% of meetings for the liaison (or one predetermined alternate) from neurosurgery (LI, LII, LIII-N, PTCI, and PTCII)
- 50% of meetings for the liaison (or one predetermined alternate) from radiology (LI, LII, PTCI, and PTCII)
- 50% of meetings for the pediatric surgery liaison (applies only to PTCI and PTCII and only if the TMD is not board-certified or board-eligible in pediatric surgery; refer to Standard 2.8)

Combined adult and pediatric programs (Level I/II adult trauma center with Level II pediatric trauma center) must hold separate adult and pediatric meetings. The pediatric meetings must be attended by the required pediatric specialists (pediatric trauma surgeons and liaisons) and the adult meetings must be attended by the adult specialists (trauma surgeons and liaisons) as specified in this standard. A representative (TMD or one predetermined alternate) must attend 50% of the other program's meetings; this representative is responsible for disseminating information to panel members of the other program.

Additional Information

Attendance requirements may be met by teleconference. Trauma multidisciplinary PIPS committee meeting attendance may be waived for military deployment, medical leave, and missionary work. Documentation in support of absences must be provided by the trauma center.

The minimum attendance for liaisons is based on the combined attendance for the alternate and the liaison. If the TMD also serves as the ICU director, this person meets the minimum attendance threshold as the TMD and the ICU director.

If a trauma surgeon only serves as a backup (i.e., is never first call for trauma surgery), they are not subject to attendance requirements. The TMD should disseminate information discussed in these meetings to everyone involved in caring for trauma patients.

Measures of Compliance

- Dates of PIPS committee meetings
- PIPS committee meeting attendance list

Resources

None

References

None

7.7 Trauma Mortality Review—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, all cases of trauma-related mortality and transfer to hospice must be reviewed and classified for potential opportunities for improvement.

Deaths must be categorized as:

- Mortality with opportunity for improvement
- Mortality without opportunity for improvement

Additional Information

Mortalities include DOA, DIED, and patients who died after withdrawal of life-sustaining care.

The goal of reviewing events is to identify potential opportunities for improvement.

A death should be designated as “mortality with opportunity for improvement” if any of the following criteria are met:

- Anatomic injury or combination of severe injuries may have been survivable under optimal conditions
- Standard protocols were not followed, possibly resulting in unfavorable consequence
- Provider care was suboptimal

Reviewing each mortality and transfer to hospice provides the greatest assurance that the trauma program will identify opportunities for improvement. Transfers to hospice require review to ensure there were no opportunities for improvement in care that might have significantly changed the clinical course that ultimately led to the decision for hospice care.

After secondary review, mortalities without opportunity for improvement (OFI) may be added to a consent agenda as part of the trauma multidisciplinary PIPS committee (peer review) agenda/minutes.

Measures of Compliance

Trauma multidisciplinary PIPS committee meeting minutes documenting review of mortalities

Resources

None

References

None

7.8 Nonsurgical Trauma Admissions Review—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, all nonsurgical trauma admissions (NSA) must be reviewed by the trauma program.

As part of secondary review, the trauma medical director must review NSA that meet either of the following criteria:

- Patients with an ISS > 9 who did not have a surgical consultation OR patients with a Nelson score ≤ 5
- Cases with an opportunity for improvement identified at primary review

Additional Information

Cases that do not meet the criteria above may be closed at primary review.

The trauma program may utilize either the Injury Severity Score (ISS) or the Nelson scoring tool for patient assessment.

Measures of Compliance

- Written PI plan that includes NSA review process (submitted as part of Standard 7.2)
- Report on all NSA
- Documentation that the cases were reviewed

Resources

Nelson Scoring Tool: <https://pubmed.ncbi.nlm.nih.gov/35337211/>

References

None

7.9 Transfer and Prehospital Care Feedback—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

All trauma centers must have a process of reviewing and providing feedback to:

- EMS agencies, related to accuracy of triage and provision of care
- Receiving and referring providers, related to the care and outcomes of patients and any potential opportunities for improvement in initial care

References

None

Additional Information

None

Measures of Compliance

- Narrative description of the process for reviewing and providing feedback to EMS agencies and referring providers
- Evidence of communication (feedback) between trauma center, EMS agencies, and receiving/referring providers evaluated during the site visit process



8

Education: Professional and Community Outreach

Rationale

Education and outreach programs are integral parts of the trauma program and are designed to help improve outcomes from trauma and minimize the effects of injury. Trauma centers have an obligation to educate future providers and ensure that the public has an opportunity to access educational resources relevant to injury care.

8.1 Public and Professional Trauma Education—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

All trauma centers must provide public and professional trauma education.

References

None

Additional Information

Examples of public and professional trauma education include:

- Advanced Trauma Life Support® (ATLS®)
- International Trauma Life Support® (ITLS®)
- Prehospital Trauma Life Support® (PHTLS®)
- STOP THE BLEED®
- Trauma Evaluation and Management™ (TEAM™)

Measures of Compliance

Documentation demonstrating public and professional trauma education provided by the trauma center

8.2 Nursing Trauma Orientation and Education—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

All trauma centers must provide trauma orientation to new nursing staff caring for trauma patients.

Nurses must participate in trauma CE corresponding to their scope of practice and patient population served.

Additional Information

Examples of orientation may include:

- Center-developed educational program that integrates PIPS-identified issues
- Education specific to patient population served

Nursing orientation may include simulation sessions, online learning, conferences, and annual training events.

Education may include internal courses or modules pertaining to trauma care.

Examples of nursing education may include:

- ATCN—Advanced Trauma Care for Nurses
- TNCC—Trauma Nursing Core Course
- PCAR—Pediatric Care After Resuscitation
- TCAR—Trauma Care After Resuscitation
- TNATC—Transport Nurse Advanced Trauma Course

Measures of Compliance

- Nursing orientation materials
- Objectives and curricula for any internal courses or modules
- CE certificates or transcripts
- Evaluated during the site visit process

Resources

None

References

None

8.3 Prehospital Provider Training—TYPE II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Resources

None

Definition and Requirements

In all trauma centers, the trauma program must participate in the training of prehospital personnel.

References

None

Additional Information

None

Measures of Compliance

Narrative description of involvement in the training of prehospital personnel

8.4 Commitment to Postgraduate Education—TYPE II

Applicable Levels

LI, PTCI

Definition and Requirements

Level I trauma centers must demonstrate commitment to postgraduate training and education by having residency rotations in trauma that meet all of the following conditions

- There must be a defined trauma curriculum and trauma-specific objectives for junior and senior residents
- The rotations must be available to, at minimum, general surgery, orthopaedic, neurosurgery, and emergency medicine residents.
- All residents on the trauma service must be from an Accreditation Council for Graduate Medicine Education (ACGME) accredited program
- There must be a sufficient volume and breadth of cases to provide general surgery senior residents the opportunity to meet the competency requirements for senior general surgery residents in trauma set forth by the ACGME
- The rotation must be continuously available to residents to assure ample exposure to trauma care

Additional Information

“Available” to residents implies that the rotation is open to receive trainees at all times and from, at minimum, the specialties mentioned above.

An adequate volume and breadth of cases to meet competency requirements implies that residents have an opportunity to gain exposure to these cases. A volume and breadth of cases without an opportunity for exposure would not meet the standard.

Measures of Compliance

- Learning objectives and curriculum for resident trauma rotation
- Rotation schedule with assigned residents, levels and primary specialty for the 12 months of the reporting period
- Letter from relevant program director that the residents are from an ACGME accredited program
- Letter from program director in General Surgery confirming that the center provides ample trauma exposure to meet general surgery training requirements
- Number of major operative trauma cases over the course of the reporting period

Resources

None

References

None



9

Research

Rationale

Level I trauma centers have an obligation to innovate and advance trauma care through research and other scholarly activities. These activities also create opportunities for the development of future trauma leaders.

9.1 Research and Scholarly Activities—TYPE II

Applicable Levels

LI, PTCI

Definition and Requirements

Level I trauma centers must demonstrate the following scholarly activities during the verification cycle:

- At least 10 trauma-related research articles*
- Participation by at least one trauma program faculty member as a visiting professor, invited lecturer, or speaker at a regional, national, or international trauma conference
- Support of residents or fellows in any of the following scholarly activities: laboratory experiences; clinical trials; resident trauma paper competitions at the state, regional, or national level; and other resident trauma research presentations

*Fulfillment of the research requirement must also meet the following criteria:

- At least three articles must be authored by adult or pediatric trauma surgeons
- Research activity must be performed at the trauma center
- If case series are to be counted, they must include more than five trauma patients
- Basic science research must involve topics directly related to the pathophysiology of injury
- At least three articles must be from disciplines other than adult or pediatric trauma surgery
- All articles must be published or accepted for publication in peer-reviewed and indexed journals
- Authors from the trauma center must meet accepted authorship requirements of the International Committee of Medical Journal Editors
- One paper from acute care surgery may be included

Measures of Compliance

- 10 trauma-related research articles
- Evidence of participation at a regional, national, or international trauma conference
- Narrative description of support of resident or fellow scholarly activities

Resources

None

References

None

Additional Information

None

Appendix A: Board Certification

Board Certification or Board Eligibility Requirements

“Board certification” or “board eligibility” refers to certification or eligibility for certification one of the following:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA)
- Royal College of Physicians and Surgeons of Canada (RCPS-C).

Lifetime board certification through any of the above meets the requirement for board certification or board eligibility.

Alternate Pathway

Physicians who have trained outside the United States or Canada may participate in the trauma program if approved by the Alternate Pathway.

The following physicians are eligible to be reviewed by the Alternate Pathway:

- Trauma surgeons
- Neurosurgeons
- Orthopaedic surgeons
- Emergency medicine physicians
- Anesthesiologist (Note: applicable to the liaisons only)

Alternate Pathway Pre-Eligibility Requirement—Step 1

- Pre-eligibility approval is required for physicians to determine that their training is equivalent to that of the United States or Canada.

Alternate Pathway Criteria—Step 2 (following pre-eligibility approval):

- Evidence of 36 hours (12 hours annually prorated for new hires) of trauma-related CME during the verification cycle. For pediatric trauma care, 9 of 36 hours must be pediatric-specific CME
- Hold current ATLS certification
- Hold active membership in at least one national or regional trauma organization and must have attended at least one meeting during the reporting period
- Trauma multidisciplinary PIPS committee meeting attendance rate of 50% during the reporting period
- Privileges to provide trauma care at the institution
- Evidence of processes and outcomes of care comparable to those of other physicians (such as a PI report by the TMD demonstrating morbidity and mortality results for patients treated by the physician)*

*There is an expectation that the care provided by the alternate pathway candidate is monitored by the TMD and specialty liaison.

Previously Approved Alternate Pathway Physicians

The following is applicable to physicians who have previously been approved by the Alternate Pathway process:

- If the physician was previously approved by the Alternate Pathway, they do not need to reapply; however, they must provide evidence of 36 hours of trauma-related CME during the verification cycle.
- If the physician covers multiple institutions and was previously approved by the Alternate Pathway at one of the institutions, they do not need to reapply.

Appendix B: Acronyms

- AAAM—Association for the Advancement of Automotive Medicine
- ACS—American College of Surgeons
- AIS—Abbreviated Injury Scale
- APP—advanced practice provider
- ATLS—Advanced Trauma Life Support
- CAA—certified anesthesiologist assistant
- CAISS—Certified Abbreviated Injury Scale Specialist
- CE—continuing education
- CME—continuing medical education
- COT—Committee on Trauma
- CRNA—certified registered nurse anesthetist
- CT—computed tomography
- DIED—died in emergency department
- DMEP—Disaster Management and Emergency Preparedness
- DOA—dead on arrival
- EMS—emergency medical service
- FTE—full-time equivalent
- GCS—Glasgow Coma Scale
- ICU—intensive care unit
- MTP—massive transfusion protocol
- NSA – nonsurgical admissions
- NTDS—National Trauma Data Standard
- OFI—Opportunity for improvement
- OPO—organ procurement organization
- OPPE—Ongoing Professional Practice Evaluation
- OR—operating room
- OTL—orthopaedic trauma leader
- PI—performance improvement
- PIPS—Performance Improvement and Patient Safety
- PRQ—prereview questionnaire
- SBIRT—Screening, Brief Intervention and Referral to Treatment
- TBI—traumatic brain injury
- TMD—trauma medical director
- TPM—trauma program manager
- TQIP—Trauma Quality Improvement Program
- TQP—Trauma Quality Programs
- VRC—Verification, Review, and Consultation

Standards Quick Reference Guide

Standard #	Standard Name	Type	LI	LII	LIII (LIII-N)*	PTCI	PTCII
1 Institutional Administrative Commitment							
1.1	Administrative Commitment	TYPE I	x	x	x	x	x
1.2	Research Support	TYPE II	x			x	
2 Program Scope and Governance							
2.1	State and Regional Involvement	TYPE II	x	x	x	x	x
2.2	Hospital Regional Disaster Committee	TYPE II	x	x	x	x	x
2.3	Disaster Management Planning	TYPE II	x	x	x	x	x
2.4	Level I Adult Trauma Patient Volume Criteria	TYPE I	x				
2.5	Level I Pediatric Trauma Patient Volume Criteria	TYPE I				x	
2.6	Adult Trauma Centers Admitting Pediatric Patients	TYPE I	x	x	x		
2.7	Trauma Multidisciplinary PIPS Committee	TYPE II	x	x	x	x	x
2.8	Trauma Medical Director Requirements	TYPE II	x	x	x	x	x
2.9	Trauma Medical Director Responsibility and Authority	TYPE II	x	x	x	x	x
2.10	Trauma Program Manager Requirements	TYPE II	x	x	x	x	x
2.11	Trauma Program Manager Responsibilities and Reporting Structure	TYPE II	x	x	x	x	x
2.12	Injury Prevention Program	TYPE II	x	x	x	x	x
2.13	Organ Procurement Program	TYPE II	x	x	x	x	x
2.14	Child Life Program	TYPE II				x	x
3 Facilities and Equipment Resources							
3.1	Operating Room Availability	TYPE I	x	x	x	x	x
3.2	Additional Operating Room	TYPE II	x	x		x	x
3.3	Operating Room for Orthopaedic Trauma Care	TYPE II	x	x	x	x	x
3.4	Blood Products	TYPE I	x	x	x	x	x
3.5	Medical Imaging	TYPE I	x	x	x	x	x
3.6	Remote Access to Radiographic Imaging	TYPE II	x	x		x	x
3.7	Cardiopulmonary Bypass Equipment	TYPE II	x	x		x	x
4 Personnel and Services							
4.1	Trauma Surgeon Requirements	TYPE II	x	x	x	x	x
4.2	Trauma Surgeon Coverage	TYPE I	x	x	x	x	x
4.3	Trauma Surgery Backup Call Schedule	TYPE II	x	x	x	x	x
4.4	Specialty Liaisons to the Trauma Service	TYPE II	x	x	x	x	x
4.5	Emergency Department Director	TYPE II	x	x	x	x	x
4.6	Emergency Department Physician Requirements	TYPE II	x	x	x	x	x

Standard #	Standard Name	Type	LI	LII	LIII (LIII-N)*	PTCI	PTCII
4.7	Emergency Department Physician Coverage	TYPE I	x	x		x	x
4.8	Pediatric Critical Care Staffing	TYPE II				x	
4.9	Neurosurgeon Requirements	TYPE II	x	x	x*	x	x
4.10	Neurosurgical Trauma Coverage	TYPE I	x	x	x*	x	x
4.11	Orthopaedic Surgeon Requirements	TYPE II	x	x	x	x	x
4.12	Orthopaedic Trauma Coverage	TYPE I	x	x	x	x	x
4.13	Specialized Orthopaedic Trauma Care	TYPE II		x		x	x
4.14	Anesthesia Services	TYPE I	x	x	x	x	x
4.15	Radiologist Access	TYPE I	x	x	x	x	x
4.16	Interventional Radiology Response for Hemorrhage Control	TYPE II	x	x		x	x
4.17	ICU Director and Surgical Critical Care Staffing	TYPE II	x	x	x	x	x
4.18	ICU Clinician Coverage	TYPE I	x	x		x	x
4.19	ICU Clinician Coverage for Level III Trauma Centers	TYPE I			x		
4.20	ICU Nursing Staffing Requirement	TYPE II	x	x	x	x	x
4.21	Surgical Specialists Availability	TYPE II	x	x		x	x
4.22	Ophthalmology Services	TYPE II	x	x		x	x
4.23	Soft Tissue Coverage Expertise	TYPE II	x			x	
4.24	Craniofacial Expertise	TYPE II	x			x	
4.25	Replantation Services	TYPE II	x	x		x	x
4.26	Medical Specialists	TYPE II	x	x	x	x	x
4.27	Child Abuse (Nonaccidental Trauma) Physician	TYPE II				x	x
4.28	Allied Health Services	TYPE II	x	x	x	x	x
4.29	Renal Replacement Therapy Services	TYPE II	x	x	x	x	x
4.30	Advanced Practice Providers	TYPE II	x	x	x	x	x
4.31	Trauma Registry Staffing Requirements	TYPE II	x	x	x	x	x
4.32	Performance Improvement Staffing Requirements	TYPE II	x	x	x	x	x
4.33	Disaster Management and Emergency Preparedness Course	TYPE II	x			x	
5 Patient Care: Expectations and Protocols							
5.1	Clinical Practice Guidelines	TYPE II	x	x	x	x	x
5.2	Trauma Surgeon and Emergency Medicine Physician Shared Responsibilities	TYPE II	x	x	x	x	x
5.3	Levels of Trauma Activation	TYPE II	x	x	x	x	x
5.4	Trauma Surgeon Response to Highest Level of Activation	TYPE I	x	x	x	x	x
5.5	Trauma Surgical Evaluation for Activations below the Highest Level	TYPE II	x	x	x	x	x
5.6	Care Protocols for the Injured Older Adult	TYPE II	x	x			

Standard #	Standard Name	Type	LI	LII	LIII (LIII-N)*	PTCI	PTCII
5.7	Assessment of Children for Nonaccidental Trauma	TYPE II	x	x	x	x	x
5.8	Massive Transfusion Protocol	TYPE I	x	x	x	x	x
5.9	Anticoagulation Reversal Protocol	TYPE II	x	x	x	x	x
5.10	Pediatric Readiness	TYPE II	x	x	x	x	x
5.11	Emergency Airway Management	TYPE I	x	x	x	x	x
5.12	Transfer Protocols	TYPE II	x	x	x	x	x
5.13	Decision to Transfer	TYPE II	x	x	x	x	x
5.14	Transfer Communication	TYPE II	x	x	x	x	x
5.15	Trauma Diversion Protocol, Hours, and Review	TYPE II	x	x	x	x	x
5.16	Neurosurgeon Response	TYPE II	x	x	x*	x	x
5.17	Neurotrauma Plan of Care for Level III Trauma Centers	TYPE II			x		
5.18	Treatment Guidelines for Neurological and Spinal Cord Injuries	TYPE II	x	x	x*	x	x
5.19	Treatment Guidelines for Orthopaedic Injuries	TYPE II	x	x	x	x	x
5.20	Orthopaedic Surgeon Response	TYPE II	x	x	x	x	x
5.21	Operating Room Scheduling Policy	TYPE II	x	x	x	x	x
5.22	Surgical Evaluation of ICU Patients	TYPE II	x	x	x	x	x
5.23	Trauma Surgeon Responsibility for ICU Patients	TYPE II	x	x	x	x	x
5.24	Communication of Critical Imaging Results	TYPE II	x	x	x	x	x
5.25	Timely CT Scan Reporting	TYPE II	x	x	x	x	x
5.26	Rehabilitation Services during Acute Phase of Care	TYPE II	x	x	x	x	x
5.27	Rehabilitation and Discharge Planning	TYPE II	x	x	x	x	x
5.28	Mental Health Assessment Protocol	TYPE II	x	x	x	x	x
5.29	Alcohol Misuse Screening and Intervention	TYPE II	x	x	x	x	x
6 Data Surveillance and Systems							
6.1	Data Quality Plan	TYPE II	x	x	x	x	x
6.2	Trauma Registry Patient Record Completion	TYPE II	x	x	x	x	x
6.3	Trauma Registry Data Collection and Submission	TYPE II	x	x	x	x	x

Standard #	Standard Name	Type	LI	LII	LIII (LIII-N)*	PTCI	PTCII
7 Performance Improvement and Patient Safety							
7.1	Trauma PIPS Program	TYPE II	x	x	x	x	x
7.2	PIPS Plan	TYPE II	x	x	x	x	x
7.3	Documented Effectiveness of the PIPS Program	TYPE II	x	x	x	x	x
7.4	Participation in Risk-Adjusted Benchmarking Programs	TYPE II	x	x	x	x	x
7.5	Physician Participation in Prehospital Performance Improvement	TYPE II	x	x	x	x	x
7.6	Trauma Multidisciplinary PIPS Committee Attendance	TYPE II	x	x	x	x	x
7.7	Trauma Mortality Review	TYPE II	x	x	x	x	x
7.8	Nonsurgical Trauma Admissions Review	TYPE II	x	x	x	x	x
7.9	Transfer and Prehospital Care Feedback	TYPE II	x	x	x	x	x
8 Education: Professional and Community Outreach							
8.1	Public and Professional Trauma Education	TYPE II	x	x	x	x	x
8.2	Nursing Trauma Orientation and Education	TYPE II	x	x	x	x	x
8.3	Prehospital Provider Training	TYPE II	x	x	x	x	x
8.4	Commitment to Postgraduate Education	TYPE II	x			x	
9 Research							
9.1	Research and Scholarly Activities	TYPE II	x			x	



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