

Chapter	Level III Requirement by Chapter	
2	2-1 Surgical commitment is essential for a properly functioning trauma center.	TYPE I
2	2-4 The trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review.	TYPE I
2	2-7 It is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 15 minutes for Level I and II trauma centers and 30 minutes for Level III trauma centers, tracked from patient arrival. The program must demonstrate that the surgeon's presence is in compliance at least 80% of the time. Demonstration of the attending surgeon's prompt arrival for patients with appropriate activation criteria must be monitored by the hospital's trauma PIPS program.	TYPE I
2	2-11 Trauma panel surgeons must respond promptly to activations, remain knowledgeable in trauma care principles, whether treating patients locally or transferring them to a center with more resources, and participate in performance review activities.	TYPE I
2	2-12 Well-defined transfer plans are essential (approved by the TMD and monitored by the PIPS program) that define appropriate patients for transfer and retention.	TYPE I
5	5-1 The hospital has the commitment of the institutional governing body and the medical staff to become a trauma center.	TYPE I
5	5-4 The multidisciplinary trauma program continuously evaluates its processes and outcomes to ensure optimal and timely care.	TYPE I
5	5-5 The trauma medical director is either a board-certified surgeon or an ACS Fellow.	TYPE I
5	5-6 The trauma medical director participates in trauma call.	TYPE I
5	5-9 The trauma director has the authority to correct deficiencies in trauma care or exclude from trauma call the trauma team members who do not meet specified criteria.	TYPE I
5	5-15 The structure of the trauma program allows the trauma director to have oversight authority for the care of injured patients who may be admitted to individual surgeons.	TYPE I
5	5-16 There is a method to identify injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners.	TYPE I
5	5-18 There is a multidisciplinary peer review committee chaired by the trauma medical director or designee, with representatives from appropriate subspecialty services.	TYPE I
5	5-23 There must be a Trauma Program Operational Process Performance Improvement Committee.	TYPE I
6	6-1 The trauma medical director has responsibility and authority to ensure compliance with verification requirements.	TYPE I
6	6-6 An attendance threshold of 80% must be met for trauma surgeon presence in the emergency department.	TYPE I
6	6-9 There is a multidisciplinary peer review committee with participation from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia.	TYPE I
7	7-1 The emergency department has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.	TYPE I

8	8-7 There is a performance improvement program that convincingly demonstrates appropriate care in the facility that treats neurotrauma patients.	TYPE I
9	9-2 Operating rooms are promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression.	TYPE I
9	9-4 There is an orthopaedic surgeon who is identified as the liaison to the trauma program.	TYPE I
11	11-1 Anesthesiology services are promptly available for emergency operations.	TYPE I
11	11-2 Anesthesiology services are promptly available for airway problems.	TYPE I
11	11-3 There is an anesthesiologist liaison designated to the trauma program.	TYPE I
11	11-7 Anesthesia services are available 24 hours a day and present for all operations.	TYPE I
11	11-8 In trauma centers without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider.	TYPE I
11	11-9 In a center without anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management.	TYPE I
11	11-12 The anesthesia liaison has been identified.	TYPE I
11	11-18 The operating room is adequately staffed and immediately available. SEE FAQ	TYPE I
11	11-20 The operating room has the essential equipment.	TYPE I
11	11-24 The PACU has qualified nurses available 24 hours per day as needed during the patient's post-anesthesia recovery phase.	TYPE I
11	11-26 The PACU has the necessary equipment to monitor and resuscitate patients.	TYPE I
11	11-28 Radiologists are promptly available, in person or by teleradiology, when requested, for the interpretation of radiographs, performance of complex imaging studies, or interventional procedures.	TYPE I
11	11-36 Conventional radiography and CT are available in all trauma centers 24 hours per day.	TYPE I
11	11-46 The trauma surgeon remains in charge of patients in the ICU.	TYPE I
11	11-49 When a critically ill trauma patient is treated locally, there must be a mechanism in place to provide prompt availability of ICU physician coverage 24 hours per day.	TYPE I
11	11-53 The trauma service retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level.	TYPE I
11	11-54 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.	TYPE I
11	11-58 A qualified nurse is available 24 hours per day to provide care during the ICU phase.	TYPE I
11	11-60 The ICU has the necessary equipment to monitor and resuscitate patients.	TYPE I
11	11-65 Level III centers must have the availability of orthopaedic surgery.	TYPE I
11	11-71 There is a respiratory therapist available and on call 24 hours per day.	TYPE I
11	11-75 Laboratory services are available 24 hours per day for the standard analyses of blood, urine, and other body fluids, including microsampling when appropriate.	TYPE I
11	11-76 The blood bank must be capable of blood typing and cross matching.	TYPE I

11	11-77 The blood bank must have an adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients.	TYPE I
11	11-78 The capability for coagulation studies, blood gases, and microbiology must be available 24 hours a day.	TYPE I
12	12-2 The hospital must provide physical therapy services.	TYPE I
15	15-1 Trauma registry data are collected and analyzed.	TYPE I