Iowa Level III Trauma Center Standards Quick Reference Guide

Standard	Standard Name	Definition and Requirements	Type
1	**Institutional Administrative Commitment**	Full support and continuous commitment from institutional leadership is vital to achieving and maintaining trauma center verification. Resource allocation (such as equipment, personnel, and administrative support), a commitment to patient safety, and an enduring focus on continuous PI are the hallmarks of strong institutional administrative support that ensures compliance with standards and the highest quality of care for trauma patients.	
1.1	Administrative Commitment	In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.	Type I
2	**Program Scope and Governance**	The trauma program and its medical staff provide the structures, processes, and personnel to comply with trauma center verification standards in order to ensure optimal care of the injured patient. This staff includes the program leadership (TPM and TMD) to oversee key functions of the trauma program. There must also be ongoing commitment from the trauma multidisciplinary PIPS committee.	
2.1	State and Regional Involvement	All trauma centers must participate in the regional and/or statewide trauma system.	Type II
2.2	Hospital Regional Disaster Committee	All trauma centers must participate in regional disaster/emergency management committees, health care coalitions, and regional mass casualty exercises.	Type II
2.3	Disaster Management Planning	All trauma programs must be integrated into the hospital's disaster plan to ensure a robust surgical response: • A trauma surgeon from the trauma panel must be included as a member of the hospital's disaster committee and be responsible for the development of a surgical response to a mass casualty event. • The surgical response must outline the critical personnel, means of contact, initial surgical triage (including subspecialty triage when appropriate), and coordination of secondary procedures. • The trauma program must participate in two hospital drills or disaster plan activations per year that include a trauma response and are designed to refine the hospital's response to mass casualty events.	Type II
2.6	Adult Trauma Centers Admitting Pediatric Patients	Adult trauma centers that care for 100 or more injured children under 15 years of age must have the following: • Pediatric emergency department area • Pediatric intensive care area • Appropriate resuscitation equipment, as outlined in the pediatric readiness toolkit	Type I

2.7	Trauma Multidisciplinary PIPS Committee	All trauma centers must have a trauma multidisciplinary PIPS committee chaired by the TMD or an associate TMD.	Type I

2.8	Trauma Medical Director Requirements	In all trauma centers, the TMD must fulfill the following requirements:
		• Hold current board certification or board eligibility in general surgery or pediatric surgery by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), or Royal College of Physicians and Surgeons of Canada (RCPS-C)
		• Serve as the director of a single trauma program
		• Be credentialed to provide trauma care
		• Hold current Advanced Trauma Life Support (ATLS) certification
		• Participate on the trauma call panel
		• Provide evidence of 36 hours of trauma-related continuing medical education (CME) during the verification cycle. For pediatric TMD, 9 of 36 hours must be pediatric-specific CME
		• In Level I trauma centers, the TMD must hold active membership in at least one national trauma organization and have attended at least one meeting during the verification cycle
		• In Level II or III trauma centers, the TMD must hold active membership in at least one regional, state, or national trauma organization and have attended at least one meeting during the verification cycle
		If a board-certified general surgeon who is not board-certified or board-eligible in pediatric surgery serves as the pediatric TMD, then the following are required:
		• The pediatric TMD must hold current Pediatric Advanced Life Support (PALS) certification
		• The center must have a written affiliation agreement with a current pediatric TMD at another ACS verified Level I pediatric trauma center. This agreement must identify the affiliate pediatric TMD and at minimum include the following responsibilities:
		  ○ Assist with process improvement, guideline development, and complex case discussions
		  ○ Attend at least 50% of trauma multidisciplinary PIPS committee meetings
		  ○ Attend the VRC site visit at the time of verification
			Type II

2.9	Trauma Medical Director Responsibility and Authority	In all trauma centers, the TMD must be responsible for and have the authority to: • Develop and enforce policies and procedures relevant to care of the injured patient • Ensure providers meet all requirements and adhere to institutional standards of practice • Work across departments and/or other administrative units to address deficiencies in care • Determine (with their liaisons) provider participation in trauma care, which might be guided by findings from the PIPS process or an Ongoing Professional Practice Evaluation (OPPE) • Oversee the structure and process of the trauma PIPS program	Type II
2.10	Trauma Program Manager Requirements	In all trauma centers, the TPM must fulfill the following requirements: • Have 1.0 full-time equivalent (FTE) commitment to the trauma program • Provide evidence of 36 hours of trauma-related continuing education (CE) during the verification cycle • Hold current membership in a national or regional trauma organization In Level II and III trauma centers, at least 0.5 FTE of the TPM's time must be spent on TPM-related activities. The remaining time must be dedicated to other roles within the trauma program.	Type II
2.11	Trauma Program Manager Responsibilities and Reporting Structure	In all trauma centers, the TPM must have a reporting structure that includes the TMD and they are to assume at minimum, the following leadership responsibilities in conjunction with the TMD and/or hospital administration • Oversight of the trauma program • Assist with the budgetary process for the trauma program • Develop and implement clinical protocols and practice management guidelines • Provide educational opportunities for staff development • Monitor performance improvement activities in conjunction with a PI coordinator (where applicable) • Serve as a liaison to administration and represent the trauma program on hospital and regional committees to enhance trauma care • Have oversight of the trauma registry	Type II

2.12	Injury Prevention Program	All trauma centers must have an injury prevention program that: • Has a designated injury prevention professional • Prioritizes injury prevention work based on trends identified in the trauma registry and local epidemiological data • Implements at least two activities over the course of the verification cycle with specific objectives and deliverables that address separate major causes of injury in the community • Demonstrates evidence of partnerships with community organizations to support their injury prevention efforts	Type II
2.13	Organ Procurement Program	In all trauma centers, an organ procurement program must be available and consist of at least the following: • An affiliation with an organ procurement organization (OPO) • A written policy for notification of the regional OPO • Protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death	Type II
3	**Facilities and Equipment Resources** The trauma program must maintain and provide the required facilities, services, and equipment for the care of the injured patient.		
3.1	Operating Room Availability	In Level I and II trauma centers, an operating room (OR) must be staffed and available within 15 minutes of notification, and in Level III trauma centers, within 30 minutes of notification.	Type I
3.3	Operating Room for Orthopedic Trauma Care	In a Level III trauma center, access to the OR must be made available for nonemergent orthopedic trauma.	Type II
3.4	Blood Products	Level III trauma centers must have an adequate supply of red blood cells and plasma available.	Type I
3.5	Medical Imaging	In Level III trauma centers, the following services must be available 24 hours per day and be accessible for patient care within the time interval specified: • Conventional radiography – 30 minutes • CT – 30 minutes • Point-of-care ultrasound – 15 minutes	Type I

4	Personnel and Services The trauma program must have access to a wide variety of personnel and services to provide timely care to the injured patient.		
4.1	Trauma Surgeon Requirements	Trauma surgeons must have direct patient care responsibilities at the institution and must meet the following qualifications: • Complete the ATLS course at least once • Have privileges in general and/or pediatric surgery • Hold current board certification or board eligibility in general surgery, or have been approved through the Alternate Pathway	Type II
4.2	Trauma Surgeon Coverage	In all trauma centers, trauma surgery coverage must be continuously available.	Type I
4.3	Trauma Surgery Backup Call Schedule	Level III trauma centers must have a documented backup call schedule or a backup plan for trauma surgery	Type II
4.4	Trauma Surgeon Presence in Operating Room	In all trauma centers, the trauma surgeon must be present in the operating suite for the key portions of operative procedures for which they are the responsible surgeon and must be immediately available throughout the procedure.	Type II
4.5	Specialty Liaisons to the Trauma Service	The trauma program must have the following designated liaisons: • Board-certified or board-eligible emergency medicine physician • Board-certified or board-eligible orthopaedic surgeon • Board-certified or board-eligible anesthesiologist • Board-certified or board-eligible ICU physician • Board-certified or board-eligible neurosurgeon*	Type II
4.6	Emergency Department Director	In Level III trauma centers, the emergency department director must be board-certified or board-eligible.	Type I
4.7	Emergency Department Physician Requirements	In all trauma centers, emergency medicine physicians involved in the care of trauma patients must be currently board-certified or board-eligible, or have been approved through the Alternate Pathway. • In Level III trauma centers, physicians must be board-certified or board-eligible in emergency medicine, pediatric emergency medicine, or a specialty other than emergency medicine. All emergency medicine physicians must have completed the ATLS course at least once. Physicians who are board-certified or board-eligible in a specialty other than emergency medicine must hold current ATLS certification.	Type II
4.11	Orthopaedic Trauma Care	Trauma centers must have board-certified or board-eligible orthopaedic surgeons continuously available for the care of orthopaedic trauma patients and must have a contingency plan for when orthopaedic trauma capabilities become encumbered or overwhelmed.	Type I

4.13	Anesthesia Services	In Level III trauma centers, anesthesia services must be available within 30 minutes of request.	Type I
4.14	Radiologist Access	In all trauma centers, a radiologist must have access to patient images and be available for imaging interpretation, in person or by phone, within 30 minutes of request.	Type I
4.16	ICU Director	All trauma centers must have an ICU surgical director who is board-certified or board-eligible in general surgery and actively participates in unit administration.	Type II
4.19	ICU Provider Coverage for Level III Trauma Centers	In Level III trauma centers, provider coverage of the ICU must be available within 30 minutes of request, with a formal plan in place for emergency coverage.	Type I
4.20	ICU Nursing Staffing Requirement	In all trauma centers, the patient-to-nurse ratio in the ICU must be 1:1 or 2:1, depending on patient acuity as defined by the hospital policy for ICU nursing staffing.	Type II
4.26	Medical Specialists	Level III trauma centers must have internal medicine continuously available.	Type II
4.28	Allied Health Services	Trauma centers must have the following allied health services available (Level III): • Respiratory therapy (24/7/365) • Nutrition support • Speech therapy • Social worker • Occupational therapy • Physical therapy	Type II
4.29	Renal Replacement Therapy Services	Level III trauma centers must have renal replacement therapy services available to support patients with acute renal failure or a transfer agreement in place if this service is not available.	Type II
4.30	Advanced Practice Providers	In all trauma centers, trauma and/or emergency department APPs who are clinically involved in the initial evaluation and resuscitation of trauma patients during the activation phase must have current ATLS certification.	Type II
4.31	Trauma Registry Staffing Requirements	In all trauma centers, there must be at least 0.5 FTE (either on- or off-site) dedicated to the trauma registry per 200-300 annual patient entries. The count of entries is defined as all patients who meet NTDS inclusion criteria, and those patients who meet inclusion criteria for hospital, local, regional and state purposes.	Type II
4.32	Certified Abbreviated Injury Scale Specialist	In all trauma centers, at least one registrar must be a current Certified Abbreviated Injury Scale Specialist (CAISS).	Type II

4.33	Trauma Registry Courses	In all trauma centers, all staff members who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting, or data validation for the trauma registry must fulfill all of the following requirements:
		• Participate in and pass the AAAM's Abbreviated Injury Scale (AIS) course for the version used at your center
		• Participate in a trauma registry course that includes all of the following content:
		  ○ Abstraction
		  ○ Data management
		  ○ Reports/report analysis
		  ○ Data validation
		  ○ HIPAA
		• Participate in an ICD-10 course or an ICD-10 refresher course every five years
			Type II

4.34	Trauma Registrar Continuing Education	In all trauma centers, each trauma registrar must accrue at least 24 hours of trauma-related CE during the verification cycle.	Type II
4.35	Performance Improvement Staffing Requirements	In all trauma centers, there must be at least 0.5 FTE dedicated performance improvement (PI) personnel when the annual volume of registry patient entries exceeds 500 patients. The count of entries is defined as all patients that meet NTDS inclusion criteria, and those patients who meet inclusion criteria for hospital, local, regional and state purposes. When the annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.	Type II
5	**Patient Care: Expectations and Protocols** The trauma program must utilize comprehensive clinical pathways and clinical practice guidelines that facilitate the standardization of patient care for the injured patient. This standardization improves the quality of care and enables the training of personnel.		
5.1	Clinical Practice Guidelines	All trauma centers must have evidence-based clinical practice guidelines, protocols, or algorithms that are reviewed at least every three years.	Type II
5.2	Trauma Surgeon and Emergency Medicine Physician Shared Responsibilities	In all trauma centers, the shared roles and responsibilities of trauma surgeons and emergency medicine physicians for trauma resuscitation must be defined and approved by the TMD.	Type II

5.3	Levels of Trauma Activation	In all trauma centers, the criteria for tiered activations must be clearly defined. For the highest level of activation, the following eight criteria must be included: 1. Confirmed blood pressure less than 90 mm Hg at any time in adults, and age-specific hypotension in children 2. Gunshot wounds to the neck, chest, or abdomen 3. GCS less than 9 (with mechanism attributed to trauma) 4. Transfer patients from another hospital who require ongoing blood transfusion 5. Patients intubated in the field and directly transport to the trauma center 6. Patients who have respiratory compromise or are in need of an emergent airway 7. Transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint) 8. Emergency physician's discretion	Type II
5.4	Trauma Surgeon Response to Highest Level of Activation	For the highest level of activation, at least 80 percent of the time, the trauma surgeon must be at the patient's bedside within 30 minutes of patient arrival.	Type I
5.5	Trauma Surgical Evaluation for Activations below the Highest Level	The trauma program must define and meet the acceptable response time to trauma surgical evaluation for activations other than the highest level.	Type II
5.7	Assessment of Children for Nonaccidental Trauma	All trauma centers must have a process in place to assess children for nonaccidental trauma.	Type II
5.8	Massive Transfusion Protocol	All trauma centers must have a massive transfusion protocol (MTP) that is developed collaboratively between the trauma service and the blood bank.	Type I
5.9	Anticoagulation Reversal Protocol	All trauma centers must have a rapid reversal protocol in place for patients on anticoagulants.	Type II
5.10	Pediatric Readiness	In all trauma centers, each emergency department must perform a pediatric readiness assessment during the verification cycle and have a plan to address identified gaps.	Type II
5.11	Emergency Airway Management	All trauma centers must have a provider and equipment immediately available to establish an emergency airway.	Type I
5.12	Transfer Protocols	All trauma centers must have clearly defined transfer protocols that include the types of patients, expected time frame for initiating and accepting a transfer, and predetermined referral centers for outgoing transfers.	Type II

5.13	Decision to Transfer	In all trauma centers, the decision to transfer an injured patient must be based solely on the needs of the patient, without consideration of their health plan or payer status.	Type II
5.14	Transfer Communication	In all trauma centers, when trauma patients are transferred, the transferring provider must directly communicate with the receiving provider to ensure safe transition of care. This communication may occur through a transfer center.	Type II
5.15	Trauma Diversion Protocol	In all trauma centers, diversion protocols must be approved by the TMD and include: • Agreement of the trauma surgeon in the decision to divert • A process for notification of dispatch and EMS agencies • A diversion log to record reasons for and duration of diversion	Type II
5.16	Trauma Diversion Hours	All trauma centers must not exceed 400 hours of diversion during the reporting period.	Type II
5.18	Neurotrauma Plan of Care for Level III Trauma Centers	All Level III trauma centers must have a written plan approved by the TMD that defines the types of neurotrauma injuries that may be treated at the center.	Type II
5.20	Treatment Guidelines for Orthopaedic Injuries	All trauma centers must have treatment guidelines for, at minimum, the following orthopaedic injuries: • Patients who are hemodynamically unstable attributable to pelvic ring injuries • Long bone fractures in patients with multiple injuries (e.g., time to fixation, order of fixation, and damage control versus definitive fixation strategies) • Open extremity fractures (e.g., time to antibiotics, time to OR for operative debridement, and time to wound coverage for open fractures) • Hip fractures in geriatric patients (e.g., expected time to OR)	Type II
5.21	Orthopaedic Surgeon Response	In all trauma centers, an orthopaedic surgeon must be at bedside within 30 minutes of request for the following: • Hemodynamically unstable, secondary to pelvic fracture • Suspected extremity compartment syndrome • Fractures/dislocations with risk of avascular necrosis (e.g., femoral head or talus) • Vascular compromise related to a fracture or dislocation • Trauma surgeon discretion The attending orthopaedic surgeon must be involved in the clinical decision-making for care of these patients.	Type II
5.22	Operating Room Scheduling Policy	All trauma centers must have an OR booking policy that specifies targets for timely access to the OR based on level of urgency and includes access targets for a range of clinical trauma priorities.	Type II

5.23	Surgical Evaluation of ICU Patients	In all trauma centers, trauma patients requiring ICU admission must be admitted to, or be evaluated by, a surgical service.	Type II
5.24	Trauma Surgeon Responsibility for ICU Patients	In all trauma centers, the trauma surgeon must retain responsibility for the trauma patient in the ICU up to the point where the trauma surgeon documents transfer of primary responsibility to another service.	Type II
5.25	Communication of Critical Imaging Results	In all trauma centers, documentation of preliminary diagnostic imaging must include evidence that critical findings were communicated to the trauma team. The final report must accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretations.	Type II
5.26	Timely CT Scan Reporting	In all trauma centers, documentation of the final interpretation of CT scans must occur no later than 12 hours after completion of the scan.	Type II
5.27	Rehabilitation Services during Acute Phase of Care	All trauma centers must meet the rehabilitation needs of trauma patients by: • Developing protocols that identify which patients will require rehabilitation services during their acute inpatient stay • Establishing processes that determine the rehabilitation care, needs, and services required during the acute inpatient stay • Ensuring that the required services during acute inpatient stay are provided in a timely manner	Type II
5.28	Rehabilitation and Discharge Planning	All trauma centers must have a process to determine the level of care patients require after trauma center discharge, as well as the specific rehabilitation care services required at the next level of care. The level of care and services required must be documented in the medical record.	Type II
5.29	Mental Health Screening	All trauma centers must meet the mental health needs of trauma patients by having: • A process for referral to a mental health provider when required	Type II
5.30	Alcohol Misuse Screening	All trauma centers must screen all admitted trauma patients greater than 12 years old for alcohol misuse with a validated tool or routine blood alcohol content testing. Programs must achieve a screening rate of at least 80 percent.	Type II
5.31	Alcohol Misuse Intervention	In Level III trauma centers, at least 80 percent of patients who have screened positive for alcohol misuse must receive a brief intervention by appropriately trained staff prior to discharge. This intervention must be documented. If brief intervention is not available as an inpatient, there must be a mechanism for referral.	Type II

6	Data Surveillance and Systems		
	High-quality data are critical to inform quality improvement and measure the performance of trauma programs. This is dependent on having well-trained registry personnel working closely with trauma leadership. High-quality data also allow for focused quality improvement activities and maximize the value of trauma benchmarking programs.		
6.1	Data Quality Plan	All trauma centers must have a written data quality plan and demonstrate compliance with that plan. At minimum, the plan must require quarterly review of data quality.	Type II
6.2	Trauma Registry Patient Record Completion	In all trauma centers, the trauma registry must be concurrent, defined as having a minimum of 80 percent of patient records completed within 60 days of the patient discharge date.	Type II

7	Performance Improvement and Patient Safety		
	Processes for identifying adverse events and implementing subsequent corrective action plans – measurable through patient outcomes – are inherent cornerstones of continuous performance improvement and patient safety (PIPS). Problem resolution, outcomes improvement, and assurances of patient safety ("loop closure") must be readily identifiable through structured PI initiatives.		
7.1	Trauma PIPS Program	In all trauma centers, the trauma PIPS program must be independent of the hospital quality program, but it must report PI activities through the hospital quality program.	Type II

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

7.3	Documented Effectiveness of the PIPS Program	All trauma centers must have documented evidence of event identification; effective use of audit filters; demonstrated loop closure; attempts at corrective actions; and strategies for sustained improvement measured over time.	Type II
7.4	Participation in Risk-Adjusted Benchmarking Programs	All trauma centers must participate in a risk-adjusted benchmarking program and use the results to determine whether there are opportunities for improvement in patient care and registry data quality.	Type II
7.5	Physician Participation in Prehospital Performance Improvement	In all trauma centers, a physician from the emergency department or trauma program must participate in the prehospital PI process, including assisting in the development of prehospital care protocols relevant to the care of trauma patients.	Type II
7.6	Trauma Multidisciplinary PIPS Committee Attendance	All trauma centers must meet the following trauma multidisciplinary PIPS committee meeting attendance thresholds: • 60 percent of meetings for the TMD (cannot be delegated to the associate TMD) • 50 percent of meetings for each trauma surgeon • 50 percent of meetings for the liaisons (or one predetermined alternate) from emergency medicine, neurosurgery, orthopaedic surgery, critical care medicine, and anesthesia	Type II
7.7	Trauma Mortality Review	In all trauma centers, all cases of trauma-related mortality and transfer to hospice must be reviewed and classified for potential opportunities for improvement. Deaths must be categorized as: • Mortality with opportunity for improvement Mortality without opportunity for improvement	Type II
7.8	Nonsurgical Trauma Admissions Review	In all trauma centers, all nonsurgical trauma admissions must be reviewed by the trauma program. As part of secondary review, the Trauma Medical Director must review non-surgical admissions that meet any of the following criteria: • No trauma or surgical consultation • ISS > 9 • Nelson Score ≤ 5 • Cases with an opportunity for improvement identified at primary review	Type II
7.9	Trauma Diversions Review	In all trauma centers, all instances of diversion must be reviewed by the trauma operations committee.	Type II

7.10	Prehospital Care Feedback	All trauma centers must have a process of reviewing and providing feedback to: • EMS agencies, related to accuracy of triage and provision of care • Referring providers, related to the care and outcomes of their patients and any potential opportunities for improvement in initial care	Type II
8	**Education: Professional and Community Outreach** Education and outreach programs are integral parts of the trauma program and are designed to help improve outcomes from trauma and minimize the effects of injury. Trauma centers have an obligation to educate future providers and ensure that the public has an opportunity to access educational resources relevant to injury care.		
8.1	Public and Professional Trauma Education	All trauma centers must provide public and professional trauma education.	Type II
8.2	Nursing Trauma Orientation and Education	All trauma centers must provide trauma orientation to new nursing staff caring for trauma patients. Nurses must participate in trauma CE corresponding to their scope of practice and patient population served.	Type II
8.3	Prehospital Provider Training	In all trauma centers, the trauma program must participate in the training of prehospital personnel.	Type II

These standards are adopted from the *Resources for Optimal Care of the Injured Patient (2022 Standards)*. The full publication can be found at https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/.

* **Note:** Level III-N Standards (3.7, 4.10, 5.17, 5.19) only apply to Level III centers that provide neurotrauma care for patients with moderate to severe TBI, defined as GCS of 12 or less at the time of emergency department arrival. These standards were eliminated as requirements in Iowa's Level III trauma centers. Additionally, standard 6.3 *Trauma Registry Data Collection and Submission* was eliminated as a requirement in Iowa's Level III trauma centers.

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