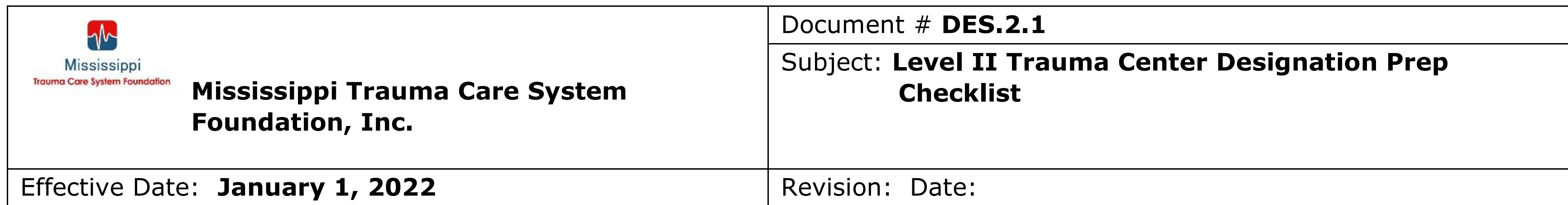

Mississippi Trauma Care System Foundation, Inc.	Document # **DES.2.1** Subject: **Level II Trauma Center Designation Prep Checklist**
Effective Date: **January 1, 2022**	Revision: Date:

Level II Trauma Centers

The following table may be utilized to align the program with the rules and regulations.

The following material is taken from the Mississippi Trauma Rules and Regs as of Nov 2020. The material has been organized in a bulleted format, and in specific cases, more detail is available in the formal Rules and Regulations.

A Level II Trauma Center is an acute care facility with the commitment, resources, and specialty training necessary to provide sophisticated trauma care, and provide leadership in performance improvement activities.

Regulation #	Item	Notes
	Hospital Organization	
4.1.2	Hospital Departments/Divisions/Sections: The Level II Trauma Center ***must*** have the following departments, divisions, or sections: 1. Emergency Medicine 2. Trauma/General Surgery 3. Orthopedic Surgery 4. Neurological Surgery 5. Anesthesia	
	Trauma Program	
4.1.3	There ***must*** be a written commitment on behalf of the entire facility to the organization of trauma care. *The written commitment shall be in the form of a resolution at the time of application passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter*	

Level II Trauma Centers

	explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient.	
	The trauma program ***must*** be established and recognized by the medical staff and hospital administration.	
	The trauma program ***must*** come under the direction of a surgeon with current or previous board certification in General Surgery.	
	An identified hospital administrative leader ***must*** work closely with the trauma medical director to establish and maintain the components of the trauma program, including appropriate financial support.	
	The trauma program location in the organizational structure of the hospital ***must*** be placed so that it may interact effectively with at least equal authority with other departments providing patient care.	
	An administrative structure ***must*** minimally include an administrator, medical director, trauma program manager (TPM), trauma registrar, and the appropriate support staff. *Administrative support includes human resources, educational activities, community outreach activities, and research.*	
	The trauma program ***must*** be multidisciplinary in nature, and the performance improvement evaluation of this care must extend to all the involved departments.	
4.1.3	Compliance with the above will be evidenced by, but not limited to: a. Governing authority and medical staff letter of commitment in the form of a resolution; b. Written policies and procedures and guidelines for the care of the trauma patient; c. Defined trauma team and written roles and responsibilities; d. Appointed Trauma Medical Director with a written job description; e. Appointed Trauma Program Manager with a written job description; f. A written Trauma Performance Improvement plan.	
	Trauma Service	
4.1.4	The trauma service ***must*** established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. *The trauma service will vary in each organization depending on the needs of the patient and the resources available.*	

Level II Trauma Centers

	The trauma service ***must*** come under the organization and direction of a surgeon with current or previous board certification in General Surgery.	
	All patients with multiple system trauma or serious injury ***must*** be evaluated and or admitted by the trauma service.	
	The surgeon responsible for the overall care of the patient ***must*** be identified.	
	Trauma Medical Director (TMD)	
4.1.5	Level II Trauma Centers ***must*** have a physician director, current or previous Board Certified in General Surgery, of the trauma program.	
	The trauma program medical director plays an important administrative role and may not direct more than one trauma center.	
	The medical director will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the trauma program. *The medical director must be given administrative support to implement the requirements specified by the State trauma plan.*	
	The director is responsible for working with the credentialing process of the hospital and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the trauma team.	
	The TMD ***must*** perform an annual assessment of the general surgeons and mid-level providers assigned to the trauma service using a formal documented process.	
	The TMD should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients.	
	The TMD in collaboration with the trauma program manager (TPM), should coordinate the budgetary process for the trauma program.	
	The TMD ***must*** be currently certified in Advanced Trauma Life Support (ATLS), maintain personal involvement in the care of the injured, maintain education in trauma care, and maintain involvement in professional organizations.	
	The TMD ***must*** be actively involved with trauma system development.	
	Trauma Program Manager (TPM)	
4.1.6	Level II Trauma Centers ***must*** have a registered nurse working full time in the role of Trauma Program Manager (TPM).	

Level II Trauma Centers

	There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.	
	Working in conjunction with the TMD, the TPM is responsible for the organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care.	
	The TPM is responsible for working with the trauma team to assure optimal patient care.	
	The TPM or his/her designee should offer or coordinate services for trauma education.	
	The TPM should liaison with local EMS personnel, the Department, and other trauma centers.	
	Trauma Team	
4.1.7	There must be identified members of the trauma team. *the team approach is optimal in the care of the multiple injured patients*	
	Policies should be in place describing the respective role of all personnel on the trauma team *The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its staff.*	
	The team leader must be a qualified general surgeon.	
	All physicians and mid-level providers (physician assistant/nurse practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in Advanced Trauma Life Support (ATLS). *ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.*	
	Minimum composition of the trauma team for a severely injured patient **shall** include: 1. Emergency Physicians and/or mid-level providers (physician assistant/nurse practitioner) 2. General/Trauma Surgeon 3. Nurses 4. Laboratory Technicians 5. Respiratory Therapists	
	Multidisciplinary Trauma Committee	
4.1.8	The purpose of the committee is to provide oversight and leadership to the entire trauma program.	

Level II Trauma Centers

	The major focus will be on PI activities, policy development, communication among all team members, establishment of standards of care, education and outreach programs, and injury prevention.	
	Each trauma center **may** choose to have one or more committees to accomplish the tasks necessary. One committee should be multidisciplinary and focus on program oversight and leadership.	
	The committee has administrative and systematic control and oversees the implementation of all program-related services, meets regularly, takes attendance, maintains minutes, and works to correct overall program deficiencies to optimize patient care.	
	Membership for the committee includes representatives from: a. Trauma Medical Director (Chairman; must be present at greater than 50% of the meetings) b. Emergency Medicine c. General Surgery d. Orthopedics e. Neurosurgery f. Anesthesia g. Operating Room h. Intensive Care i. Respiratory Therapy j. Radiology k. Laboratory l. Rehabilitation m. Prehospital Care Providers n. Administration o. Pediatrics p. Nursing q. Trauma Program Manager	

Level II Trauma Centers

	The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.	
	The trauma center ***may*** wish to accomplish performance improvement activities at this same committee or develop a separate peer review committee. *This committee should handle peer review independent from department-based review. This committee must be multidisciplinary, meet regularly, and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.*	
	Subchapter 2 Clinical Components	
4.2.1	Level II Trauma Centers ***must*** maintain published call schedules and have the following physician coverage immediately available 24 hours/day	
	Emergency Medicine	
	Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or midlevel provider (Physician Assistant/Nurse Practitioner) ***must*** be in the specified trauma resuscitation area upon patient arrival. *Response time for Alpha Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Activations is 45 minutes from the time notified to respond.*	
	Trauma/General Surgery	
	Trauma/General Surgery. The trauma surgeon on-call ***must*** be unencumbered and immediately available to respond to the trauma patient. *The general surgeon is expected to be in the emergency department upon the arrival of the seriously injured patient.*	
	Hospital policy ***must*** be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient.	
	The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is ***mandatory***.	
	The on-call surgeon ***must*** be dedicated to the trauma center and not on-call at any other hospital.	
	There ***must*** be a backup surgeon schedule published.	

Level II Trauma Centers

	A system ***must*** be developed to assure notification of the on- call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process.	
	Orthopedic Surgery	
	It is ***desirable*** to have the orthopedists dedicated to the trauma center solely while on-call, or a backup schedule should be available.	
	The maximum response time for all trauma patients is 60 minutes from the time notified to respond.	
	Neurologic Surgery	
	It is ***desirable*** to have the neurosurgeon dedicated to the trauma center solely while on-call, or a backup schedule should be available	
	The maximum response time for all trauma patients is 30 minutes from the time notified to respond.	
	It is ***desirable*** the following specialists be on-call and available 24 hours/day: a. Critical Care Medicine b. Obstetrics/Gynecologic Surgery c. Plastic Surgery d. Radiology e. Thoracic Surgery* **A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).*	
	Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.	
	Policies and procedures should exist to notify the transferring hospital of the patient's condition.	
Qualifications of Surgeons on the Trauma Team		
4.2.2	Basic to qualification for trauma care for any surgeon is current or previous Board Certification in a surgical specialty *Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty.*	

Level II Trauma Centers

	The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.	
	Alternate criteria in lieu of board certification are as follows: a. A Non-board certified general surgeon must have completed a surgical residency program. b. He/she must be licensed to practice medicine. c. He/she must be approved by the hospital's credentialing committee for surgical privileges. d. The surgeon must meet all criteria established by the TMD to serve on the trauma team. e. The surgeon's experience in caring for the trauma patient must be tracked by the PI program. f. The TMD must attest to the surgeon's experience and quality as part of the recurring granting of trauma team privileges. g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.	
	The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care.	
	The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level II facility) and determine if the patient needs transport to a higher level of care. *If transport is required, he/she is accountable for the coordination of the process with the receiving physician at the receiving facility.*	
	If the patient is to be admitted to the Level II Trauma Center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized.	
	Guidelines should be written at the local level to determine which types of patients should be admitted to the Level II Trauma Center or which patients should be considered for transfer to a higher level of care.	
	General Surgeons taking trauma call ***must*** have eight (8) hours of trauma-specific continuing education over three years. *This can be met within the 40-hour requirement by licensure.*	
	The orthopedic liaison and neurosurgery liaison ***must*** participate in a multidisciplinary trauma committee and the PI process. Committee attendance must be at least fifty percent (50%) over a year's period of time.	

Level II Trauma Centers

Qualifications of Emergency Physicians		
4.2.3	For those physicians providing emergency medicine coverage, current or previous board certification in Emergency Medicine or General Surgery is required or current certification in ATLS.	
	Alternative criteria for the non-boarded physician working in the Emergency Department are as follows: a. He/she ***must*** be licensed to practice medicine. b. He/she ***must*** be approved by the hospital's credentialing committee for emergency medicine privileges. c. The physician ***must*** meet all criteria established by the trauma and emergency medical director to serve on the trauma team. d. The physician's experience in caring for the trauma patient ***must*** be tracked by the PI program. e. The emergency medical director ***must*** attest to the physician's experience and quality as part of the recurring granting of trauma team privileges. f. ATLS ***must*** be obtained within 18 months of hire.	
	The emergency medicine liaison ***must*** participate in a multidisciplinary trauma committee and the PI process.	
	Committee attendance ***must*** be at least fifty percent (50%) over a year's period of time.	
	Emergency physicians ***must*** be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians)	
	it is ***required*** they be involved in at least eight (8) hours of trauma-related continuing education (CME) every 3 years.	
Subchapter 3 Facility Standards		
Emergency Department		
4.3.1	The facility ***mus***t have an emergency department, division, service, or section staffed so trauma patients are assured immediate and appropriate initial care.	
	The emergency physician ***must*** be in-house 24 hours/day and immediately available at all times.	
	The emergency department medical director ***must*** meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and current or previous board certification in emergency medicine.	

Level II Trauma Centers

	The director of the emergency department, along with the Trauma Medical Director (TMD), ***will*** establish trauma-specific credentials that ***should*** exceed those that are required for general hospital privileges. *Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification, and specialty board certification.*	
	The emergency medicine physician or designee ***will*** be responsible for activating the trauma team based on predetermined response protocols	
	The emergency medicine physician or designee ***will*** provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area.	
	The emergency department ***must*** have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient.	
	The emergency department medical director, or designee, ***must*** act as a liaison and participate with the multidisciplinary trauma committee	
	The emergency department medical director, or designee, ***must*** act as a liaison and participate with the trauma PI process	
	There ***should*** be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day.	
	Emergency nurses staffing the trauma resuscitation area ***must*** be a current provider of Trauma Nurse Core Curriculum (TNCC), or Advanced Trauma Care for Nurses (ATCN)	
	Emergency nurses staffing the trauma resuscitation area ***must*** participate in the ongoing PI process of the trauma program.	
	Nurses ***must*** obtain TNCC or ATCN within 18 months of assignment to the ER.	
	*The list of **required** equipment necessary for the ED can be found online at the Department's website.*	
	Surgical Suites/Anesthesia	
Rule 4.3.2	An operating room ***must*** be adequately staffed and available within 30 minutes of the time of notification	
	Availability of the operating room personnel and timeliness of starting operations ***must*** be continuously evaluated by the trauma performance improvement process, and measures must be implemented to ensure optimal care.	

Level II Trauma Centers

	If the staff is not in-house, hospital policy ***must*** be written to assure notification and prompt response.	
	The OR nurses ***should*** participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.	
	The surgical nurses are an integral member of the trauma team and ***must*** participate in the ongoing PI process of the trauma program and must be represented on the multidisciplinary trauma committee.	
	The OR supervisor ***must*** be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma patient during a busy operative schedule.	
	There ***must*** be an on-call system for additional personnel for multiple patient admissions.	
	The anesthesia department in a Level II Trauma Center ***must*** be organized and run by an anesthesiologist who is experienced and devoted to the care of the injured patient.	
	A licensed anesthesia provider ***must*** be immediately available with a mechanism established to ensure early notification of the on-call provider. *Anesthesiologists or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement.*	
	Hospital policy ***must*** be established to determine when the licensed anesthesia provider must be immediately available for airway control and assisting with resuscitation.	
	The availability of the licensed anesthesia provider and the absence of delays in airway control or operative anesthesia ***must*** be documented and monitored by the PI process. *The maximum response time for all trauma patients is 30 minutes from the time notified to respond.*	
	*The list of **required** equipment for Surgery and Anesthesia can be found online at the Department's website.*	
Post-Anesthesia Care Unit (PACU)		
4.3.3	It is ***essential*** to have a PACU staffed 24 hours/day and available to the postoperative trauma patient.	
	If the staff is not in-house, hospital policy ***must*** be written to assure early notification and prompt response.	
	If this availability requirement is met with a team on call from outside the hospital, the availability of the PACU nurses and compliance with this requirement ***must*** be documented	
	PACU staffing ***should*** be in sufficient numbers to meet the critical needs of the trauma patient.	

Level II Trauma Centers

<table>
<tr><td></td><td>The list of <u>required</u> equipment necessary for the PACU can be found online at the Department's website.</td><td></td></tr>
<tr><td colspan="3">Intensive Care Unit (ICU)</td></tr>
<tr><td>4.3.4</td><td>Level II Trauma Centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.</td><td></td></tr>
<tr><td></td><td>The surgical director or co-director must be the TMD, or general surgeon taking trauma call.
The director is responsible for the quality of care and administration of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.</td><td></td></tr>
<tr><td></td><td>The trauma surgeon assumes and maintains responsibility for the care of the serious or multiple injured patients.</td><td></td></tr>
<tr><td></td><td>A surgically directed ICU physician team is <u>desirable.</u>
The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties but must be led by a qualified surgeon consistent with the medical staff privileging process of the institution.</td><td></td></tr>
<tr><td></td><td>The trauma surgeon <u>must</u> maintain control over all aspects of care, including but not limited to respiratory care, management of mechanical ventilation and placement and use of pulmonary catheters, as well as management of fluids, electrolytes, antimicrobials, and enteral and parenteral nutrition.</td><td></td></tr>
<tr><td></td><td>There <u>must</u> be physician coverage for the ICU at all times.
A physician credentialed by the facility must be promptly available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.</td><td></td></tr>
<tr><td></td><td>Level II Trauma Centers <u>must</u> provide staffing in sufficient numbers to meet the critical needs of the trauma patient.</td><td></td></tr>
<tr><td></td><td>Critical care nurses <u>must</u> be available 24 hours per day.</td><td></td></tr>
<tr><td></td><td>ICU nurses are an integral part of the trauma team and as such, <u>shall be</u> represented on the multidisciplinary trauma committee and participate in the PI process of the trauma program at least 50% of the time.</td><td></td></tr>
<tr><td></td><td>The list of <u>required</u> equipment necessary for the ICU can be found online at the Department's website.</td><td></td></tr>
<tr><td colspan="3">Subchapter 4 Clinical Support Services</td></tr>
<tr><td></td><td>Respiratory Therapy Service</td><td></td></tr>
<tr><td>4.4.1</td><td>the service <u>must</u> be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatments for the</td><td></td></tr>
</table>

Level II Trauma Centers

	injured patient.	
	Radiological Service	
	A radiological service ***must*** have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures.	
	A technician ***must*** be in-house and immediately available for computerized tomography (CT) for both head and body.	
	Specialty procedures such as Sonography and Angiography ***must*** be available to the trauma team.	
	It is ***desirable*** that MRI services be available to the trauma team.	
	The radiologist liaison ***must*** attend at least 50 percent of committee meetings and should educate and guide the entire trauma team in the appropriate use of radiologic services.	
	A staff radiologist ***must*** be promptly available, when requested, for the interpretation of radiographs, the performance of complex imaging studies, or interventional procedures.	
	The radiologist ***must*** ensure the preliminary interpretations are promptly reported to the trauma team	
	radiology services ***must*** monitor the interpretation reported to the trauma team	
	The written policy ***must*** exist delineating the prioritization/availability of the CT scanner for trauma patients.	
	The Trauma Center ***must*** have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in the radiology department.	
	Clinical Laboratory Service	
4.4.3	*A clinical laboratory service **must** have the following services available inhouse 24 hours/day:*	
	Access to a blood bank and adequate storage facilities.	
	Sufficient quantities of blood and blood products must be maintained at all times.	
	Blood typing and crossmatch capabilities must be readily available.	
	Standard analysis of blood, urine, and other body fluids, including micro sampling when appropriate	
	Blood gas and pH determinations *(this function may be performed by services other than the clinical laboratory service, when applicable)*	

Level II Trauma Centers

	Alcohol and drug screening	
	Coagulation studies	
	Microbiology	
	Trauma Centers of all levels ***must*** have a massive blood transfusion protocol developed collaboratively between the trauma service and the blood bank	
	Acute Hemodialysis	
4.4.4	There ***must*** be a written protocol to transfer the patient to a facility that provides this service if this service is not available at the Level II Trauma Center.	
	Burn Care	
4.4.5	There ***must*** be a written protocol to transfer the patient to a Burn Center, if appropriate burn care is not available at the Level II Trauma Center.	
	Policies and procedures ***shall be*** in place to assure that the appropriate care is rendered during the initial resuscitation and transfer of the patient.	
	Rehabilitation/Social Services	
4.4.6	The rehabilitation of the trauma patient and the continued support of the family members are an important part of the Trauma System.	
	Each facility ***will be*** required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center.	
	Hospitals ***will be*** required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the multidisciplinary rehabilitation team.	
	The rehabilitation services ***must*** minimally include; a. Occupational Therapy b. Physical Therapy c. Speech Pathology d. Social Work e. Psychological Therapy	

Level II Trauma Centers

	f. Nutritional support	
	Prevention/Public Outreach	
4.4.7	Level II Trauma Centers ***will be*** responsible for participating with appropriate agencies, professional groups and hospitals in their geographic area to develop a strategic plan for public awareness. *This plan **must** take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies.*	
	Prevention programs ***must*** be specific to the needs of the geographic area.	
	A trauma center's prevention program ***must*** include and track partnerships with other community organizations.	
	At a minimum, the trauma registry data ***must*** be utilized to identify injury trends and focus on prevention needs.	
	Staff members at the Level II trauma center ***should*** provide consultation to staff members at other facilities in the geographic area. *Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills.*	
	Trauma physicians ***should*** provide a formal follow-up to referring physicians/designees about specific patients to educate the practitioner for the benefit of further injured patients.	
	Transfer Guidelines	
4.4.8	Level II Trauma Centers ***shall*** work in collaboration with the referral trauma facilities in the system and develop interfacility transfer guidelines. *These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.*	
	Education	
4.4.9	Level II Trauma Centers ***must*** have internal trauma education programs, including training in trauma for physicians, nurses, ancillary staff, and prehospital providers.	
	Level II Trauma Centers ***must*** have a written trauma education plan.	