



**IDAHO TIME SENSITIVE
EMERGENCY SYSTEM**
TRAUMA | STROKE | STEMI

Level V Trauma Center

Application & Resource Tool Kit

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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TSE Frequently Asked Questions

Why a TSE program?

The 2014 Idaho Legislature approved and funded a plan to develop a statewide Time Sensitive Emergency (TSE) system of care that addresses three of the top five causes of deaths in Idaho: trauma, stroke, and heart attack. Studies show that organized systems of care improve patient outcomes, reduce the frequency of preventable death, and improve the quality of life of the patient.

How does the TSE program work?

The Idaho Department of Health and Welfare provides oversight and administrative support for the day-to-day operation of the program.

A governor-appointed TSE Council made up of health care providers, EMS agencies, and administrators of hospitals representing both urban and rural populations is responsible for establishing Rules and Standards for the TSE system. The Council is the statewide governing authority of the system.

The state has been divided into six regions. Each of these has a Regional TSE Committee made up of EMS providers, hospital providers and administrators, and public health agencies. The regional committees will be the venue in which a wide variety of work is conducted such as education, technical assistance, coordination, and quality improvement. The Regional TSE Committees will have the ability to establish guidelines that best serve their specific community, in addition to providing a feedback loop for EMS and hospital providers.

What guiding principles are the foundation of the TSE system?

- Apply nationally accepted evidence-based practices to time sensitive emergencies;
- Ensure that standards are adaptable to all facilities wishing to participate;
- Ensure that designated centers institute a practiced, systematic approach to time sensitive emergencies;
- Reduce morbidity and mortality from time sensitive emergencies;
- Design an inclusive system for time sensitive emergencies;
- Participation is voluntary; and
- Data are collected and analyzed to measure the effectiveness of the system.

How often does a center need to be verified?

Every three years.

How much does it cost to be verified and designated?

Verification is done once every three years. The on-site survey fee is \$1,500 and must be submitted with the application. Designation is valid for three years. The designation fee may be paid in three annual payments of \$1,000 or in one payment of \$3,000.

Whom do I contact if I have questions about the application process?

Idaho Time Sensitive Emergency Program

P.O. Box 83720
Boise, ID 83720-0036
tse@dhw.idaho.gov
<http://tse.idaho.gov/>

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Please do not hesitate to contact us with any questions or concerns regarding the application process. We would be happy to help you in any way we can. We may also be able to direct you to additional resources to assist you in meeting these standards.

Application Process

To apply for designation as a Level V Trauma Center in Idaho:

1. Complete and print the application. Submit one application per facility. A completed application includes:
 - A. Facility and Personnel Profile;
 - B. Certification Statement;
 - C. Pre-Survey Questionnaire; and
 - D. Required Attachments
2. Obtain the required signatures on the Certification Statement.
3. Put the application in a binder with labeled, tabbed dividers between each section: Profile, Certification, PSQ (Pre-Survey Questionnaire), and Attachments.
4. Mail the completed application and on-site survey fee (\$1,500) to:
[Make checks payable to: Bureau of EMS and Preparedness](#)

Bureau of EMS and Preparedness
Time Sensitive Emergency Program
P.O. Box 83720
Boise, ID 83720-0036

Or for FedEx, UPS, etc.:
2224 E. Old Penitentiary Road
Boise, ID 83712

TSE Program staff will notify you within 10 business days of receipt of the application and confirm that the application is complete.

Application for Level V Trauma Center Designation

A. Hospital and Personnel Profile

Hospital Name:		
Mailing Address:	City:	Zip:
Physical Address:	City:	Zip:
Phone:	County:	
Application Contact and Title:		
Phone:	E-Mail:	

Hospital Administrator/Chief Executive Officer:	
Phone:	E-Mail:
Trauma Program Manager:	
Phone:	E-Mail:
Trauma Medical Director:	
Phone:	E-Mail:
Emergency Department Medical Director:	
Phone:	E-Mail:
Emergency Department Nursing Director:	
Phone:	E-Mail:

B. Certification Statement

I, _____ (CEO/COO), on behalf of _____ (hospital), voluntarily agree to participate in the Idaho Time Sensitive Emergency system as a Level V Trauma Center. We will work with emergency medical services and other hospitals in our area to streamline triage and transport of trauma patients and participate in our Regional Time Sensitive Emergency Committee.

I certify that:

- A. The information and documentation provided in this application is true and accurate.
- B. The facility meets the State of Idaho criteria to be designated as a Level V Trauma Center.
- C. We will participate in the Idaho TSE Registry; and
- D. We will notify the Time Sensitive Emergency Program Manager immediately if we are unable to provide the level of trauma service we have committed to in this application.

Chair, Governing Entity (Hospital Board)

Date

Chief Executive Officer

Date

Trauma Medical Director

Date

Trauma Program Manager

Date

C. Pre-Survey Questionnaire

Answer every question. If you require additional space, please include a separate sheet. Once complete, print and sign the application (Certification Statement). Label all attachments and place them in the "Attachments" section. Do not hesitate to contact the TSE program staff if you have any questions regarding your application. (208) 334-4904

Criteria labeled as "Desired" will not effect your verification. If any "Essential" criteria are deficient at the time of the on-site survey, the hospital will not be verified.

1. Trauma System

Time Sensitive Emergencies (TSE)

1.1 Is your staff involved in regional trauma system planning, development and operation? **Essential**

Yes No

Explain:

Center Mission

1.2 Attach a copy of the current resolution supporting the trauma center from the medical staff (See sample on page 24). Label as "Attachment #1". **Essential**

1.3 Attach a copy of the current resolution supporting the trauma center from the hospital board (See sample on page 25). Label as "Attachment #2". **Essential**

1.4 Are you a health care facility (as defined in section 10 of the TSE Rules) with the commitment, medical staff, personnel, and training necessary to provide initial care and stabilization of the trauma patient?

Essential

Yes

No

Explain:

2. Description of Trauma Center

Description of the Trauma Center

2.1 Is your trauma program empowered to address issues that involve multiple disciplines? Essential

Yes

No

Explain:

2.2 Can you provide initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and assure maximum stabilization prior to referral to an appropriate higher level of care?
Essential Yes No
Explain:

Trauma Leadership

Trauma Medical Director

2.3 Do you have a Trauma Medical Director with the authority and administrative support to lead the program (See sample job description on page 26)? **Essential** Yes No
Attach a copy of the Trauma Medical Director job description. Label as "Attachment #3".

2.4 Is your Trauma Medical Director current in ATLS? **Essential** Yes No
Attach supporting documentation. Label as "Attachment #4".

2.5 Does your Trauma Medical Director maintain personal involvement in patient care, staff education, and professional organizations? **Essential** Yes No
Explain:

2.6 Are your Trauma Team providers reviewed by the Trauma Medical Director and credentialed by the medical staff and governing board? **Essential** Yes No
Explain:

2.7 Is your Trauma Medical Director responsible for developing and directing the quality improvement program (PIPS)? **Essential** Yes No
Explain:

2.8 Is your Trauma Medical Director accountable for all trauma care and does he or she exercise administrative authority for the trauma program? **Essential** Yes No
Explain:

2.9 Does your Trauma Medical Director participate in at least 50% of the internal QI process? **Essential**

Yes No

Attach supporting documentation. Label as "Attachment #5".

Trauma Program Manager

2.10 Do you have a Trauma Program Manager? **Essential**

Yes No

Does he or she show evidence of educational preparation and clinical experience caring for injured patients (See sample job description on page 28)?

Yes No

Attach a copy of the Trauma Program Manager job description. Label as "Attachment #6".

Explain:

2.11 Is your Trauma Program Manager responsible for the use of trauma registry data for quality improvement and trauma education? **Essential**

Yes No

Explain:

2.12 Does your Trauma Program Manager work with the Trauma Medical Director to address the multidisciplinary needs of the trauma program? **Essential** Yes No
Explain:

2.13 Does the Trauma Program Manager serve as a liaison to local EMS agencies and accepting centers? **Essential** Yes No

3. Clinical Functions

3.1 Does your facility clearly define the criteria for trauma activation (See sample on page 30)? **Desired** Yes No
Explain:

3.2 During the hours of operation, is your facility staffed to ensure immediate and appropriate care to trauma patients? **Essential** Yes No

Explain:

3.3 Do you have written protocols to determine which types of patients are admitted and which are transferred (See example on page 31)? **Essential** Yes No

Attach supporting documentation. Label as "Attachment #7".

3.4 As the local trauma authority do you assume the responsibility for providing training for prehospital and hospital-based providers? **Desired** Yes No

Explain:

3.5 Do you have established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient? **Essential** Yes No

Trauma Team

- 3.6 Do you have policies and procedures that describe the roles of all personnel on the Trauma Team?
Essential Yes No
- 3.7 At a minimum, does your Trauma Team consist of:
- a. A physician or midlevel provider? **Essential** Yes No
 - b. A registered nurse or licensed practical nurse? **Essential** Yes No
- 3.8 Do all Trauma Team members participate in match criteria? **Essential** Yes No
- Do you have supporting documentation? Yes No
- 3.9 Are all Trauma Team physicians and midlevel providers credentialed by the medical staff and governing board? **Essential** Yes No
- Explain:

Emergency Department

- 3.10 During the hours of operation, do you have health care providers (MD, DO, FNP, PA) available? **Essential** Yes No
- Is the provider on-site within 30 minutes of patient arrival with an 80% achievement rate? Yes No
- Do you have supporting documentation? Yes No
- 3.11 During the hours of operation, is your facility staffed by RN/LPNs at levels necessary to meet the needs of the trauma patient? **Essential** Yes No
- Do you have supporting documentation? Yes No

3.12 Do your trauma providers have documentation of training and knowledge of care for the trauma patient? Essential	Yes	No
Do you have supporting documentation?	Yes	No

3.13 Addressed in 3.12 **Essential**

Collaborative Clinical Services

Radiology

3.14 Do you have a written policy to delineate the availability of CT services to the trauma patient? Essential	Yes	No
Do you have supporting documentation?	Yes	No

Other Surgical Specialists

3.15 Do you have a posted list of specialists who are promptly available from inside and outside your facility? Essential	Yes	No
Do you have supporting documentation?	Yes	No

5. Interhospital Transfer

5.1 Is your decision to transfer an injured patient to a specialty care facility in an acute situation based solely on the needs of the patient? Essential	Yes	No
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Attach supporting documentation. Label as "Attachment #8".

5.2 Do you have transfer protocols in place with higher level trauma centers (See sample on page 32)? Essential	Yes	No
--	-----	----

Do you have transfer protocols in place with specialty referral centers (e.g. burn, pediatric, and rehabilitation centers)?	Yes	No
---	-----	----

Attach a list of protocols and/or agreements. Label as "Attachment #9".

5.3 Is there a mechanism for direct physician-to-physician contact for arranging patient transfer? **Essential**

Yes No

Explain:

5.4 Addressed in 5.2. **Desired**

5.5 Do you have guidelines addressing which patients (including pediatric patients) should be transferred and the safe transport of those patients? **Essential**

Yes No

Attach supporting documentation. Label as "Attachment #10".

6. PIPS

Visit the TSE website at <http://tse.idaho.gov/> for a downloadable copy of *Developing a PIPS Program*.

6.1 Do you have a PIPS program to ensure optimal care and continuous improvement of care? **Essential**

Yes No

Note: This criteria can be fulfilled by participation in regional QI case reviews.

Explain:

6.5 Does your PIPS program have audit filters to review and improve pediatric and adult patient care?
Desired Yes No
Attach a list of the audit filters. Label as "Attachment #11".

6.6 Do you use the registry to support your PIPS program? **Essential** Yes No
Explain:

6.7 Are deaths categorized as unanticipated mortality with opportunity for improvement, anticipated mortality with opportunity for improvement, or mortality without opportunity for improvement?
Essential Yes No

6.8 Does your PIPS program work with receiving facilities to provide and obtain feedback on all transferred patients? **Essential** Yes No
Explain:

6.9 Do you perform a PIPS review of all admissions and transfers? **Essential** Yes No
Explain:

6.10 Are the results of analysis documented and do they define corrective strategies? **Desired** Yes No
Explain:

6.11 Does your facilities registered nursing staff participate in the internal QI program? **Essential** Yes No
Explain:

6.12 Do you have a system to notify dispatch and EMS agencies when on divert status (See sample on page 34)? **Essential** Yes No
 Attach supporting documentation. Label as "Attachment #12".

- 6.13 Do you have a functioning internal QI process that:
- a. Has clearly stated goals and objectives? **Essential** Yes No
 - b. Develops standards of care? **Essential** Yes No
 - c. Has a process to train trauma providers? **Desired** Yes No
 - d. Has explicit quality indicators and filters? **Essential** Yes No
 - e. Has a peer review process that includes prehospital providers? **Essential** Yes No
 - f. Has a method for comparing patient outcomes with computed survival probability? **Essential** Yes No
 - g. Evaluates autopsy information on all trauma deaths? **Desired** Yes No

8. TSE Registry

8.1 Is trauma registry data collected, analyzed, and used to support the PIPS program? **Essential** Yes No
 Explain:

8.2 Is your trauma data submitted to the TSE Registry (Idaho Trauma Registry) within 180 days of treatment at least 80% of the time? **Essential** Yes No
 Attach a letter from the TSE Registry (Idaho Trauma Registry) supporting your answer. Label as "Attachment #13".

8.3 Do you have a process in place to verify that TSE Registry data is accurate and valid? **Essential**

Yes

No

Explain:

8.4 Does the trauma program ensure that registry data confidentiality measures are in place.? **Essential**

Yes

No

Explain:

9. Outreach & Education

9.1 Do you support public education and awareness? **Essential**

Yes

No

Attach supporting documentation. Label as "Attachment #14".

10. Prevention

10.1 Do you participate in injury prevention? **Essential** Yes No

Attach a list of all activities in the past 3 months. Label as "Attachment #15".

10.2 Do you base injury prevention activities on local data? **Desired** Yes No

Explain:

11. Disaster Planning and Management

11.1 Do you have a disaster plan described in your Disaster Manual (See page 36 for *Creating a Disaster Plan*)? **Essential** Yes No

Sample Medical Staff Resolution

WHEREAS, traumatic injury is the leading cause of death for Idahoans between the ages of 1 and 44 years; and

WHEREAS, [HOSPITAL] strives to provide optimal trauma care; and

WHEREAS, treatment at a trauma hospital that participates in a standardized system of trauma care can significantly increase the chance of survival for victims of serious trauma; and

WHEREAS, participation in the Idaho Time Sensitive Emergency System will result in an organized and timely response to patients' needs, a more immediate determination of patients' definitive care requirements, improved patient care through the development of the hospital's performance improvement program and an assurance that those caring for trauma patients are educationally prepared:

THEREFORE; BE IT RESOLVED that the medical staff of [HOSPITAL] resolves to support the hospital's trauma program and to participate with initiatives in the furtherance of the standards published by the Idaho Time Sensitive Emergency System for Level V Trauma Centers.

IN WITNESS THEREOF, I have hereunto subscribed my name this [DAY] day of [MONTH], [YEAR].

Chief of Staff

Sample Hospital Board Resolution

WHEREAS, traumatic injury is the leading cause of death for Idahoans between the ages of 1 and 44 years; and

WHEREAS, [HOSPITAL] strives to provide optimal trauma care; and

WHEREAS, treatment at a trauma hospital that participates in a standardized system of trauma care can significantly increase the chance of survival for victims of serious trauma; and

WHEREAS, participation in the Idaho Time Sensitive Emergency System will result in an organized and timely response to patients' needs, a more immediate determination of patients' definitive care requirements, improved patient care through the development of the hospital's performance improvement program and an assurance that those caring for trauma patients are educationally prepared:

THEREFORE; BE IT RESOLVED that the board of directors of [HOSPITAL] resolve to provide the resources necessary to achieve and sustain a Level V Trauma Center designation.

IN WITNESS THEREOF, I have hereunto subscribed my name this [DAY] day of [MONTH], [YEAR].

Chairman of the Board

Sample Trauma Program Medical Director Job Description

Job Title: Trauma Program Medical Director

Qualifications:

1. MD, PA or NP.
2. Member in good standing of the hospital or clinic medical staff.
3. Currently certified in Advanced Trauma Life Support (ATLS).
4. Three years clinical experience in emergency/trauma care.
5. Two years administrative experience.
6. Ability to establish and maintain effective interpersonal relationships.
7. Ability to accept and implement change.
8. Ability to solve problems and make decisions.
9. Demonstrated history of positive relations with colleagues, support staff, hospital-based providers, administrators, and patients.

Nature and Scope: The Trauma Medical Director is responsible for the ongoing development, growth and oversight/authority of the Trauma Program. The Trauma Medical Director is responsible for promoting high standards of practice through development of trauma policies, protocols and practice guidelines; participating in performance improvement monitoring; and oversee staff education. He/she has authority to act on all trauma performance improvement and administrative issues and critically review trauma deaths and complications that occur within the center. Decisions affecting the care of trauma patients will not be made without the knowledge, input and approval of the Trauma Medical Director.

Principal Duties and Responsibilities:

Administration:

- Participate in the development and writing of trauma policies, protocols and practice guidelines.
- Implement all trauma program policies and procedures as they pertain to patient care.
- Organize, direct and integrate the trauma program with all other departments and services within the hospital or clinic.
- Promote a cooperative and collaborative working environment among the clinical disciplines involved in trauma care.
- Maintain an effective working relationship with the medical staff, trauma service staff, administration and other departments.
- Assess need for equipment, supplies, and budget.
- Assist the Trauma Program Coordinator in developing and meeting the trauma program budgetary goals.
- Oversee, participate in, and develop projects that ensure the cost-effectiveness of care provided by physicians and hospital.

Program Initiatives:

- Develop and provide input on the development and maintenance of practice guidelines, policies, and methodologies for trauma care.
- Participate in site review by regulatory agencies.
- Organize, direct and implement departmental practices to assure continued compliance with applicable laws including the guidelines established by the Idaho Time Sensitive Emergency System.
- Demonstrate positive interpersonal relationship with colleagues, referral MDs, hospital personnel, and patients/families in order to achieve maximum operational effectiveness and customer satisfaction.
- Assure transfer agreements are in place and in good standing; maintain relationship with receiving

facilities; and foster collaborative relationships.

- Make appropriate referrals for specialty services and communicate regularly with referring physicians as appropriate.
- Participate in regional activities affecting the trauma program.
- Attend local and national meetings and conferences to remain current regarding issues relevant to the performance of duties.
- Demonstrate consistent, efficient, cost effective, and quality trauma care at all times.
- Participate in trauma patient/family satisfaction projects as developed by hospital.

Performance Improvement:

- Determine and implement PI activities appropriate to the trauma program.
- Oversee the trauma PI program and participate in other quality initiatives that deal with the care of injured patients.
- Review and investigate trauma PI in collaboration with the Trauma Program Manager and refer to the appropriate committees.
- Monitor compliance with trauma treatment guidelines, policies and protocols.
- Assure that the quality and appropriateness of patient care are monitored and evaluated and that appropriate actions based on findings are taken on a consistent basis.
- Report quality of care issues promptly to appropriate individuals, including Trauma Program Manager and hospital administration.
- Identify and correct deficiencies in trauma care policies, guidelines and protocols.
- Consult with appropriate medical staff and administration regarding quality care issues and adverse outcomes; identify areas to improve patient care.
- Assist the Trauma Program Manager in evaluating the effectiveness of corrective actions resulting from PI processes.

Clinical Education:

- Support the requirements for trauma CME by participating and assisting in the education and training of center personnel physicians and specialists.
- Provide education for hospital staff regarding trauma program policies and appropriate medical practices.

Community Outreach:

- Maintain relations with community organizations whose activities relate to trauma care and injury prevention.
- Participate in hospital outreach activities as requested by administration.
- Develop and participate in trauma community education and injury prevention activities.
- Function as a liaison to other centers within the region.

Sample Trauma Program Manager Job Description

POSITION: *Trauma Program Manager*

REPORTS TO: *Trauma Medical Director*

KEY RESPONSIBILITIES:

Provide leadership and support to trauma team and trauma medical director.

Coordinate the allocation of unit resources and nursing staff.

Support a positive, professional working environment.

EDUCATION/LICENSURE:

Licensed and currently registered as an RN or LPN in the state of Idaho.

Must maintain competency and continuing education in area of specialization and in professional practice.

Has taken and passed ACLS and TNCC at least once.

QUALIFICATIONS:

3-5 years of clinical emergency department experience is required.

PHYSICAL DEMANDS AND WORK REQUIREMENTS:

Demonstrate good oral and written communication skills.

Able to care for patients with infectious diseases.

Ability to sit for 3-5 hours per day.

Able to stand for 3-5 hours per day.

Ability to walk for 3-5 hours day.

Behavioral Expectations

Adhere to facility standards for courtesy, respect, privacy, communication, responsiveness, teamwork, professionalism, and safety.

Embrace organization's mission, vision and values.

Act as a role model to staff.

Patient Care

Coordinate with physicians, nurses, and other hospital staff to evaluate and address specific patient care issues.

Assess the needs for policies procedures, guidelines, supplies and equipment relating to the care of trauma patients in coordination with the Trauma Medical Director, hospital administration and clinicians.

Participate in community trauma education and prevention programs.

Participate in case review.

Responsible for trauma education of nursing staff.

Serve as an internal resource for staff in all departments to network in order to provide high quality trauma patient care.

Act as an extended liaison for EMS agencies and the community.

Develop inter-facility systems with other providers through procedure consistency.

Participate in trauma care at the community, state, and/or national levels.

Performance Implementation/Improvement

Assist the Trauma Medical Director and hospital administration in the development, implementation, and evaluation of a quality plan that is multi-disciplinary and focused on patient outcomes.

Coordinate the identification, investigation, reporting, and follow-up of incidents and quality issues throughout the program, while maintaining confidentiality.

Assist with performance improvement activities on the unit, auditing documentation as appropriate.

Supervise the collecting of data entered into the TSE registry.

Utilize data to facilitate performance improvement activities and trend reports while protecting confidentiality.

Education

Keep abreast of happenings on assigned nursing unit as documented by attendance at 75% of staff meetings or initialing meeting minutes and demonstrating knowledge and understanding of current information.

Complete annual mandatory hospital education.

Response to Graded Activation

For each priority activation, the Trauma Team members are:

Priority-1 Activation

- Emergency provider (present within 30 minutes of patient's arrival)
- Emergency department RN or LPN
- Emergency department tech or EMT
- Respiratory therapy
- Laboratory technician
- Radiology technician
- Emergency department unit secretary

Priority-2 Activation

- Emergency provider (present within 30 minutes of patient's arrival)
- Emergency department RN or LPN
- Emergency department tech or EMT
- Radiology technician
- Laboratory technician
- Emergency department HUC

Priority-3 Activation

- Emergency provider (present within 30 minutes of patient's arrival)
- Emergency department RN or LPN
- Emergency department tech or EMT

Criteria for Consideration of Transfer

Central Nervous System

- Penetrating injury/open fracture, with or without cerebrospinal fluid leak
- Depressed skull fracture
- GCS <14 or deterioration
- Spinal cord injury or major vertebral injury

Chest

- Major chest wall injury or pulmonary contusion
- Wide mediastinum or other signs suggesting great vessel injury
- Cardiac injury
- Patients who may require prolonged ventilation

Pelvis/Abdomen

- Unstable pelvic ring disruption
- Pelvic fracture with shock or other evidences of continuing hemorrhage
- Open pelvic injury
- Solid organ injury

Major Extremity Injuries

- Fracture/dislocation with loss of distal pulses
- Open long-bone fractures
- Extremity ischemia

Multiple-System Injury

- Head injury combined with face, chest, abdominal, or pelvic injury
- Burns with associated injuries
- Multiple long-bone fractures
- Injury to more than two body regions

Co-morbid Factors

- Age >55 years
- Children \leq 5 years of age
- Cardiac or respiratory disease
- Insulin-dependent diabetes, morbid obesity
- Pregnancy
- Immunosuppression

Secondary Deterioration (Late Sequelae)

- Mechanical ventilation required
- Sepsis
- Single or multiple organ system failure (deterioration in central nervous, cardiac, pulmonary, hepatic, renal, or coagulation systems)
- Major tissue necrosis

Transfer Agreement Example

This agreement is made and entered into by and between YOUR FACILITY NAME, CITY, STATE, a nonprofit corporation (hereinafter called "YOUR FACILITY") and RECEIVING FACILITY NAME, CITY, STATE, a nonprofit corporation, (hereinafter called "RECEIVING FACILITY"):

WHEREAS, both YOUR FACILITY and RECEIVING FACILITY desire, by both means of this Agreement, to assist physicians and the parties hereto in the treatment of trauma patients (e.g., burn, traumatic brain injuries, spinal cord injuries, pediatrics); and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of trauma patients transferred, (b) the continuity of the care and treatment appropriate to the needs of trauma patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional health care of trauma patients.

IT IS, THEREFORE, AGREED by and between the parties as follows:

PATIENT TRANSFER: The need for transfer of a patient from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the patient's attending physician in such physician's own medical judgment. When a transfer is recommended as medically appropriate, a trauma patient at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by RECEIVING FACILITY will be made pursuant to admission policies and procedures of RECEIVING FACILITY.

YOUR FACILITY agrees that it shall:

Notify RECEIVING FACILITY as far in advance as possible of transfer of a trauma patient.

Transfer to RECEIVING FACILITY the personal effects, including money and valuables and information relating to same.

Make every effort within its resources to stabilize the patient to avoid all immediate threats to life and limbs. If stabilization is not possible, YOUR FACILITY shall either establish that the transfer is the result of an informed written request of the patient or his or her surrogate or shall have obtained a written certification from a physician or other qualified medical person in consultation with a physician that the medical benefits expected from the transfer outweigh the increased risk of transfer.

Affect the transfer to RECEIVING FACILITY through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.

YOUR FACILITY agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records necessary to continue the patient's treatment and to provide identifying and other information.

RECEIVING FACILITY agrees to state where the patient is to be delivered and agrees to provide information about the type of resources it has available.

Bills incurred with respect to services performed by either party to the Agreement shall be collected by the party rendering such services directly from the patient, third party, and neither party shall have any liability to the other for such charges.

This agreement shall be effective from the date of execution and shall continue in effect indefinitely. Either party may terminate this agreement on thirty (30) days notice in writing to the other party. If either party shall have its license to operate revoked by the state, this Agreement shall terminate on the date such revocation becomes effective.

Each party to the Agreement shall be responsible for its own acts and omissions and those of their employees and contractors and shall not be responsible for the acts and omissions of the other institutions.

Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any hospital or nursing home on either a limited or general basis while this agreement is in effect.

Neither party shall use the name of the other in any promotional or advertising material unless review and written approval of the intended use shall first be obtained from the party whose name is to be used.

This agreement shall be governed by the laws of the State of Minnesota. Both parties agree to comply with the Emergency Medical Treatment and Active Labor Act of 1986, and the Health Insurance Portability and Accountability Act of 1996 and the rules now and hereafter promulgated thereunder.

This Agreement may be modified or amended from time to time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of the Agreement.

YOUR FACILITY

RECEIVING FACILITY

SIGNED BY:

SIGNED BY:

DATE:

DATE:

Trauma Diversion Policy

Purpose:

Occasions may arise when one or more essential hospital resources are functioning at maximum capacity or otherwise unavailable and it is in the best interests of the trauma patient to be directed to an alternative facility for care.

Policy:

The need to go on “trauma divert” is a rare situation but might occur in the following circumstances:

- The emergency department is saturated; demand for critical patient care resources exceeds availability.
- Emergency department resources are fully committed due to an external disaster/multiple-casualty event.
- Emergency department resources are unavailable due to an internal disaster or catastrophic mechanical failure.

In such rare cases, the emergency department physician may make the decision to divert trauma patients for a short period of time. The need to remain on divert status should be reviewed at least hourly to provide for the shortest possible time on divert.

The diversion of trauma patients only pertains to incoming ambulance patients and not to walk-in patients. A patient incoming via ambulance while on “trauma divert” will be accepted if the EMS provider and monitoring physician determine that the patient is experiencing a condition such that transport to the next closest appropriate trauma hospital could reasonably result in increased morbidity or death. “Trauma divert” status is a request to EMS personnel to transport the patient to another facility. The patient or EMS personnel may decline the request to divert provided they have been properly apprised of the potential for delayed treatment affecting the care of the patient.

Ambulance patients who have arrived on hospital property will be admitted to the emergency department and evaluated by a physician regardless of the hospital’s diversion status.

Procedure:

Going on divert:

1. The emergency department physician will decide on the need to go on “trauma divert.” The physician will notify the emergency department charge nurse.
2. The charge nurse notifies the following of trauma divert status:
 - a. Emergency department nursing staff
 - b. EMS dispatch center(s) (e.g. sheriff departments); request EMS personnel to call hospital early with patient information

b. [NEIGHBORING HOSPITAL(S)]

3. The emergency department charge nurse begins a “Trauma Divert Tracking Log.”

When contacted by EMS with information regarding a seriously injured trauma patient, the emergency department staff person taking report notifies the EMS crew that the hospital is on trauma divert and immediately puts the crew in contact with the emergency department physician. The physician will determine if the patient is to be seen in the emergency department or diverted to a nearby facility. The decision whether or not to divert must be accomplished very quickly in order to minimize the amount of time the patient spends in transit.

Going off divert:

1. The emergency physician who initiated the closure must:
 - a. Continuously evaluate the need to remain on trauma divert.
 - b. Make the decision as to when the hospital is no longer on trauma divert.
 - c. Notify the emergency department charge nurse when no longer on trauma divert.
2. The charge nurse notifies:
 - a. Emergency department nursing staff
 - b. EMS dispatch center
 - c. [NEIGHBORING HOSPITAL(S)]
3. The emergency department charge nurse completes the “Trauma Divert Tracking Log” and forwards it to the trauma program manager.

Creating a Disaster Plan

1. Establish a hospital disaster committee consisting of the following:
 - a. Chair;
 - b. Vice-chair administrative representative;
 - c. Trauma surgeon representative;
 - d. Trauma service administrative representative;
 - e. Security representative;
 - f. Medical staff representative from surgery, anesthesiology, pathology, radiology, infectious disease, medicine, pediatrics, and emergency medicine;
 - g. Radiation safety officer;
 - h. Nursing staff representatives (ED, OR, inpatient);
 - i. Medical records representative;
 - j. Information technology representative;
 - k. Communications representatives;
 - l. Social service representatives;
 - m. Public relations representative;
 - n. Supply representative; and
 - o. Pastoral care representative.

2. Document potential disasters for the region.
 - a. Evaluate local geography, demographics, industry, and epidemiologic data for hazards.
 - b. Determine the regional history of natural hazards.
 - c. Sources of information about hazards could include fire department, law enforcement agencies, National Oceanic and Atmospheric Administration, US Army Corps of Engineers, and Department of Transportation (hazardous material on highways and railroads).

3. Establish interagency and inter-institutional agreements.

4. Determine realistic institutional capacity and capability.
 - a. Determine maximum number of beds, categories (for example, ICU, ward, adult, pediatric, burn), and locations.

- b. Develop a protocol to assess inpatients for potential early discharge or relocation to make beds available for casualties.
 - c. Plan a mechanism to place a hold on elective and non-urgent surgery.
5. Determine desired and available basic and disaster supplies, including hospital inventory and emergency stockpile.
- a. Blood supply arrangements should be made with the Red Cross and other suppliers of blood and included in simulation exercises.
 - b. Stockpiles of reinforcement supplies available on a 24-hour basis should be located among commercial sources, other institutions, the military, and FEMA, so that they can be obtained readily by telephone.
 - c. Food, water, and energy needs should be considered for specific disasters: consider sources, amounts, and length of time.
6. Develop a flow chart of mass casualties through hospital areas, ensuring the following:
- a. Patient flow is unidirectional (to avoid bottlenecks in ED and radiology).
 - b. Patient traffic does not enter and leave any area through the same door.
7. Designate hospital space for the following:
- a. Patient unloading area
 - i. Ground vehicles require careful traffic control with provision for buses and trucks.
 - ii. Helicopters need a designated landing area.
 - b. Triage criteria should be developed according to types of injured patients seen and number of victims involved in the disaster.
 - c. A triage area should be designated. Depending on the configuration of the hospital, access to the triage area, and the number of patients involved, this area may or may not use the ED. (For mass casualties, an area other than the ED should be used. The ED should be reserved for patient care.)
 - d. Critical stabilization area (usually the ED);
 - e. Preoperative area, immediate and delayed;
 - f. Operative area;
 - g. Postoperative area;
 - h. Burn treatment area;

- i. Minor surgery area;
 - J. Hazardous chemical or radioactive material decontamination areas and receptacles for contaminated materials;
 - k. Expectant area (for dying patients);
 - l. Morgue;
 - m. Psychiatric area within the institution or at nearby schools, hotels, or motels for psychiatrically trained medical, nursing, social service, and security personnel to work with the following:
 - i. People from the disaster area, including rescue personnel;
 - ii. People disturbed by the news generated by the disaster; and
 - iii. Family, friends, and others.
 - n. Press conference room with space for many telephones and for minor amenities outside the patient-care perimeter;
 - o. Record and evidence area;
 - p. Recruitment and assignment office to assist in assessing and assigning volunteers; and
 - q. Disaster support center, including the following:
 - i. Administrative control center; and
 - ii. Communications center.
8. Develop a system to summon and assign personnel to designated patient-care areas. Call-up needs should consist of internal and external call-up. ED and other in-hospital personnel will be assigned as hospital first responders for key posts until external call-up can be affected. Keep assignments flexible and updated. Do quarterly updates of telephone number rosters. A designated reporting area away from the ED for sign-in should be established.
9. Personnel resources:
- a. Hospital disaster commander and emergency operating center liaison plus at least 2 alternates based in the disaster support center
 - b. The triage officer should be a physician who has the knowledge necessary for optimally using the resources required to care for severely injured patients. Physicians need to be available for field triage as part of a disaster site medical team and for in-house triage as assigned by the disaster commander. Non-physician medical personnel may serve in this roll in certain settings if properly trained.
 - c. Physicians, nurses, a radiation safety officer, and administrative staff are assigned to specific patient-care areas. Develop an instruction packet for use in each patient-care area describing their specific functions during a disaster.

- d. A chief security officer in charge of the perimeter and other security to assist in identifying various people, control the press, act as morgue officer under the pathologist's supervision, and inventory victims' valuables and evidentiary materials.
- e. Public relations-media person: 1 person using the press conference technique should be the sole communication link with the press.
- f. Patient transport personnel.

10. Provision for food and rest for disaster personnel:

- a. Shift schedules to allow regular rotations to equalize workload and prevent provider fatigue; and
- b. Critical incident stress management program to recognize and treat providers who show signs of stress, exhaustion, and/or emotional disability.

11. Communications system compatible with other EMS elements (Consider the possibility that the present system might be overwhelmed or disrupted.):

- a. Intra-agency operating center:
 - i. Emergency operating center
 - ii. Fire department, law enforcement agencies, and ambulance and helicopter services
 - iii. Predetermined method of radio frequency selection to be used by each agency
 - iv. Provision for "secondary distribution" of casualties from overloaded facilities to those with more capacity to assure maximal casualty treatment
- b. Inter-hospital system

12. Establish medical record and patient identification systems, including identification of triage category.

13. Define institutional and staff security.

- a. Secure perimeter of hospital
- b. Secure perimeter of patient-care area
- c. Provide for ready access to all areas of hospital through elevator control and in-hospital crowd control
- d. Ensure personnel security (control and identification)
- e. Identify a designated area for members of the press
- f. Perform regional hazard assessment
 - i. Radiation protection

- ii. Hazardous material protection
- iii. Emphasis of neutrality in riot situations

14. Debrief and counsel disaster and rescue personnel on a routine basis.

15. Critique each disaster response, and modify the plan to reduce future errors within 24 hours of disaster.

16. Transfer agreements

- a. Protocols should include the flexibility needed for disasters.

Additional Resources

Links to Additional Resources

American Burn Association: www.ameriburn.org

American College of Surgeons – Committee on Trauma: <http://facs.org/trauma/index.html>

American Trauma Society: www.amtrauma.org

Association for the Advancement of Automotive Medicine: <http://aaam.org/>

Centers for Disease Control & Prevention, Guidelines for the Field Triage for the Injured Patient: <http://www.cdc.gov/FieldTriage/>

Eastern Association for the Surgery of Trauma: <http://www.east.org/resources/treatment-guidelines/triage-of-the-trauma-patient>

Emergency Nurses Association: www.ena.org

Resources for the Optimal Care of the Injured Patient 2006:

<https://web4.facs.org/ebusiness/ProductCatalog/ProductCategory.aspx?id=26>

Society of Trauma Nurses: <http://www.traumanurses.org/>