SITE SURVEY REPORT--LEVEL I TRAUMA CENTER

STATE OF FLORIDA DEPARTMENT OF HEALTH Division of Emergency Preparedness and Community Support

KEY: N/A = NOT APPLICABLE

- **A** = EVIDENCE OF SUBSTANTIAL COMPLIANCE WITH THE STANDARDS
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IDENTIFY COMMENTED AREAS RESPONSIBLE FOR BY THE POSITION ABBREVIATION

FTMD = FLORIDA TRAUMA MEDICAL DIRECTOR

- **DH** = DEPARTMENT OF HEALTH
- **TS** = TRAUMA SURGEON
- **NS** = NEUROSURGEON
- **EP** = EMERGENCY PHYSICIAN
- **TN** = TRAUMA NURSE

CR = CREDENTIAL REVIEWER

STANDARD I -- ADMINISTRATIVE

			N/A	Α	С	U
Α.	Dem	onstrated commitment to trauma care.				
FTMD	1.	A board of directors' resolution of commitment of hospital financial, human, and physical resources to treat all trauma patients at the level of hospital's approval, regardless of color creed, sex, nationality, place of residence, or financial class.				
FTMD	2.	A board of directors' resolution of commitment to participate in the state regional trauma system and the local or regional trauma system, if one exists.				
FTMD, DH	3.	A trauma budget that provides sufficient support to the trauma service and program within the hospital.				
FTMD, DH	4.	Institution of procedures to document and review all transfers with neighboring hospitals and trauma centers for transfers into and out of the hospital.				
FTMD, DH	5.	Policies and procedures for the maintenance of the services essential to a trauma center and system.				
FTMD	6.	Providing patient care data as requested by the department or its agent.				
FTMD	7.	Formal written patient transfer agreements with neighboring hospitals and trauma centers.				

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STANDARD I – ADMINISTRATIVE (continued)

		N/A	Α	С	U
B. FTMD, TS	The hospital's chief executive officer (CEO) has overall responsibility for compliance with all trauma center standards. The CEO or his or her designee shall ensure that all staff involved with the care of the trauma patient is aware of their responsibilities as required by the trauma center standards.				
C. FTMD, TS	The hospital shall ensure that the trauma medical director is responsible and accountable for administering all aspects of trauma care. Therefore, the trauma medical director shall be empowered to enforce the trauma center standards with other medical and clinical departments in the hospital. The trauma program manager shall perform under the direction of the trauma medical director and shall interact with all departments on behalf of the medical director.				
D. FTMD, TS	When there are issues that the trauma medical director has been unable to resolve through the hospital's organizational structure, the hospital shall provide a specific mechanism to ensure that the medical staff or CEO address such unresolved issues. This mechanism shall include direct consultation with the affected services, including, but not limited to, trauma and emergency services.				
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STANDARD I - ADMINISTRATIVE (continued)

		N/A	Α	С	U
E. FTMD, TS	The trauma service medical director is responsible for credentialing and attesting to the medical ability of all personnel who provide trauma services. Appointment or removal of personnel from the trauma service shall be done by the trauma service medical director pursuant to procedures, policies, or bylaws of the hospital.				
F. FTMD, TS	The hospital shall ensure that the procedures, policies, or bylaws address circumstances in which the trauma service medical director determines that an attending physician's actions compromise the health, safety, or welfare of trauma patients. In such case, procedures, policies, or bylaws shall address options such as temporary or permanent removal of the physician from the trauma service, or other appropriate remedial measure.				
G. FTMD, TS	The trauma medical director shall have oversight responsibility for trauma patient care and shall monitor trauma patient care on an ongoing basis as delineated in Standard XVIII.				
H. ftmd, ts	When the trauma medical director is unavailable to the trauma service (such as vacation, out-of-town conference, or illness), the medical director shall delegate authority to another trauma surgeon to carry out the above administrative functions.				
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STANDARD II -- TRAUMA SERVICE

		N/A	Α	С	U
Α.	Organizational Requirements Dedicated and defined service.				
TS	1. A designated medical director contracted to direct and oversee the operation of the trauma service. The medical director position for the trauma service shall be paid by the hospital and documented by a written job description and organizational chart.				
TN	2. A designated trauma program manager for the trauma service. The trauma program manager position for the trauma service shall be paid by the hospital and documented by a written job description and organizational chart.				
TN	 A trauma registrar for the trauma service. The trauma registrar position for the trauma service shall be paid by the hospital and documented by a written job description and organizational chart. a. A recommended staffing model is: one full time equivalent trauma registrar will be required to process more than 750 to 1,000 patients annually 				
TS	 At least one qualified trauma surgeon (as described in Standard III.A) to be in-hospital and on primary trauma call at all times to provide trauma service care. 				
TS	 At least one qualified trauma surgeon (as described in Standard III.A) to be on backup trauma call at all times to provide trauma service care. 				
TS	6. At least one qualified pediatric trauma surgeon for the trauma service (as described in Standard III.A.3.b).				
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STANDARD II -- TRAUMA SERVICE (continued)

			N/A	Α	С	U
В.		nistrative Requirements The trauma service medical director shall re the following:				
	1.	The following physicians participating on the trauma service meet and maintain the qualifications, certifications, and trauma-related continuing medical education (CME) data as required in Standards III.A and B and Standard V.B:				
TS		a. Pediatric and general trauma surgeons.				
TS		b. Emergency physicians.				
TS	2.	As surgeons change, the trauma medical director must ensure that the new surgeons have the qualifications delineated in Standard III.A.3 and that they sign the General Surgeons Commitment Statement. The trauma service shall keep a current and up-to-date commitment statement on file in the hospital's trauma center application at all times for Department of Health review.				
TS	3.	The trauma service maintains morbidity and mortality information, including discussions and actions by the quality management committee described in Standard XVIII.				
CR 4. Nursing personnel have completed their trauma-related continuing education requirements as delineated in Standard VIII.						
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СОМ	MENTS	: :				

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STANDARD II -- TRAUMA SERVICE (continued)

			N/A	Α	С	U
FTMD	5.	Evidence is on file of active membership of the trauma service medical director and the trauma program manager in the local or regional trauma agency, or local health planning council or advisory group if no trauma agency exists.				
FTMD	6.	A written plan is on file that describes the hospital's interaction with the local or regional trauma agency, if one exists, and other county and regional medical response or treatment resources during disaster and mass casualty situations.				
FTMD	7.	The hospital submits trauma data to the state Division of Emergency Preparedness and Community Support, Bureau of Emergency Medical Oversight, Trauma Program, trauma registry program in accordance with "The Florida Trauma Registry Manual, adopted by Rule 64J-2.006, Florida Administrative Code.				
FTMD	8.	The trauma service has a current and up-to-date trauma center application on file and available at all times for Department of Health review.				
тs	9.	The TC shall provide, within the facility, pediatric trauma patient care services, from emergency department admission through rehabilitation, that are separate and distinct from adult trauma patient care services.				
C.	Medic	al and Patient Care Requirements				
	1.	The trauma service medical director shall ensure that patient care protocols exist for a minimum of the following departments:				
TS		a. Trauma Resuscitation Area.				
TS		b. Intensive Care Unit and Pediatric Intensive Care Unit.				
TS		c. Operating Room and Post-Anesthesia Recovery/Post- Anesthesia Care Unit.				
TS		d. Medical Surgical Unit.				

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STANDARD II -- TRAUMA SERVICE (continued)

_				N/A	Α	С	U
	2.		rauma service medical director shall ensure that policies and cols are developed for a minimum of the following:				
TS		a.	Priority admission status for trauma patients.				
TS		b.	Patient transfers into and out of the hospital.				
TS	3.		rauma service medical director shall approve all trauma-related nt care protocols before implementation.				
ΤS	4.	progr	rauma service medical director in coordination with the trauma am manager shall monitor compliance with trauma-related cols through the trauma quality management process.				
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D.			s of Leadership Staff At a minimum, this evidence shall ollowing:				
	1.	Trau	ma Medical Director	N/A	Α	С	U
TS CR		a.	Proof of board certification in general surgery.				
TS CR		b.	Documentation that the hospital granted the medical director full and unrestricted privileges to provide general surgical and trauma care surgical services for adult and pediatric patients.				
TS CR		C.	Documentation that the medical director manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), at least eight of which are pediatric if the medical director manages pediatric trauma patients. These cases may include operative and non- operative interventions.				
TS CR		d.	Documentation of a minimum of ten Category I CME credits every year in trauma-related topics, five of which shall be in pediatric trauma if the medical director manages pediatric trauma patients.				
TS CR		e.	A written attestation from the Chief of Neurosurgery indicating that the trauma service medical director is capable of providing initial stabilization measures and instituting diagnostic procedures for patients, both adult and pediatric, with neural trauma.				
TS CR		f.	Current ATLS instructor certification.				
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STANDARD II -- TRAUMA SERVICE (continued)

N/A A C U
N/A A C I

	2. Tra ı	uma Program Manager		
TN CR	a.	Documentation of current Florida Registered Nurse licensure.		
TN CR	b.	Documentation of current Emergency Nurses Association Trauma Nursing Core Course (TNCC) training or equivalent.		
TN CR	C.	Documentation of a minimum of ten contact hours every year in trauma-related topics, five of which must be in pediatric trauma.		
DEFICI	ENCIES:			

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Α.	Gener	al o	r Per	diatric Surgery	N/A	 -	
FTMD, TS	1.	The ass ava cov Pu	ere sl signe ailable /erag rsuar	hall be a minimum of five qualified trauma surgeons, d to the trauma service, with at least two trauma surgeons e to provide primary (in-hospital) and backup trauma ge 24 hours a day at the trauma center when summoned. In to Standard II.A.6, there shall be at least one qualified c trauma surgeon for the trauma service.			
FTMD, 2. TS		tak Su wh wit stip	es tr rgeor ich b h th oulate spital	auma surgeon who is a member of the trauma service and rauma call shall sign the Department of Health's General ns Commitment Statement, DH Form 2032-E, January 2010, ecomes part of the facility's official application packet on file e Department of Health. The commitment statement es that, during his or her scheduled period of primary in- or backup trauma call, the trauma surgeon agrees to the ns listed below:			
		a.	Pri	mary trauma call:			
TS			1.	To be physically present in-hospital to meet all trauma alert patients in the trauma resuscitation area at the time of the trauma alert patient's arrival.			
TS			2.	To perform no elective surgery or procedures, during the on-call period, that would render the trauma surgeon unavailable to arrive promptly to a trauma alert patient.			
TS			3.	To refrain from taking general surgery emergency calls or trauma calls at any other facility while on trauma call at the primary facility.			
DEFIC	CIENCIE	ES:					
СОМ	MENTS:	:					

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b.	Ва	ckup trauma call	N/A	Α	С	U
TS	1.	When the trauma surgeon on primary call takes a trauma patient to surgery, the trauma surgeon on backup trauma call shall become the primary trauma surgeon and shall arrive promptly when summoned.				
TS	2.	To perform no elective surgery or procedures, during the on-call period, that would render the trauma surgeon unavailable to become the primary trauma surgeon.				
TS	3.	To refrain from taking general surgery emergency calls or trauma calls at any other facility while on trauma call at the primary facility.				
TS	4.	To refrain from any activity that would delay or prohibit the trauma surgeon from becoming the primary trauma surgeon when notified.				
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3.	Traur	na surgeon qualifications.				
	a.	For a general surgeon:	N/A	Α	С	U
CR		(1) Proof of board certification or actively participating in the certification process with a time period set by each specialty board in general surgery, or proof of meeting the definition of alternate criteria.				
		Alternate Criteria for the Non-Board-Certified General Surgeon in a Level I Trauma Center. In rare cases in a Level I trauma center, a non- board-certified general surgeon who meets all 4 of the following criteria may be included on the trauma call panel:				
		1. Has provided exceptional care of trauma patients				
		2. Has numerous publications and presentations				
		3. Has published excellent research				
		4. Is documented to provide excellent teaching.				
CR		(2) Documentation that the hospital granted the general surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services for adult and pediatric patients.				
TS CR		(3) Documentation that the general surgeon manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), at least eight of which are pediatric if the general surgeon manages pediatric trauma patients. These cases may include operative and non-operative interventions.				
TS CR		(4) Documentation of a minimum of ten Category I CME credits every year in trauma-related topics, five of which shall be in pediatric trauma if the general surgeon manages pediatric trauma patients. The general surgeon may apply CME credits earned during any given year for the completion of ATLS certification toward meeting this requirement.				

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TS CR (5) A written attestation from the Chief of Neurosurgery indicating that the general surgeon is capable of providing initial stabilization measures and instituting diagnostic procedures for patients, both adult and pediatric, with neural trauma. This statement shall be on file and available for Department of Health review. Image: Comparison of the comparison o				N/A	Α	С	U
DEFICIENCIES:	TS CR	(5)	indicating that the general surgeon is capable of providing initial stabilization measures and instituting diagnostic procedures for patients, both adult and pediatric, with neural trauma. This statement shall be				
		(6)	Current ATLS provider certificate.				

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STANDARD III -- SURGICAL SERVICES -- STAFFING AND ORGANIZATION (continued) N/Å

		N/A	Α	С	U
b.	For a pediatric surgeon:				r
TS CR	(1) Proof of board certification or actively participating the certification process with a time period set by each specialty board in pediatric surgery, or proof meeting the definition of alternate criteria.				
	Alternate Criteria for the Non-Board-Certified Pediatric Surgeon in a Level I Trauma Center. rare cases in a Level I trauma center, a non- board-certified general surgeon who meets all the following criteria may be included on the trauma call panel:				
	1. Has provided exceptional care of trauma patier	nts			
	2. Has numerous publications and presentations				
	3. Has published excellent research				
	4. Is documented to provide excellent teaching.				
TS CR	(2) When the number of pediatric surgeons on staff is few to sustain the pediatric trauma panel, general surgeons who are board-certified or actively participating in the certification process with a time period set by each specialty board may serve on th trauma team.				
TS CR	(3) Documentation that the hospital granted the pediat surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services specific to pediatric patients.				
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			N/A	Α	С	U
TS CR	(4)	Documentation that the pediatric surgeon manages a minimum of 12 pediatric trauma cases per year (average of three trauma cases per quarter). These cases may include operative and non-operative interventions.				
TS CR	(5)	Documentation of a minimum of ten Category I CME credits every year in trauma-related topics, five of which shall be in pediatric trauma. The pediatric surgeon may apply CME credits earned during any given year for the completion of ATLS certification toward meeting this requirement. (See Note #1.)				
TS CR	(6)	A written attestation from the Chief of Neurosurgery indicating that the pediatric surgeon is capable of providing initial stabilization measures and instituting diagnostic procedures for pediatric patients with neural trauma. This statement shall be on file and available for Department of Health review.				
TS CR	(7)	Current ATLS provider certification.				
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STANDARD III -- SURGICAL SERVICES -- STAFFING AND ORGANIZATION (continued)

			N/A	Α	С	U
4.	gener	r surgical residents (PGY-4 or above) may fill the in-hospital al surgical requirement if the trauma service medical director es the following:				
TS CR	а.	A qualified general surgeon (or pediatric surgeon for pediatric patients) is on trauma call and shall arrive promptly at the TC when summoned.				
	b.	The trauma medical director attests in writing that each resident is capable of the following:				
TS CR		 Providing appropriate assessment and responses to emergent changes in patient condition. 				
TS CR		(2) Instituting initial diagnostic procedures.				
TS CR		(3) Initiating surgical procedures.				
TS CR		This statement shall be on file and available for Department of Health review for each general surgical resident that fills this requirement.				
TS CR	C.	When a trauma alert patient is identified, the attending trauma surgeon shall be summoned and take an active role by participating in patient care during the resuscitation.				
TS CR	d.	The attending trauma surgeon shall also accompany the senior surgical resident to the operating room.				
TS CR	e.	Each general surgical resident has current ATLS provider certification.				
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В.		Ne	urological Surgery		
NS	1.		imum of one qualified neurosurgeon to provide in-hospital trauma erage 24 hours a day at the trauma center.		
	2.	neu	dence shall be on file that clearly describes the qualifications of each irosurgeon who takes trauma call. At a minimum, this evidence shall ude the following:		
NS	a.	pro	of of board certification or actively participating in the certification cess with a time period set by each specialty board in neurosurgery, proof of meeting the definition of alternate criteria.		
		trau	ernate Criteria for Non-Board-Certified Neurosurgeon in a Level I uma center. In rare cases in a Level I trauma center, a non-board- tified specialist who does not meet all of the following 9 criteria:		
NS		1.	A letter by the trauma medical director indicating this critical need in the trauma program because of the physician's experience or the limited physician resources in general surgery within the hospital trauma program.		
NS CR		2.	Evidence that the neurosurgeon completed an accredited residency training program in that specialty. This completion must be certified by a letter from the program director.		
NS CR		3.	Documentation of current status as a provider or instructor in the Advanced Trauma Life Support (ATLS) program.		
NS CR		4.	A list of the 48 hours of trauma-related continuing medical education (CME) during the past 3 years.		
NS		5.	Documentation that the neurosurgeon is present for at least 50% of the trauma performance improvement and educational meeting.		
NS		6.	Documentation of membership or attendance at local, regional, and national trauma meetings during the past 3 years.		
NS		7.	A list of patients treated during the past year with accompanying Injury Severity Score and outcome data.		
NS		8.	Performance improvement assessment by the trauma medical director demonstrating that the morbidity and mortality results for patients treated by the neurosurgeon compare favorably with the morbidity and mortality results for comparable patients treated by other members of the trauma call panel.		
NS		9.	Licensed to practice medicine and approved for full and unrestricted neurosurgical privileges by the hospital's credentialing committee. OR		

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STARNDARD III-SURGICAL SERVICES—STAFFING & ORGANIZATION (continued)	N/A	Α	С	U
NS May be included on the trauma panel if he or she meets the following criteria:				
1. Has provided exceptional care of trauma patients				
Has numerous publications and presentations.				
3. Has published excellent research.				
Is documented to provide excellent teaching.				
 b Documentation that the hospital has granted the neurosurgeon privileges to provide neurosurgical and trauma care services for adult and pediatric patients. 				
3. Senior neurosurgical residents, PGY-2 or above, may fill the in-hospital neurosurgeon requirement only if the trauma medical director and the Chief of Neurosurgery ensure the following:			-	
NS a. An attending neurosurgeon is on trauma call and available to arrive promptly at the TC to provide stabilization, diagnostic procedures, or definitive operative care.				
b. The trauma medical director and the Chief of Neurosurgery attest in writing that the senior neurosurgical resident is capable of the following:				
NS (1) Providing appropriate assessment and responses to emergent changes in patient condition.				
NS (2) Instituting initial diagnostic procedures.				
NS This statement shall be on file and available for department review for each senior neurosurgical resident that fills the neurosurgeon requirement.				
NS c. There is evidence on file that each resident has completed at least two years of neurosurgical training.				
DEFICIENCIES: COMMENTS:				

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			N/A	Α	С	U					
	4.	General trauma surgeons (or the senior surgical residents, PGY-4 or above, who are fulfilling the in-hospital requirement as described in Standard III.A.4) may fill the in-hospital neurosurgeon requirement only if the trauma medical director and the Chief of Neurosurgery ensure the following:									
NS		a. An attending neurosurgeon is on trauma call and shall arrive promptly at the TC when summoned.									
NS		b. The Chief of Neurosurgery shall provide written protocols for the general trauma surgeons regarding the initiation of neurologic resuscitation and evaluation for head and spinal cord injuries. The protocols shall also include criteria for immediate summoning of or consultation with the attending on-call neurosurgeon.									
C.		ons in the following specialties shall be available to arrive promptly at when summoned:									
CR	1.	Cardiac surgery.									
CR	2.	Hand surgery.	surgery.								
CR	3.	Microsurgery capabilities.									
CR	4.	Obstetric/gynecologic surgery.									
CR	5.	Ophthalmic surgery.									
CR	6.	Oral/maxillofacial surgery.									
CR	7.	Orthopedic surgery.									
CR	8.	Otorhinolaryngologic surgery.									
CR	9.	Plastic surgery.									
CR	10.	Thoracic surgery.									
CR	11.	Urologic surgery.									
D. CR	board period specia	All surgeons staffing the services listed in items C.1-11 above shall be board certified or actively participating in the certification process with a time period set by each specialty board for certification in their respective specialties, and granted privileges by the hospital to care for adult and pediatric patients.									
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STANDARD IV -- NON-SURGICAL SERVICES -- STAFFING AND ORGANIZATION

		Ν	A/A	Α	С	U
A. TS	for tr certif set b anes certif resid requi	sthesia An anesthesiologist shall be in-hospital and promptly available auma patient care 24 hours a day. The anesthesiologist shall be board ied or actively participating in the certification process with a time period y each specialty board and have privileges from the hospital to provide thesia and trauma care services for adult and pediatric patients. A ied registered nurse anesthetist (C.R.N.A.) or a senior anesthesia ent (CA-3 or above) may, however, fill the in-hospital anesthesiologist irement only if the trauma service medical director ensures the irements in the standards document.				
тs	1.	A staff anesthesiologist is on trauma call and available to arrive promptly at the TC when summoned.				
	2.	The trauma service medical director and the Chief of Anesthesiology attest in writing that each C.R.N.A. or resident is capable of the following:				
TS		a. Providing appropriate assessment and responses to emergent changes in patient condition.				
TS		b. Starting anesthesia for any trauma patients that the attending trauma surgeon determines are in need of operative care (pending the arrival of the anesthesiologist on trauma call). This statement shall be on file and available for Department of Health review for each C.R.N.A. or senior anesthesia resident that fills the anesthesiologist requirement.				
TS		This statement shall be on file and available for department review for each CRNA or senior anesthesia resident that fills the anesthesiologist requirement.				
TS	3	Evidence is on file that that each resident has completed at least 24 months of clinical anesthesiology.				
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STANDARD IV -- NON-SURGICAL SERVICES -- (continued)

В.		The following non-surgical specialties shall be available 24 hours a day to N/A A C arrive promptly at the TC when summoned:								
FTMD	1.	Cardiology.								
FTMD	2.	Gastroenterology.								
FTMD	3.	Hematology.								
FTMD	4.	Infectious diseases.								
FTMD	5.	Internal medicine.								
FTMD	6.	Nephrology.								
FTMD	7.	Pathology.								
FTMD	8.	Pediatrics.								
FTMD	9.	Psychiatry.								
FTMD	10.	Pulmonary medicine.								
FTMD	11.	Radiology.								
FTMD	All specialists staffing the services listed in B.1-11 above shall be board certified or actively participating in the certification process with a time period set by each specialty board in their respective specialties, and granted medical staff privileges by the hospital to care for adult and pediatric patients.									
COMN										

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STANDARD V -- EMERGENCY DEPARTMENT

				N/A	Α	С	U
Α.	Facili	ty Requ	uirements				
FTMD, EP	1.	for tra	usily accessible and identifiable resuscitation area designated numa alert patients. This area shall be large enough to allow nbly of the full trauma team.				
FTMD, EP	2.		urces, staff, and equipment necessary to treat the pediatric a patient.				
FTMD, EP	3.	adequ	rauma resuscitation area shall be of adequate size and contain uate trauma care equipment and supplies to simultaneously rm at least two multi-system trauma alert patient resuscitations.				
FTMD, EP	4.		rity measures in place in the resuscitation area designed to ct the life and well-being of assigned TC staff, patients, and es.				
FTMD, EP	5.		ties to accommodate the simultaneous unloading of two EMS d units.				
FTMD, EP	6.	resus betwe into th patien	e shall be a helicopter landing site in close proximity to the citation area. Close proximity means that the interval of time een the landing of the helicopter and the transfer of the patient he resuscitation area will be such that no harmful effect on the nt's outcome results. All helicopter landing sites shall also meet llowing requirements:				
FTMD, EP		a.	The site shall be licensed by the Florida Department of Transportation.				
FTMD, EP		b.	Use of the air space shall be approved by the Federal Aviation Administration.				
FTMD, EP		C.	Documentation shall be on file with the trauma service indicating that the TC develops and maintains protocols and provides training during employee orientation regarding the safe loading and unloading of patients from a helicopter, as well as precautions to ensure the safety of staff or bystanders while in the vicinity of the aircraft.				
	CIENCII MENTS						

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				N/A	Α	С	U		
В.	Physi	cian F	Requirements						
	1.	shall medi be or provi phys	gnated Emergency Department Medical Director: Evidence be on file indicating that the trauma center has designated a ical director for the emergency department. Evidence shall also in file that describes the qualifications of the medical director to ide trauma-related medical and organizational leadership to icians, nursing, and hospital support staffs. At a minimum, this ence shall include the following:						
EP CR		a.	Proof of board certification in emergency medicine.						
EP		b.	Documentation that the hospital granted privileges to the emergency department medical director to provide trauma and other emergency care services for adult and pediatric patients.						
EP CR		C.	Documentation of a minimum of five Category I CME credits every year in trauma-related topics, at least two of which are in pediatric trauma.						
EP		d.	Documentation of a full-time practice in emergency medicine (may include both administrative and patient care hours).						
EP CR		e.	Current ATLS provider certification.						
EP	2.	duty pedia medi	rgency Physicians At least one emergency physician is on in the emergency department 24 hours a day to cover adult and atric trauma patient care services. The emergency department ical director shall ensure that the emergency physicians, during assigned shifts, comply with the following conditions:						
EP		a.	During assigned shifts, must be physically present in-hospital to meet all trauma alert patients in the trauma resuscitation area at the time of the trauma alert patient's arrival.						
EP		b.	During assigned shifts, must assume trauma team leadership if the trauma surgeon on trauma call is not physically present at the time of the trauma alert patient's arrival in the trauma resuscitation area.						
EP		C.	During assigned shifts, must transfer the care of the trauma patient to the attending trauma surgeon upon his or her arrival in the resuscitation area.						
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				N/A	Α	С	U
3.	resu		s of the emergency physicians working in the area. At a minimum, this evidence shall include the				
	a.	Certi	ication and experience				
CR		(1)	Proof of board certification or actively participating in the certification process with a time period set by each specialty board in emergency medicine, or proof of meeting the definition of alternate criteria.				
			Alternate Criteria for the Non-Board-Certified Pediatric Surgeon in a Level I Trauma Center. In rare cases in a Level I trauma center, a non- board-certified general surgeon who meets all 4 of the following criteria may be included on the trauma call panel:				
			 Has provided exceptional care of trauma patients Has numerous publications and presentations Has published excellent research Is documented to provide excellent teaching. 				
			4. Is documented to provide excellent teaching.				
DEFICIENC	IES:					1	<u> </u>
COMMENTS	5:						

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			N/A	Α	С	U
STANDARD	V E	MERGENCY DEPARTMENT (continued)				
CR		(2) Board certification or actively participating in the certification process with a time period set by each specialty board in a primary care specialty and a written attestation by the emergency department medical director that the physician has worked as a full-time emergency physician for at least three out of the last five years.				
CR	a.	Documentation of a minimum of five Category I CME credits every year in trauma-related topics, at least two of which are in pediatric trauma if the emergency physician cares for pediatric trauma patients.				
CR	b.	Documentation that the hospital granted privileges to the emergency physician to provide trauma and other emergency care services for adult and pediatric patients.				
CR	C.	Current ATLS provider certification.				
COMMENTS	:					

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4.		mergency physicians who care for only pediatric trauma nts, the evidence shall include the following:	N/A	<u>A</u>	C	U
	а.	Certification and experience				
CR		(1) Proof of board certification or actively participating in the certification process with a time period set by each specialty board in pediatric emergency medicine, or proof of meeting the following definition of alternate criteria:				
		The non-board-certified physician must have completed an approved residency program. The physician must be licensed to practice medicine and approved for emergency medicine privileges by the hospital's credentialing committee. The physician must meet all criteria established by the trauma director and emergency medicine director. The physician must have experience in caring for trauma patients, which must be tracked by the PI program. The trauma director [and] emergency medicine director must attest to this physician's experience and quality of patient care as a part of the recurring granting of trauma team privileges consistent with the hospital's policy. This individual is expected to meet all other qualifications for members of the trauma team.				
CR		(2) Board certification in a primary care specialty or emergency medicine and a written attestation by the emergency department medical director that the physician has worked as a full-time emergency physician for at least three out of the last five years.				
CR	a.	Documentation of a minimum of five Category I CME credits every year in trauma-related topics, at least two of which are in pediatric trauma.				
CR	b.	Documentation that the hospital granted privileges to the emergency physician to provide trauma and other emergency care services for pediatric patients.				
CR	C.	Current ATLS provider certification.				
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				N/A	Α	С	U
	5.	fellow the re	Y-3 emergency medicine chief resident or emergency medicine may fill the requirements of meeting trauma alert patients in suscitation area only if the emergency department medical or ensures the following:				
EP		a.	An attending emergency physician, who meets the qualifications delineated in items B.2 and 3, is in the emergency department 24 hours per day.				
		b.	The trauma service medical director and the emergency department medical director attest in writing that each participating resident or fellow is capable of the following:				
EP			(1) Providing appropriate assessment and responses to emergent changes in patient condition.				
EP			(2) Instituting initial diagnostic procedures.				
EP			(3) Providing definitive emergent care.				
EP		C.	Documentation on file indicating that each PGY-3 resident or fellow has completed at least 24 months of emergency medicine experience and has current ATLS provider certification.				
C.	Resus	citation	Area Nursing and Support Personnel Staffing Requirements				
	1.		scitation Area Nursing and Support Personnel Staffing rements.				
TN		a.	At a minimum, two nurses (R.N.s) per shift shall be in- hospital and taking primary assignment for the resuscitation area.				
TN CR		b.	All resuscitation area nurses shall fulfill all initial and recurring training requirements as delineated in Standard VIII within the time frames provided.				
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TN	Other nursing and technical support staff A. Number of nursing personnel and technical staff members assigned to provide patient care in the resuscitation area (in excess of the minimum requirement provided in item C.1.a above) shall be established by each trauma center and shall ensure adequate care of the trauma patient. b. The trauma center shall have a designated and trained staff member to record pertinent patient information on a trauma flow sheet during each trauma alert (may be one of the nurses specified in item C.1.a above). S:		
TN k	 assigned to provide patient care in the resuscitation area (in excess of the minimum requirement provided in item C.1.a above) shall be established by each trauma center and shall ensure adequate care of the trauma patient. b. The trauma center shall have a designated and trained staff member to record pertinent patient information on a trauma flow sheet during each trauma alert (may be one of the nurses specified in item C.1.a above). 		
	member to record pertinent patient information on a trauma flow sheet during each trauma alert (may be one of the nurses specified in item C.1.a above).		
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STANDARD V -- EMERGENCY DEPARTMENT (continued)

D.	Resu	uscitatio	on Area Documentation Requirements	N/A	Α	С	U
EP	1.		auma team shall use a trauma flow sheet of one or more to document patient care in the resuscitation area.				
	2.	The tr follow	auma flow sheet shall provide a sequential account of the ing:	-			
EP		a.	The time EMS called trauma alert.				
EP		b.	The time of the trauma alert patient's arrival in the resuscitation area.				
EP		C.	The prehospital or hospital reason for the trauma alert being called.				
EP		d.	The time of arrival for each trauma team member and physician consultant.				
EP		e.	Serial physiological measurements and neurological status.				
EP		f.	All invasive procedures performed and results.				
EP		g.	Laboratory tests.				
EP		h.	Radiological procedures.				
EP		i.	The time of disposition and the patient's destination from the resuscitation area.				
EP		j.	Complete nursing assessment.				
EP		k.	Weight for pediatric trauma patients.				
EP		Ι.	Immobilization measures.				
EP		m.	Total burn surface area and fluid resuscitation calculations for burn patients.				

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E.	Emer	gency Department Responsibilities	N/A	Α	С	U
EP	1.	The emergency department shall summon the trauma team when the facility is notified of a trauma alert en route that meets state/regional trauma alert criteria.				
EP	2.	The emergency department physician shall evaluate all trauma patients not identified as a trauma alert utilizing trauma scorecard methodology. (See Rules 64J-2.004 and 64J-2.005, Florida Administrative Code.) Once the emergency department physician identifies the patient as a trauma alert patient, he or she shall call an in-hospital trauma alert and summon the trauma team.				
EP	3.	The trauma team, physician consultants, and other support personnel shall arrive promptly when notified of a trauma alert and summoned. The trauma team, physician consultants, and other support personnel shall ensure that their response times are documented in each patient's record on the trauma flow sheet.				
	4.	The trauma team shall include, at a minimum, the following:				
EP		a. A trauma surgeon (as team leader).				
EP		b. An emergency physician.				
EP		c. At least two trauma resuscitation area registered nurses.				
The	trauma r	nedical director may also require other disciplines to participate on this to	eam.			
~~	ICIENCI					
CON	IMENTS	÷				

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STANDARD VI -- OPERATING ROOM AND POST-ANESTHESIA RECOVERY AREA

			VA	_	0	<u> </u>
Α.	Opera	iting Room				
FTMD, TS	1.	At least one adequately staffed operating room immediately available for adult and pediatric trauma patients 24 hours a day.				
FTMD, TS	2.	A second adequately staffed operating room available within 30 minutes after the primary operating room is occupied with an adult or pediatric trauma patient.				
	3.	The operating team shall consist minimally of the following:				
TS		a. One scrub nurse or technician.				
TS		b. One circulating registered nurse.				
TS		c. One anesthesiologist immediately available.				
B.	Post-A	Anesthesia Recovery (PAR)		·		
TN	1.	The PAR area (the surgical intensive care unit is acceptable) is adequately staffed with registered nurses and other essential personnel 24 hours a day.				
FTMD, TS	2.	A physician credentialed by the hospital to provide care in the ICU or emergency department shall be in-hospital and available to respond immediately to the PAR for care of adult and pediatric trauma patients 24 hours a day.				
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STANDARD VII -- INTENSIVE CARE UNIT (ICU) AND PEDIATRIC INTENSIVE CARE UNIT (PICU)

			N/A	Α	С	U
The a	dult IC	U must be separate and distinct from the PICU.				
Adult	t ICU					
1.	Phys	ician Requirements:				
	a.	The trauma medical director or trauma surgeon designee is responsible for adult trauma patient care in the ICU. Part of these responsibilities includes ensuring that an attending trauma surgeon remains in charge of the patient's care to coordinate all therapeutic decisions. The attending trauma surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise.				
	b.	An attending trauma surgeon may transfer primary responsibility for a stable adult patient with a single-system injury (for example, neurological) from the trauma service if it is mutually acceptable to the attending trauma surgeon and the surgical specialist of the accepting service.				
	C.	The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for adult trauma patients in the ICU for emergent situations when the trauma service medical director or trauma surgeon designee is not available.				
	-					
	Aduli 1.	Adult ICU 1. Phys a. b.	 Physician Requirements: The trauma medical director or trauma surgeon designee is responsible for adult trauma patient care in the ICU. Part of these responsibilities includes ensuring that an attending trauma surgeon remains in charge of the patient's care to coordinate all therapeutic decisions. The attending trauma surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise. An attending trauma surgeon may transfer primary responsibility for a stable adult patient with a single-system injury (for example, neurological) from the trauma service if it is mutually acceptable to the attending trauma surgeon and the surgical specialist of the accepting service. The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for adult trauma service medical director or trauma surgeon designee is not available. 	The adult ICU must be separate and distinct from the PICU. Adult ICU 1. Physician Requirements: a. The trauma medical director or trauma surgeon designee is responsible for adult trauma patient care in the ICU. Part of these responsibilities includes ensuring that an attending trauma surgeon remains in charge of the patient's care to coordinate all therapeutic decisions. The attending trauma surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise. b. An attending trauma surgeon may transfer primary responsibility for a stable adult patient with a single-system injury (for example, neurological) from the trauma surgeon and the surgical specialist of the accepting service. c. The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for adult trauma service medical director or trauma surgeon designee is not available. CIENCIES:	The adult ICU must be separate and distinct from the PICU. Adult ICU 1. Physician Requirements: a. The trauma medical director or trauma surgeon designee is responsible for adult trauma patient care in the ICU. Part of these responsibilities includes ensuring that an attending trauma surgeon remains in charge of the patient's care to coordinate all therapeutic decisions. The attending trauma surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise. b. An attending trauma surgeon may transfer primary responsibility for a stable adult patient with a single-system injury (for example, neurological) from the trauma surgeon and the surgical specialist of the accepting service. c. The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for adult trauma service medical director or trauma surgeon designee is not available. CIENCIES:	The adult ICU must be separate and distinct from the PICU. Adult ICU 1. Physician Requirements: a. The trauma medical director or trauma surgeon designee is responsible for adult trauma patient care in the ICU. Part of these responsibilities includes ensuring that an attending trauma surgeon remains in charge of the patient's care to coordinate all therapeutic decisions. The attending trauma surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise. b. An attending trauma surgeon may transfer primary responsibility for a stable adult patient with a single-system injury (for example, neurological) from the trauma service if it is mutually acceptable to the attending trauma surgeon and the surgical specialist of the accepting service. c. The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for adult trauma service medical director or trauma surgeon designee is not available. CIENCIES:

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STANDARD VII -- ICU AND PICU (continued)

			N/A	Α	С	U
TS	d.	The TC shall track by way of the trauma registry all adult trauma patients, whether under the primary responsibility of the trauma service or of another surgical or non-surgical service, through the quality management process to evaluate the care provided by all health care disciplines.				
2.	Nursi	ing Requirements				
TN	a.	The ratio of nurses to trauma patients in the ICU shall be a minimum of 1:2, and shall be increased above this as dictated by patient acuity.				
TN, CR	b.	The ICU nursing staff shall satisfy all initial and recurring training requirements, as listed in Standard VIII, in the time frames provided.				
COMMENT	S:					

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STANDARD VII -- ICU AND PICU (continued)

C. Pedi	atric ICU				
1.	Physician Requirements	N/A	Α	С	U
TS	a. The trauma medical director or trauma surgeon designee is responsible for pediatric trauma patient care in the PICU. Part of these responsibilities includes ensuring that an attending trauma surgeon or pediatric surgeon remains in charge of the pediatric patient's care to coordinate all therapeutic decisions. The attending trauma surgeon or pediatric surgeon shall obtain consultations from medical and surgical specialists as needed to provide specific expertise.				
TS	b. An attending trauma surgeon or pediatric surgeon may transfer primary responsibility for a stable pediatric patient with a single-system injury (for example, neurological) from the trauma service if it is mutually acceptable to the attending trauma surgeon or pediatric surgeon and the surgical specialist of the accepting service.				
TS	c. The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for pediatric trauma patients in the PICU for emergent situations when the trauma service medical director or trauma surgeon designee is not available.				
TS	d. The TC shall track by way of the trauma registry all pediatric trauma patients, whether under the primary responsibility of the trauma service or of another surgical or non-surgical service, through the quality management process to evaluate the care provided by all health care disciplines.				
COMMENT					

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STANDARD VII -- ICU AND PICU (continued)

	2.	Nurs	ing Requirements	N/A	Α	С	U
TN		a.	The ratio of nurses to trauma patients in the PICU shall be a minimum of 1:2, and shall be increased above this as dictated by patient acuity.				
TN, CR		b.	The PICU nursing staff shall satisfy all initial and recurring training requirements, as listed in Standard VIII, in the time frames provided.				
D. tn	Nursii flow s		umentation in the ICU and PICU shall be on a 24-hour patient				
E. TN	There	shall b	e immediate access to clinical laboratory services.				
	CIENCI	LU.					
СОМ	MENTS	÷					

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STANDARD VIII -- TRAINING AND CONTINUING EDUCATION PROGRAMS

		N/A	Α	С	U
	Evidence shall be available indicating the completion of trauma-related continuing education in the hours and time frames provided for the personnel listed below. Time frames begin the effective date the hospital earns provisional trauma center status, or the employee's subsequent date of assignment to the indicated trauma care area.				
Α.	Registered nurses assigned to following departments shall obtain the specified number of trauma-related contact hours:				
CR	1. ED/trauma resuscitation area 16 contact hours every two years.				
CR	2. Operating room and post-anesthesia recovery eight contact hours every two years.				
CR	3. Intensive care unit and pediatric intensive care unit eight contact hours every two years.				
CR	4. Medical surgical/step down unit for both adult and pediatric eight contact hours every two years.				
CR	5. Rehabilitation unit – eight contact hours every two years.				
CR	6. Burn unit eight contact hours every two years.				
B. cr	Licensed practical nurses assigned to the above departments shall complete eight contact hours every two years.				
C . cr	Paramedics assigned to the above departments shall complete four contact hours of trauma-related continuing education every two years.				
D. cr	Should the nurse or paramedic provide care to both adult and pediatric or only pediatric trauma patients, then at least half of the contact hours mentioned in A.1-5, B, and C shall be in pediatric trauma.				
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STANDARD IX -- EQUIPMENT

			N/A	Α	С	U
Α.	Trau	ma Resuscitation Area				
EP	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator oxygen masks and cannulae, and oxygen.				
EP	2.	Autotransfusion.				
EP	3.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.				
EP	4.	Doppler monitoring capability.				
EP	5.	Electrocardiograph/oscilloscope/defibrillator.				
EP	6.	Monitoring equipment for blood pressure and pulse and an electrocardiogram (ECG).				
EP	7.	Pacing capability.				
EP	8.	Pulse oximetry.				
EP	9.	Skeletal traction devices.				
EP	10.	Standard devices and fluids for intravenous (IV) administration.				
EP	11.	Sterile surgical sets for airway, chest, vascular access, diagnostic peritoneal lavage, and burr hole capability.				
EP	12.	Suction devices and nasogastric tubes.				
EP	13.	Telephone and paging equipment for priority contact of trauma team personnel.				
EP	14.	Thermal control devices for patients, IV fluids, and environment.				
EP	15.	Two-way radio communication with prehospital transport vehicles (radio communications shall conform to the State EMS Communications Plan).				
DEF						

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STANDARD IX – EQUIPMENT (continued)

			N/A	Α	С	U
В.	Oper	ating Room				
TS	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator suction devices, oxygen masks and cannulae, and oxygen.				
TS	2.	Anesthesia monitoring equipment.				
TS	3.	Autotransfusion.				
TS	4.	Cardiopulmonary bypass capability.				
TS	5.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.				
TS	6.	Craniotomy/burr hole and intracranial monitoring capabilities.				
TS	7.	Endoscopes.				
тs	8.	Invasive hemodynamic monitoring and monitoring equipment for blood pressure, pulse, and ECG.				
TS	9.	Operating microscope.				
TS	10.	Orthopedic equipment for fixation of pelvic, longbone, and spinal fractures and fracture table.				
TS	11.	Pacing capability.				
TS	12.	Standard devices and fluids for IV administration.				
TS	13.	Thermal control devices for patients, IV fluids, and environment.				
TS	14.	X-ray capability.				

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STANDARD IX - EQUIPMENT (continued)

-			N/A	Α	С	U
C.	Post	-Anesthesia Recovery				
TS	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator suction devices, oxygen masks and cannulae, and oxygen.				
TS	2.	Autotransfusion.				
TS	3.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.				
TS	4.	Intracranial pressure monitoring.				
TS	5.	Invasive hemodynamic monitoring and monitoring equipment for blood pressure, pulse, and ECG.				
TS	6.	Pacing capability.				
TS	7.	Pulse oximetry.				
TS	8.	Standard devices and fluids for IV administration.				
TS	9.	Sterile surgical sets for airway and chest.				
TS	10.	Thermal control devices for patients and IV fluids.				
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STANDARD IX – EQUIPMENT (continued)

-		· · ·	N/A	Α	С	U
D.	Inten	sive Care Unit and Pediatric Intensive Care Unit				
TS	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator suction devices, oxygen masks and cannulae, and oxygen.				
TS	2.	Auto transfusion.				
TS	3.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.				
TS	4.	Compartment pressure monitoring devices.				
TS	5.	Intracranial pressure monitoring capabilities.				
TS	6.	Invasive hemodynamic monitoring.				
TS	7.	Orthopedic equipment for the management of pelvic, longbone, and spinal fractures.				
TS	8.	Pacing capabilities.				
TS	9.	Pulse oximetry.				
TS	10.	Scales.				
TS	11.	Standard devices and fluids for IV administration.				
TS	12.	Sterile surgical sets for airway and chest.				
TS	13.	Thermal control devices for patients, IV fluids, and environment.				
E.	Medio	cal Surgical Unit				
TS	1.	Airway control and ventilation equipment, including laryngoscopes, endotracheal tubes of all sizes, bag-mask resuscitator, and sources of oxygen.				
TS	2.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.				
TS	3.	Standard devices and fluids for IV administration.				
TS	4.	Suction devices.				
DEF		ES:				
CON	IMENTS):				

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STANDARD X -- LABORATORY SERVICES

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STANDARD XI—ACUTE HEMODIALYSIS CAPABILITY

		N/A	Α	С	U
A. ts,tn	Acute hemodialysis capability shall be available for trauma patients 24 hours				
	a day.				
DEFIC	CIENCIES:				
сом	MENTS:				

STANDARD XII -- RADIOLOGICAL SERVICES

			N/A	Α	С	U
Α.		ce Capabilities – The following radiological service capabilities for na alert patients shall be available in-hospital 24 hours per day:				
TS,NS	1.	Angiography (of all types) with a maximum response time until the start of the procedure of 60 minutes.				
TS,NS	2.	Computerized tomography (CT).				
TS,NS	3.	Routine radiological studies.				
Сом	MENTS	S:				

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STAN	STANDARD XII RADIOLOGICAL SERVICES (Continued)				С	U
В.	servic	ng Requirements – Radiological staff needed to perform radiological ses for trauma alert patients shall be available 24 hours a day. At a num, this includes the following:				
TS,NS	1.	A radiologist, board certified or actively participating in the certification process with a time period set by each specialty board, and granted privileges by the hospital to provide radiological services for adult and pediatric patients, shall be in-hospital and promptly available 24 hours a day. A chief radiology resident may fill the in-hospital requirement only if the trauma service medical director ensures the following:				
TS,NS		a. A staff radiologist is on trauma call and available to arrive promptly at the TC when summoned.				
		b. The trauma service medical director and the Chief of Radiology attest in writing that each participating resident is capable of the following:				
TS,NS		(1) Authorizing any radiological studies required for adult and pediatric trauma alert patients.				
TS,NS		(2) Providing appropriate evaluation of adult and pediatric trauma alert patient radiological studies.				
TS,NS	2.	A CT technician shall be in-hospital 24 hours a day.				1
TS,NS	3.	A radiological technician shall be available in-hospital 24 hours per day.				
C.	CT So	canner Requirements				
TS,NS	1.	At least one CT scanner shall be available for trauma alert patients, and be located in the same building as the resuscitation area. CT scanners located in remote areas of the hospital campus (that requires moving the patient from one building to another), in mobile vans, or in other institutions, do not meet this requirement.				
TS,NS	2.	If the TC has only one CT scanner, a written plan shall be in place describing the steps to be taken if the apparatus is in use or becomes temporarily inoperable. The plan must include trauma patient transfer agreements.				
	CIENCII					

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STANDARD XIII -- ORGANIZED BURN CARE

				N/A	Α	С	U
Α.	The	TC s	shall have written policies and procedures for triage, assessment,				
TS,EP			ion, emergency treatment, and transfer (either into or out of the				
			f burn patients. Policies and procedures shall also be written				
	rega	arding	g in-hospital management, including rehabilitation, of burn patients.				
В.			ma center is capable of providing specialized care, dedicated beds,				
			blies or equipment appropriate for the care of a patient with major or				
			nt burns (See Note #6) when the facility meets one of the following				
		eria:					
TS,EP	1.		verified by the American Burn Association Committee on Burn				
			nter Verification of the American College of Surgeons.				
	2.		monstrates that the facility and burn center staff meet the following alifications:				
TS,EP		a.	The facility shall admit an average of 60 or more patients with				
			acute burn injuries annually. At least 40 patients shall meet the				
			major or significant burn criteria.				
TS,EP		b.	General surgeons or plastic surgeons who are the primary				
			managing physicians managing burn cases shall obtain a				
			minimum of two burn-related CMEs each calendar year as part of their total CMEs.				
TS,EP		0	Each general surgeon or plastic surgeon who is the primary				
13,67		C.	managing physician shall participate in the management of burn				
			patient admissions or resuscitations.				
TS,EP		d.	Burn unit nursing staff shall obtain a minimum of two burn-related				
,		ч.	contact hours each calendar year as part of their total CMEs.				
DEFIC							·
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STANDARD XIII -- ORGANIZED BURN CARE (continued)

		N/A	Α	С	U
TS,EP	e. The facility shall provide at least one burn-related community education or prevention program each calendar year.				
C. TS,EP	If the trauma center is not capable of providing specialized care, dedicated beds, and supplies or equipment appropriate for the care of a patient with major or significant burns (See Note #6), the facility shall have a written transfer agreement with such a facility. The trauma center shall also have written medical transfer policies and protocols to ensure the timely and safe transfer of the burn patient.				
	CIENCIES: MENTS:				

STANDARD XIV -- ACUTE SPINAL CORD AND BRAIN INJURY MANAGEMENT CAPABILITY

		N/A	Α	С	U
A. NS	The TC shall have written policies and procedures for triage, assessment, stabilization, emergency treatment, and transfer (either into or out of the facility) for brain or spinal cord injured patients. Policies and procedures shall also be written regarding in-hospital management, including rehabilitation, for brain or spinal cord injured patients.				
B. NS	The trauma center shall be designated by the Department of Health, Brain and Spinal Cord Injury Program, as a spinal cord injury acute care center or brain injury acute care center,				
	<u>OR</u>				
	Have a written transfer agreement in place with such a facility, and written medical transfer policies and protocols for when to initiate a transfer to ensure the timely and safe transfer of the brain or spinal cord injured patient.				
DEFIC	CIENCIES:				
COM	/IENTS:				

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STANDARD XV -- ACUTE REHABILITATIVE SERVICES

		N/A	<u> </u>	<u> </u>	U
traum injury	a patients as candidates for rehabilitative services. At a minimum, the categories shall include trauma patients with musculoskeletal,				
The tr ensur	auma service medical director or trauma program manager shall e that trauma patients have an evaluation by any or all of the following				
1.	Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon.				
2.	Neuropsychologist				
3.	Nursing personnel may include the following:				
	a. Trauma program manager or designee.				
	b. Clinical nurse specialist.				
	c. Rehabilitation nurse.				
4.	Occupational therapist.				
5.	Physiatrist or medical director of the rehabilitation services department.				
6.	Physical therapist.				
7.	Speech therapist.				
record	. Documentation shall include any short or long-term rehabilitation				
CIENCI	ES:				
MENTS	:				
	traum injury cognit The tr ensur (as ap 1. 2. 3. 3. 4. 5. 6. 7. The or goals CIENCI	surgeon. 2. Neuropsychologist 3. Nursing personnel may include the following: a. Trauma program manager or designee. b. Clinical nurse specialist. c. Rehabilitation nurse. 4. Occupational therapist. 5. Physiatrist or medical director of the rehabilitation services department. 6. Physical therapist.	The trauma medical director shall establish injury categories to identify trauma patients as candidates for rehabilitative services. At a minimum, the injury categories shall include trauma patients with musculoskeletal, cognitive, and other neurological impairments. The trauma service medical director or trauma program manager shall ensure that trauma patients have an evaluation by any or all of the following (as appropriate to the patient's injury) within 7 days of inpatient admission: 1. Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon. 2. Neuropsychologist 3. Nursing personnel may include the following: a. Trauma program manager or designee. b. Clinical nurse specialist. c. Rehabilitation nurse. 4. Occupational therapist. 5. Physical therapist. 6. Physical therapist. 7. Speech therapist. <t< td=""><td>The trauma medical director shall establish injury categories to identify trauma patients as candidates for rehabilitative services. At a minimum, the injury categories shall include trauma patients with musculoskeletal, cognitive, and other neurological impairments. The trauma service medical director or trauma program manager shall ensure that trauma patients have an evaluation by any or all of the following (as appropriate to the patient's injury) within 7 days of inpatient admission: 1. Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon. 2. Neuropsychologist 3. Nursing personnel may include the following: a. Trauma program manager or designee. b. Clinical nurse specialist. c. Rehabilitation nurse. 4. Occupational therapist. 5. Physical therapist. 7. Speech therapist.</td><td>The trauma medical director shall establish injury categories to identify trauma patients as candidates for rehabilitative services. At a minimum, the injury categories shall include trauma patients with musculoskeletal, cognitive, and other neurological impairments. The trauma service medical director or trauma program manager shall ensure that trauma patients have an evaluation by any or all of the following (as appropriate to the patient's injury) within 7 days of inpatient admission: 1. Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon. 2. Neuropsychologist 3. Nursing personnel may include the following: a. Trauma program manager or designee. b. Clinical nurse specialist. c. Rehabilitation nurse. 4. Occupational therapist. 5. Physiatrist or medical director of the rehabilitation services department. 6. Physical therapist. 7. Speech therapist. 7.</td></t<>	The trauma medical director shall establish injury categories to identify trauma patients as candidates for rehabilitative services. At a minimum, the injury categories shall include trauma patients with musculoskeletal, cognitive, and other neurological impairments. The trauma service medical director or trauma program manager shall ensure that trauma patients have an evaluation by any or all of the following (as appropriate to the patient's injury) within 7 days of inpatient admission: 1. Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon. 2. Neuropsychologist 3. Nursing personnel may include the following: a. Trauma program manager or designee. b. Clinical nurse specialist. c. Rehabilitation nurse. 4. Occupational therapist. 5. Physical therapist. 7. Speech therapist.	The trauma medical director shall establish injury categories to identify trauma patients as candidates for rehabilitative services. At a minimum, the injury categories shall include trauma patients with musculoskeletal, cognitive, and other neurological impairments. The trauma service medical director or trauma program manager shall ensure that trauma patients have an evaluation by any or all of the following (as appropriate to the patient's injury) within 7 days of inpatient admission: 1. Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon. 2. Neuropsychologist 3. Nursing personnel may include the following: a. Trauma program manager or designee. b. Clinical nurse specialist. c. Rehabilitation nurse. 4. Occupational therapist. 5. Physiatrist or medical director of the rehabilitation services department. 6. Physical therapist. 7. Speech therapist. 7.

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STANDARD XV -- ACUTE REHABILITATIVE SERVICES (Continued)

		N/A	Α	С	U
D. ts,ns	The physician with primary responsibility for the patient shall review the assessment and recommendations within 48 hours and document the review in the patient's medical record.				
E.	The trauma center shall have one of the following for long-term rehabilitative services:				
TS,NS	1. A designated rehabilitation unit that is accredited by the Commission on Accreditation of Rehabilitative Facilities.				
TS,NS	2. A rehabilitation unit designated by the Department of Health, Brain and Spinal Cord Injury Program, as a spinal cord or brain injury rehabilitation center.				
TS,NS	3. A written transfer agreement in place with one of the above stated facility types, and written medical transfer policies and protocols for when to initiate a transfer to ensure the timely and safe transfer of the trauma patient.				
СОМ	MENTS:				

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STANDARD XVI -- PSYCHOSOCIAL SUPPORT SYSTEMS

		<u>N/A</u>	Α	C	U
A. tn,ts	The TC shall have written policies and protocols to provide mental health services, child protective services, and emotional support to trauma patients or their families. At a minimum, the policies and protocols shall include qualified personnel to provide the services and require that the personnel shall arrive promptly at the TC when summoned.				
В.	Qualified personnel may include, but are not limited to the following:				
TN,TS	1. Nurses (in addition to resuscitation area personnel).				
TN,TS	2. Pastoral or spiritual care representatives.				
TN,TS	3. Patient advocates or representatives.				
TN,TS	4. Physician consultants.				
TN,TS	5. Psychologists or psychiatrists.				
TN,TS	6. Social service workers.				
C. tn,ts	Drug and alcohol counseling and referral services shall be available for patients and their families.				
D. tn,ts	The personnel listed in B.1-6 shall document these interventions in the patient's medical record.				
	VENTS:				

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STANDARD XVII -- OUTREACH PROGRAMS

_		N/A	Α	С	U
A. FTMD, DH	The trauma service shall have written evidence documenting active involvement in at least two public education programs (one general and one pediatric) and two public trauma prevention programs (one general and one pediatric) per calendar year.				
FTMD, DH	1. Injury prevention programs shall be chosen based upon the epidemiologic needs of the community served by the trauma center.				
FTMD, DH	2. Hospital-specific evaluation methods shall be implemented to determine the effectiveness of the injury prevention programs.				
B. TS,EP TN	Consultations or feedback to EMS or the transferring hospital regarding any patient admitted to the intensive care unit when performance improvement issues related to prehospital care are applicable.				
C. TS,EP TN	24-hour availability of telephone consultation with members of the hospital's trauma team and physicians of the community and outlying areas. Scheduled on-site consultations with members of the hospital's trauma team shall be available with physicians of the community and outlying areas. Evidence of these consultations shall be documented.				
D. TS,EP TN	Evidence of contact with referring physicians regarding patient transfers shall be documented in all cases.				
DEFIC	CIENCIES:				
COM	MENTS:				

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STANDARD XVII -- OUTREACH PROGRAMS (continued)

				N/A	Α	С	U
E. TS	year educa hospi	to provi ation, a ital. Th	a minimum of 10 multidisciplinary conferences conducted per ide trauma case review for the purpose of case management, and correction of system issues for both prehospital and in- be case review must include at least one adult and one pediatric ent when appropriate.				
	1.	The	conference shall include the review of the following:				
TS		a.	The local and regional emergency medical service system.				
TS		b.	Individual case management.				
TS		C.	The trauma center or system.				
TS		d.	Solution of specific problems, including organ procurement and donation.				
TS		e.	Trauma care education.				
	2.		der to be considered a multidisciplinary conference there shall t least one representative from the following departments:				
TS		a.	Trauma service.				
тѕ		b.	Emergency department.				
TS		C.	Neurosurgery.				
TS		d.	Orthopedics.				
TS		e.	Nursing.				
TS		f.	Social work.				
TS		g.	Rehabilitation medicine.				
TS		h.	Laboratory.				
TS		i.	X-ray.				
TS		j.	Prehospital providers.				
TS		k.	Hospital administration.				
DEF	CIENCI	ES:					

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STANDARD XVIII -- QUALITY MANAGEMENT

auma qua bllowing: . The adm	lence on file indicating the governing body's commitment to the lity improvement program. This evidence shall include the trauma service medical director must have authority and				
adm	•				ļ
of c	inistrative support to implement changes related to the process are and outcomes across multiple specialty departments.				
pop trau ider and	ma program's monitoring and evaluation process must show tification of process/outcome issues, corrective actions taken, loop closure, when applicable, for evaluations of the desired				
nproveme	nt program. This evidence shall include procedures and				
dire	ctor and trauma program manager shall review all trauma patient				
a.	All trauma alert cases admitted to the hospital (patients identified by the state trauma scorecard criteria in Rules 64E-2.017 and 64E-2.0175, Florida Administrative Code).				
b.	Critical or intensive care unit admissions for traumatic injury.				
С.	All operating room admissions for traumatic injury (excluding same day discharges or isolated, non-life threatening orthopedic injuries).				
d.	Any critical trauma transfer into or out of the hospital.				
e.	All in-hospital traumatic deaths, including deaths in the trauma resuscitation area.				
/	popul trau iden and effer ritten evic provemen echanism Pop direc recc a. b. c.	 population that is integrated into the hospital-wide program. The trauma program's monitoring and evaluation process must show identification of process/outcome issues, corrective actions taken, and loop closure, when applicable, for evaluations of the desired effects. Tritten evidence on file indicating an active and effective trauma quality provement program. This evidence shall include procedures and echanisms for at least the following: Population of cases for review The trauma service medical director and trauma program manager shall review all trauma patient records from the following categories: a. All trauma alert cases admitted to the hospital (patients identified by the state trauma scorecard criteria in Rules 64E-2.017 and 64E-2.0175, Florida Administrative Code). b. Critical or intensive care unit admissions for traumatic injury. c. All operating room admissions for traumatic injury (excluding same day discharges or isolated, non-life threatening orthopedic injuries). d. Any critical trauma transfer into or out of the hospital. e. All in-hospital traumatic deaths, including deaths in the trauma resuscitation area. 	population that is integrated into the hospital-wide program. The trauma program's monitoring and evaluation process must show identification of process/outcome issues, corrective actions taken, and loop closure, when applicable, for evaluations of the desired effects. Iritten evidence on file indicating an active and effective trauma quality provement program. This evidence shall include procedures and echanisms for at least the following: Population of cases for review The trauma service medical director and trauma program manager shall review all trauma patient records from the following categories: a. All trauma alert cases admitted to the hospital (patients identified by the state trauma scorecard criteria in Rules 64E-2.017 and 64E-2.0175, Florida Administrative Code). b. Critical or intensive care unit admissions for traumatic injury. c. All operating room admissions for traumatic injury (excluding same day discharges or isolated, non-life threatening orthopedic injuries). d. Any critical trauma transfer into or out of the hospital. e. All in-hospital traumatic deaths, including deaths in the trauma resuscitation area.	population that is integrated into the hospital-wide program. The trauma program's monitoring and evaluation process must show identification of process/outcome issues, corrective actions taken, and loop closure, when applicable, for evaluations of the desired effects. iritten evidence on file indicating an active and effective trauma quality provement program. This evidence shall include procedures and echanisms for at least the following: Population of cases for review The trauma service medical director and trauma program manager shall review all trauma patient records from the following categories: a. All trauma alert cases admitted to the hospital (patients identified by the state trauma scorecard criteria in Rules 64E-2.017 and 64E-2.0175, Florida Administrative Code). b. Critical or intensive care unit admissions for traumatic injury. c. All operating room admissions for traumatic injury (excluding same day discharges or isolated, non-life threatening orthopedic injuries). d. Any critical trauma transfer into or out of the hospital. e. All in-hospital traumatic deaths, including deaths in the trauma resuscitation area.	population that is integrated into the hospital-wide program. The trauma program's monitoring and evaluation process must show identification of process/outcome issues, corrective actions taken, and loop closure, when applicable, for evaluations of the desired effects. iritten evidence on file indicating an active and effective trauma quality provement program. This evidence shall include procedures and echanisms for at least the following: Population of cases for review The trauma service medical director and trauma program manager shall review all trauma patient records from the following categories: a. All trauma alert cases admitted to the hospital (patients identified by the state trauma scorecard criteria in Rules 64E-2.017 and 64E-2.0175, Florida Administrative Code). b. Critical or intensive care unit admissions for traumatic injury. c. All operating room admissions for traumatic injury (excluding same day discharges or isolated, non-life threatening orthopedic injuries). d. Any critical trauma transfer into or out of the hospital. e. All in-hospital traumatic deaths, including deaths in the trauma resuscitation area.

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STANDARD XVIII -- QUALITY MANAGEMENT (continued)

				N/A	Α	С	U
	2.		ess/outcome indicators The facility shall monitor a total of ten ators relevant to process or outcome measures.				
		a.	The facility must monitor four state-required indicators relevant to process and outcome.				
DH,TS TN			1. All deaths				
DH,TS TN			 Any trauma patient with an unplanned re-admittance to the hospital within thirty days of discharge. 				
DH,TS TN			3. Any trauma patient readmitted to ICU, or an unplanned admission to the ICU from a medical/surgical unit.				
DH,TS TN			4. Percentage of all traumatic C1, C2 and/or C3 spinal cord injury patients permanently dependent on mechanical ventilator support who were admitted or transferred to the ICU during the quarter or who remained in the ICU from the previous quarter; who received the diaphragm pacer surgery and were discharged to a less restrictive facility, home or home-health. (See Note #8 for eligibility criteria for the Diaphragm Pacer Program)				
dh,ts Tn		b.	The facility must identify and monitor six indicators relevant to its respective facility for a period of six months and submit these indicators to the Department of Health.				
	CIENCIE						
COMI	MENTS	:					

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 Committee shall review and discuss each case referred by the trauma medical director or trauma program manager. The members shall recommend or take action on those cases where the committee finds opportunities for improving performance, system process, or outcomes. (The trauma medical director is responsible for monitoring the outcome of each case referred to persons or committees outside the TQM committee. The medical director is also responsible for providing a comprehensive report to the TQM committee regarding those referrals.) DH,TS 5. Resolution and follow-up The TQM committee shall evaluate and document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient outcomes. DEFICIENCIES: 	 Deficiency of the transmission of	TN DH,TS	3.	program manager shall evaluate each case identified by one of the indicators in Standard XVIII.B.2.a and b to determine whether the case should be referred to the TQM committee for further review.		
IN committee shall review and discuss each case referred by the trauma medical director or trauma program manager. The members shall recommend or take action on those cases where the committee finds opportunities for improving performance, system process, or outcomes. (The trauma medical director is responsible for monitoring the outcome of each case referred to persons or committees outside the TQM committee. The medical director is also responsible for providing a comprehensive report to the TQM committee regarding those referrals.) DH,TS 5. Resolution and follow-up The TQM committee shall evaluate and document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient outcomes. DEFICIENCIES:	 Committee shall review and discuss each case referred by the trauma medical director or trauma program manager. The members shall recommend or take action on those cases where the committee finds opportunities for improving performance, system process, or outcomes. (The trauma medical director is responsible for monitoring the outcome of each case referred to persons or committees outside the TQM committee. The medical director is also responsible for providing a comprehensive report to the TQM committee regarding those referrals.) DH,TS 5. Resolution and follow-up The TQM committee shall evaluate and document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient outcomes. DEFICIENCIES: 					
™ document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient outcomes. DEFICIENCIES:	TN document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient outcomes.		4.	committee shall review and discuss each case referred by the trauma medical director or trauma program manager. The members shall recommend or take action on those cases where the committee finds opportunities for improving performance, system process, or outcomes. (The trauma medical director is responsible for monitoring the outcome of each case referred to persons or committees outside the TQM committee. The medical director is also responsible for providing a comprehensive report to the TQM		
		DH,TS TN	5.	document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient		
	COMMENTS:	TN		document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient outcomes.		
COMMENTS:		COM	MENTS	S:		

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STANDARD XVIII -- QUALITY MANAGEMENT (continued)

		N/A	Α	С	U
C. TS,TN DH	The TQM committee shall meet a minimum of 10 times per year to review trauma cases referred by the trauma service medical director or trauma program manager, including cases identified by the indicators listed in and other cases with quality of care concerns, systems issues, morbidity, or mortality.				
DFFIC					<u> </u>
COM	MENTS:				

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STANDARD XVIII -- QUALITY MANAGEMENT (continued)

uma quality management committee shall be composed of at least the ig persons: Trauma service medical director (as chairperson). Trauma program manager. Medical director of emergency department or emergency physician designee. Trauma surgeon, other than the trauma service medical director.				
Trauma program manager. Medical director of emergency department or emergency physician designee. Trauma surgeon, other than the trauma service medical director.				
Medical director of emergency department or emergency physician designee. Trauma surgeon, other than the trauma service medical director.				
designee. Trauma surgeon, other than the trauma service medical director.				
Runaical appoint other than trauma surragen, such as neurosurragen				
Surgical specialist other than trauma surgeon, such as neurosurgeon, orthopedic surgeon, and pediatric surgeon.				
Representative from administration.				
Operating room nursing director or designee.				
Emergency department nursing director or designee.				
ntensive care unit nursing director or designee.				
be another representative from the trauma service in addition to the medical director) at the trauma quality management committee				
	Stropedic surgeon, and pediatric surgeon. Representative from administration. Operating room nursing director or designee. Emergency department nursing director or designee. Intensive care unit nursing director or designee. shall be at least one of the above committee members (there must be another representative from the trauma service in addition to the medical director) at the trauma quality management committee gs. S:	Representative from administration. Operating room nursing director or designee. Emergency department nursing director or designee. Intensive care unit nursing director or designee. shall be at least one of the above committee members (there must be another representative from the trauma service in addition to the medical director) at the trauma quality management committee gs.	Representative from administration. Image: Comparison of the signed is a comparison of the sis a comparison of the sis a comparison of the s	Representative from administration.

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STANDARD XVIII -- QUALITY MANAGEMENT (continued)

F.	meeti minut	auma service shall maintain written minutes of all TQM committee ngs for at least three years. The trauma service shall have these es available for the Department of Health to review upon request. The es shall include all items specified in the standards document.	N/A	Α	С	U
FTMD TS DH	1.	The names of attendees.				
FTMD TS DH	2.	The subject matter discussed, including an analysis of all issues related to each case referred by the trauma service medical director or the trauma program manager, cases involving morbidity or mortality determining whether they were disease related or provider related and the preventability, and cases with other quality of care concerns.				
FTMD TS DH	3.	A summary of cases with variations not referred to the committee.				
FTMD TS DH	4.	A description of committee discussion of cases not requiring action, with an explanation for each decision.				
FTMD TS DH	5.	Any action taken to resolve problems or improve patient care and outcomes.				
FTMD TS DH	6.	Evidence that the committee evaluated the effectiveness of any action taken to resolve problems or improve patient care and outcomes.				
DEFIC	CIENCI	ES:				

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STANDARD XVIII -- QUALITY MANAGEMENT (continued)

G.	quart subm	terly rep nitted at	quality management committee shall prepare and submit a port to the Department of Health. The reports shall be t the end of each calendar year quarter by the 15 th of the ving the end of the previous quarter. The report shall:	N/A	A	С	U
	1.	quali woul	every case selected for corrective action by the trauma ty management committee (do not include information that d identify the patient) and shall provide the following rding each case:				
DH		a.	Hospital case number.				
DH		b.	Description of questionable care.				
DH		C.	Corrective action taken. If corrective action is not necessary, an explanation is required.				
DH	2.		he clinical indicators with the number of patients per ter, number identified, and committee involvement.				
DH	3.		all the complications experienced by trauma patients in the ter by number of patients and number of total patients in the ter.				
DEFI		IES:		4			

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DH 3. Injury severity score? DH 4. Discharge diagnosis(es) (narrative description of top 10 minimum)?		
DH2.Mechanism of injury?DH3.Injury severity score?DH4.Discharge diagnosis(es) (narrative description of top 10 minimum)?		
DH 3. Injury severity score? DH 4. Discharge diagnosis(es) (narrative description of top 10 minimum)?		
DH 4. Discharge diagnosis(es) (narrative description of top 10 minimum)?		
minimum)?		
DH 5. Discharge data?		
DH 6. Case criterion (a) from section B.1.a-e?		
DH 7. Applicable indicators that identified cases for review (B.2.a and b)?		
DH 8. Quality improvement review data?		
DH 9. Is there a quality improvement review disposition (for example, pending, acceptable, or unacceptable, with preventable, unpreventable, or possibly preventable for all deaths)?		
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STANDARD XIX -- TRAUMA RESEARCH

			N/A	Α	С	U
Α.		e trauma service shall conduct ongoing clinical and research programs in uma patient care and a Level I trauma center program must have:				
1 тs	wor auti Tra wor invo orth	ree articles published in a 3-year period. These articles must result from rk related to the trauma center. Of the three articles, at least 1 must be hored or coauthored by members of the general surgery trauma team. numa-related articles co-authored by members of other disciplines or rk done in collaboration with other trauma centers; sub-specialists plved in trauma care for examples: neurosurgery, emergency medicine, nopedics, radiology, anesthesia, and rehabilitation; and participation in lticenter investigations may be included in the remainder, and				
2		the 7 following trauma related scholarly activities, 4 must be nonstrated:				
TS	а	Leadership in major trauma organizations. There must be evidence of this leadership for a Level I organization. Evidence includes membership in trauma committees of any of the regional and national trauma organizations such as the American Association for the Surgery of Trauma (AAST), Western Trauma Association, Eastern Association for the Surgery of Trauma, and the ACS Committee on Trauma.				
TS	b	Peer-reviewed funding for trauma research. There should be demonstrated evidence of funding of the center from a recognized government or private agency or organization.				
TS	С	Evidence of dissemination of knowledge to include review articles, book chapters, technical documents, Web-based publications, editorial comments, training manuals, and trauma-related course material.				
TS	d	Display of scholarly application of knowledge as evidenced by case reports or reports of clinical series in journals included in MEDLINE.				
TS	е	Participation as a visiting professor or invited lecturer at national or regional trauma conferences.				
TS	f	Support of resident participation in institution-focused scholarly activity, including laboratory experiences, clinical trials, or resident trauma paper competitions at the state, regional, or national level.				
TS	g	Mentorship of residents and fellows, as evidenced by the development of a trauma fellowship program or successful matriculation of graduating residents into trauma fellowship programs.				

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STANDARD XIX TRAUMA RESEARCH (Continued)		N/A	Α	С	U	
В. тs	dem	The institution will have a designated trauma research director and demonstrate current involvement in and commitment to research in adult and pediatric trauma care.				
C.		hods of demonstrating the trauma center's involvement and commitment include, but not be limited to the following:				
TS	1.	Commitment of resources.				
TS	2.	Outcome, mechanism, or process-related studies.				
TS	3.	Regular meetings of research group.				
TS	4.	Funded studies.				
TS	5.	Effort, publications in peer review journal or regional or national presentations.				
TS	6.	Multidisciplinary studies.				
TS	7.	Concluded studies.				
TS	8.	Proposals reviewed by Institutional Review Board.				
DEFI	CIENO	CIES:				

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STANDARD XX – DISASTER PLANNING AND MANAGEMENT

		N/A	Α	С	U
Α.	The trauma center shall meet the disaster related requirements pursuant to				
DH,TS	s. 395.1055(1)c, F.S., and the Agency for Health Care Administration,				
EP	Comprehensive Emergency Management Plan, Chapter 59A-3.078, Florida				
	Administrative Code, and JACHO Standards.				
DEELC					
DEFIC					
COMN	IENTS:				

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SITE SURVEYOR OVERALL EVALUATION OF COMPLIANCE WITH STATE-APPROVED TRAUMA CENTER STANDARDS

NAME OF FACILITY:

ACCEPTABLE	
ACCEPTABLE WITH CORRECTIONS	
UNACCEPTABLE	

DEFICIENCIES / COMMENTS:

SURVEYOR'S NAME:
DATE:
SURVEYOR'S SIGNATURE:

DATE: _____