Town Hall Meeting

to Discuss the New Trauma Center Standards

PHILIPS

Sponsored by Philips / Trauma Center Consulting Services

TSN Webinars

Welcome

Robert Fojut
Editor
Trauma System News

TSN Webinars

Housekeeping

Questions: Click the Q&A icon

Replay: Link will arrive by email tomorrow

Town Hall: Presenter

Angie Chisolm, MBA, BSN, RN, CFRN, TCRN
Consulting Manager, Trauma Center Consulting Services
Healthcare Transformation Services, Philips

Town Hall: Goals

Why we are doing this webinar

Town Hall: Agenda

- Performance improvement
- Trauma registry
- Nursing education
- Surgical and medical specialties
- Other requirements
- *Question + Comments + Discussion*

Town Hall: Disclaimer

- This webinar is not intended to replace guidance and directives from the American College of Surgeons (ACS)
- This information is not all-inclusive but highlights key changes to the standards
- Attendees are responsible for reading and understanding the 2022 Standards and confirming any interpretation through the ACS Committee on Trauma

Town Hall

Performance Improvement

Town Hall: PIPS

4.34 PI Staffing Requirements – Type II **NEW

All trauma centers must have at least 0.5 FTE dedicated performance improvement personnel when patient entries exceed 500

When the annual volume exceeds 1000 patient entries, there must be at least 1.0 FTE PI personnel

*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

Town Hall: PIPS

2014 Standards

CD 2.17 The processes of event identification and levels of review must result in the development of corrective action plans, and methods of monitoring, reevaluation, and benchmarking must be present – **Type II**

CD 16.2 Problem resolution, outcome improvements, and assurance of safety ("loop closure") must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation **Type II**

2022 Standards

7.3 Documented Effectiveness of the PIPS Program – Type II
All trauma centers must have documented evidence of event identification; effective use of audit filters; demonstrated loop closure; attempts at corrective action plans; and strategies for sustained improvement measured over time.

Includes:

- Peer review minutes
- Loop closure documentation (ex. PDSA)
- Monitoring of event rates (dashboards)
- OPPE
- Benchmarking reports (TQIP)

Town Hall: PIPS

2014 Standards	2022 Standards
5.18 Programs that admit more than 10 percent of injured patients to nonsurgical services must review all nonsurgical admissions through the PIPS process. **Type II**	**7.8 Nonsurgical Trauma Admissions Review – Type II** In all trauma centers, all nonsurgical trauma admissions must be reviewed by the trauma program. Minimum review by TMD: • NSA w/o trauma or surgical consult • ISS > 9 • Identified OFI

Town Hall: PIPS / Audit Filters

- **Surgeon arrival time for the highest level of activation**
- **Delay in response for urgent assessment by the neurosurgery and orthopedic specialists**
- Delayed recognition of or missed injuries
- Compliance with prehospital triage criteria, as dictated by regional protocols
- Delays or adverse events associated with prehospital trauma care
- **Compliance of trauma team activation, as dictated by program protocols**
- **Accuracy of trauma team activation protocols**
- **Delays in care due to the unavailability of emergency department physician (Level III)**
- Unanticipated return to the OR
- **Unanticipated transfer to the ICU or intermediate care**
- **Transfers out of the facility for appropriateness and safety**
- **All nonsurgical admissions (excludes isolated hip fractures)**
- **Radiology interpretation errors or discrepancies between the preliminary and final reports**
- **Delays in access to time-sensitive diagnostic or therapeutic interventions**
- **Compliance with policies related to timely access to the OR for urgent surgical intervention**
- **Delays in response to the ICU for patients with critical needs**
- Lack of availability of essential equipment for resuscitation or monitoring
- MTP activations
- **Significant complications and adverse events**
- Transfers to hospice
- **All deaths: inpatient, died in emergency department (DIED), DOA**
- **Inadequate or delayed blood product availability**
- **Patient referral and organ procurement rates**
- Screening of eligible patients for psychological sequelae
- Delays in providing rehab services
- **Screening of eligible patients for alcohol misuse**
- **Pediatric admissions to nonpediatric trauma centers**
- **Neurotrauma care at Level III trauma centers**
- **Neurotrauma diversion**

Town Hall: PIPS

2014 Standards	2022 Standards
5.10 The TMD must chair and attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings. **Type II**	**7.6 PIPS Committee Attendance – Type II** - TMD must attend 60% of meetings and cannot be delegated to associate TMD **New:** - Attendance requirements may be met by teleconference - If a trauma surgeon is only backup, not subject to attendance requirements

Town Hall: PIPS / Care Protocols – New CDs

5.6 Care Protocols of the Injured Older Adult – Type II
- new for Levels I and II

5.9 Anticoagulation Reversal Protocol – Type II
- All trauma centers must have a rapid reversal protocol for patients on anticoagulants

5.10 Pediatric Readiness – Type II
- All trauma centers must evaluate its pediatric readiness and have a plan to address any deficiencies in the ED

5.29 Mental Health Screening – Type II
- All trauma centers must have a screening and referral process for psychological sequelae

Town Hall: PIPS / Care Protocols - Changes

2014 Standards	2022 Standards
3.6 Type II The trauma center must not be on bypass (diversion) more than 5 percent of the time. (I, II, III)	**5.16 Trauma Diversion Hours – Type II** All trauma centers must not exceed 400 hours of diversion during the reporting period.

Town Hall: PIPS / Care Protocols - Changes

2014 Standards	2022 Standards
CD 11.58 In Level I, II, and III trauma centers, the trauma surgeon must retain responsibility for the patient and coordinate all therapeutic decisions – **Type I**	**5.24** 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**
CD 5.17 In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. **Type II**	**5.23 Surgical Evaluation of ICU Patients – Type II** - In all trauma centers, trauma patients requiring admission to ICU must have a surgical evaluation. - there must be a policy that defines the expected timeframe for the evaluation

Trauma Registry

Town Hall: Registry Staffing

2014 Standards

CD 15.9 In Level I, II, and III trauma centers, One full-time equivalent employee dedicated to the registry must be available to process the data capturing the NTDS data set for each 500–750 admitted patients annually – **Type II**

2022 Standards

4.30 Trauma Registry Staffing Requirements – Type II
- All trauma centers must have 0.5 FTE's per 200 – 300 annual patient entries* (1 FTE : 400 – 600)

- combined adult and peds programs must have a pediatric lead registrar

*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

Town Hall: Registry Education

2014 Standards

CD 15.7 In Level I, II, and III trauma centers, the registrar must attend or have previously attended two courses within 12 months of being hired: **Type II**

1. the American Trauma Society's Trauma Registrar Course or equivalent provided by a state trauma program; and
2. the Association of the Advancement of Automotive Medicine's Injury Scaling Course

2022 Standards

4.31 Certified AIS Specialist – Type II
- All trauma centers must have at least one registrar current in CAISS

4.32 Trauma Registry Courses – Type II
All trauma centers – all registrars must have the following:
- most recent AIS course
- Registry course
- ICD-10 course or refresher every 5 years

4.33 Trauma Registrar CE – Type II
- Each registrar must accrue 24 hours of trauma-related CE during the cycle

Town Hall: Registry Data Quality

2014 Standards	2022 Standards
CD 15.10 In Level I, II, III and IV trauma centers, strategies for monitoring data validity are essential. **Type II**	**6.1 Data Quality Plan – Type II** 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. **Measures of Compliance** • Written data quality plan • Written results summarizing internal and/or external data validation • Trauma center's trauma registry data validation report(s) • Evidence of a comprehensive review of the TQP Data Center Validation Summary Report • Evidence of a comprehensive review of the TQP Data Center Submission Frequency Report (if applicable

1-Minute Break

Would you like to have a follow-up conversation with Angie on any of these points?

Nursing Education

Town Hall: Nursing Education

8.2 Nursing Trauma Orientation and Trauma – Type II

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

Examples of orientation may include:

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

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

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

Examples of nursing education may include:

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

Surgical and Medical Specialties

Town Hall: Trauma Medical Director

2014 Standards

Trauma Medical Director Requirements – Type II

CD 5.7 In Level I and II the TMD must maintain an appropriate level of trauma-related extramural continuing medical education (16 hours annually, or 48 hours in 3 years).

CD 5.8 Membership and active participation in regional or national trauma organizations are essential for the trauma director in Level I and II trauma centers and are desirable for TMDs in Level III and IV facilities

2022 Standards

2.8 Trauma Medical Director Requirements – Type II
In all trauma centers, the TMD must fulfill the following requirements:

- 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

Town Hall: EM Medical Director

2014 Standards	2022 Standards
CD 7.1 The emergency departments of Level I, II, and III trauma centers must have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients – **Type I**	**4.6 Emergency Department Director – Type I** All trauma centers must have a board-certified or board eligible emergency department physician medical director. In Level I and II trauma centers, the emergency department medical director must be board-certified or board-eligible in emergency medicine or pediatric emergency medicine.

Town Hall: Emergency Medicine Coverage

2014 Standards	2022 Standards
CD 7.2 An emergency physician must be present in the department at all times in a Level I and Level II trauma centers – **Type I**	**4.8 Emergency Department Physician Coverage – Type I** In Level I and II trauma centers, a board-certified or board eligible emergency medicine physician must be present in the emergency department at all times.

Town Hall: Orthopedic Response

2014 Standards

CD 9.7 In Level I and II centers, orthopedic surgeon must be available in the trauma resuscitation area within 30 minutes after consultation has been requested by the surgical trauma team leader for multiply injured patients based on institution-specific criteria.– **Type II**

2022 Standards

5.21 Orthopedic Surgeon Response – Type II
In all trauma centers, an orthopedic 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

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

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

Town Hall: Orthopedic Surgery

2014 Standards	2022 Standards
CD 9.5 In a Level I trauma center the orthopedic care must be overseen by an individual who has completed a fellowship in orthopedic traumatology approved by the Orthopedic Trauma Association (OTA) – **Type I**	**4.11 Orthopedic Trauma Care – Type I** - Level I peds must have at least one board certified / eligible ortho surgeon with pediatric orthopedic fellowship **4.12 Specialized Orthopedic Trauma Care – Type II** - Level II adult, Level I/II peds must have an orthopedic surgeon who has completed an OTA fellowship or transfer protocols in place specifying the types of injuries for transfer **3.3 Operating Room for Orthopedic Trauma Care – Type II** ****NEW CD** - Level I and II must have a dedicated OR prioritized for nonemergent orthopedic trauma - Level III access must be made available for nonemergent orthopedic trauma

Town Hall: Other Surgical Specialties

4.21 Surgical Specialist Availability – Type I
- Cardiothoracic surgery is someone with expertise to manage cardiac injury – can be trauma surgeon, vascular surgeon, cardiac surgeon, cardiothoracic surgeon, etc.

4.22 Soft Tissue Coverage Expertise – Type I
- Level I must have the capability for comprehensive soft tissue coverage, including microvascular expertise for free flaps (transfer agreements do not apply)

4.23 Craniofacial Expertise – Type I **NEW CD
- Level I must have capability to diagnose and manage acute facial fractures. (Orange book was “should”)

4.24 Replantation Services – Type II
- Level I and II must have replantation services or transfer process in place
- triage can include diversion to replantation center

Town Hall: Interventional Radiology

2014 Standards	2022 Standards
CD 11.33 In Level I and II trauma centers qualified radiologists must be available within 30 minutes to perform complex imaging studies, or interventional procedures **Type II**	**4.15 IR Response for Hemorrhage Control – Type II** Level I and II trauma centers must have the necessary human and physical resources continuously available so that an endovascular or interventional radiology procedure for hemorrhage control can begin within 60 minutes of request. The response time is tracked from request to arterial puncture.

Town Hall: Geriatrics

4.5 Specialty Liaisons to the Trauma Service – Type II
- Geriatric provider (applies only to Level I and II)

Geriatric Provider Liaison In Level I and II trauma centers, the geriatric liaison may be:

- a geriatrician, or
- a physician with expertise and a focus in geriatrics, or
- an APP with certification, expertise, and a focus in geriatrics.

The role of the liaison is to assist in the development and implementation of geriatric protocols and to be available for patient consultation.

Town Hall: Other Medical Specialties

4.16 ICU Director – Type II (Type I in "orange" book)
- Level I requires ICU surgical director board certified / eligible in SCC

4.18 Intensivist Staffing – Type II **NEW CD
- Level II adult must have at least one intensivist board certified / eligible in surgical critical care

4.25 Medical Specialists – Type II
- Level I and II must have (not continuously available):
  - Pain management with expertise in regional nerve blocks
  - Physiatry
  - Psychiatry
- Level III trauma centers must have internal medicine continuously available.

4.26 Child Abuse (NAT) Physician – Type II **NEW CD
- Level I and II peds must have board certified / eligible or special interest in child abuse

Other Requirements

Town Hall: Trauma Program Manager

2014 Standards

CD 5.22 In Level I, II, and III trauma centers, in addition to administrative ability, the TPM must show evidence of educational preparation and clinical experience in the care of injured patients **Type II**

CD 5.23 In Level I and II trauma centers, the TPM must be full-time and dedicated to the trauma program. **Type II**

CD 5.24 The TPM must show evidence of educational preparation, with a minimum of 16 hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients. **Type II**

2022 Standards

2.10 Trauma Program Manager Requirements – **Type II**
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.

Town Hall: Disaster Management

2.3 Disaster Management Planning – Type II
-Level I must include an ortho surgeon as a member of the hospital's disaster committee

4.35 Disaster Management and Emergency Preparedness Course – Type II ****NEW CD**
- Level I adult/peds the trauma surgeon liaison to the disaster committee must complete the DMEP course at least once

Questions?
Comments?
Ideas?

Click the Q&A icon

TSN Webinars

Thank You

Replay link
Exit survey