American College of Surgeons

Consultation/Verification Program

Reference Guide of Suggested Classification

Level I	Chapter	CD	Requirement by Chapter	
http://www.facs.org/trauma/verifivisitoutcomes.html				
•	1	1- 1	1-1 All trauma centers must participate in the state and/or regional trauma system planning, development, or operation.	TYPE II
•	2	2- 1	2-1 Surgical commitment is essential for a properly functioning trauma center.	TYPE I
•	2	2- 2	2-2 Trauma centers must be able to provide on their campus the necessary human and physical resources to properly administer acute care consistent with their level of verification.	TYPE II
•	2	2- 3	2-3 A Level I trauma center must meet admission volume performance requirements (one of the following): **a)** Admit at least 1200 trauma patients yearly, **b)** 240 admissions with an Injury Severity Score (ISS) of more than 15, **c)** An average of 35 patients with an ISS of more than 15 for the trauma panel surgeons (general surgeons who take trauma all).	TYPE I
•	2	2- 4	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 II
•	2	2- 5	2-5 General surgeon or appropriate substitute (postgraudate-year 4 or 5 resident) must be in house 24 hours a day for major resuscitations (must be present and participate in major resuscitations, therapeutic decisions, and operations).	TYPE I
•	2	2- 6	2-6 The PIPS program must define the conditions requiring the attending surgeon's immediate hospital presence.	TYPE II
•	2	2- 7	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 form 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- 8	2-8 The trauma surgeon on call must be dedicated to the trauma center while on duty.	TYPE I

•	2	2- 9	2-9 A published backup call schedule for trauma surgery must be available.	TYPE II
•	2	2-14	2-14 and 2-15 Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children: Trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body, there must be a pediatric emergency department area, pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program.	TYPE II
•	2	2-15	2-15, Refer to CD 2-14	TYPE II
•	2	2-16	2-16 For adult trauma centers admitting fewer than 100 injured children younger than 15 years, these resources are desirable. These hospitals must, however, review the care of their injured children through their PIPS program.	TYPE II
•	3	3- 1	3-1 The trauma director is involved in the development of the trauma center's bypass protocol.	TYPE II
•	3	3- 2	3-2 The trauma surgeon is involved in the decisions regarding bypass. The surgeons should be actively involved in prehospital personnel training, the PIPS process, and development of trauma components of EMS.	TYPE II
•	3	3- 3	3-3 The trauma program must participate in the development and improvement of pre-hospital care protocols and patient safety programs.	TYPE II
•	3	3- 4	3-4 The facility can not exceed the maximum divert time of 5%	TYPE II
•	4	4- 1	4-1 A mechanism for direct physician to physician contact is present for arranging patient transfers.	TYPE II
•	4	4 -2	4-2 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient; for example, payment method is not considered.	TYPE II
•	5	5- 1	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- 2	5-2 There is a current resolution (reaffirmed every three years) supporting the trauma center from the hospital board.	TYPE II
•	5	5- 3	5-3 There is a current resolution (reaffirmed every three years) supporting the trauma center from the medical staff.	TYPE II
•	5	5- 4	5-4 The multidisciplinary trauma program continuously evaluates its processes and outcomes to ensure optimal and timely care.	TYPE I
•	5	5- 5	5-5 The trauma medical director is either a board-certified surgeon or an ACS Fellow.	TYPE I

•	5	5- 6	5-6 The trauma medical director participates in trauma call.	TYPE I
•	5	5- 7	5-7 The trauma medical director is current in Advanced Trauma Life Support.	TYPE II
•	5	5- 8	5-8 The trauma director is a member and an active participant in national or regional trauma organizations.	TYPE II
•	5	5- 9	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 II
•	5	5-10	5-10 The criteria for a graded activation are clearly defined by the trauma center and continuously evaluated by the PIPS program. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	5	5-11	5-11 Programs that admit more than 10% of injured patients to nonsurgical services have demonstrated the appropriateness of that practice through the PIPS process. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	5	5-12	5-12 Seriously injured patients are admitted or evaluated by an identifiable surgical service staffed by credentialed providers.	TYPE I
•	5	5-13	5-13 There is sufficient infrastructure and support to the trauma service to ensure adequate provision of care.	TYPE I
•	5	5-14	5-14 In teaching facilities, the requirements of the Residency Review Committee are met.	TYPE II
•	5	5-17	5-17 The trauma program manager shows evidence of educational preparation (a minimum of 16 hours of trauma-related continuing education per year) and clinical experience in the care of injured patients.	TYPE II
•	5	5-18	5-18 There is a multidisciplinary peer review committee chaired by the trauma medical director or designee, with representatives from appropriate subspecialty services.	TYPE II
•	5	5-19	5-19 Adequate (>50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.	TYPE II
•	5	5-20	5-20 The core group is adequately defined by the trauma medical director.	TYPE II
•	5	5-21	5-21 The core group takes at least 60% of the total trauma call hours each month.	TYPE II
•	5	5-22	5-22 The trauma medical director ensures and documents dissemination of information and findings from the peer review meetings to the non-core surgeons on the trauma call panel.	TYPE II
•	5	5-23	5-23 There must be a Trauma Program Operational Process Performance Improvement Committee.	TYPE II

•	6	6- 1	6-1 The trauma medical director has responsibility and authority to ensure compliance with verification requirements.	TYPE II
•	6	6- 2	6-2 The general surgeon must be board-certified or meet the Alternate Pathway or is an ACS fellow.	TYPE II
•	6	6- 3	6-3 The trauma surgeon must have privileges in general surgery.	TYPE II
•	6	6- 4	6-4 The trauma surgeon on call must be dedicated to the trauma service while on duty.	TYPE I
•	6	6- 5	6-5 A published back-up call schedule for trauma surgery must be available.	TYPE II
•	6	6- 6	6-6 An attendance threshold of 80% must be met for trauma surgeon presence in the emergency department.	TYPE I
•	6	6- 7	6-7 The criteria for the highest level of activations are clearly defined and evaluated by the PIPS program. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	6	6- 8	6-8 A mechanism for documenting trauma surgeon presence in the operating room for all trauma operations is in place.	TYPE II
•	6	6- 9	6-9 There is a multidisciplinary peer review committee with participation from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia.	TYPE II
•	6	6-10	6-10 Adequate (>50%) attendance by general surgery (core group) at the multi-disciplinary peer review committee is documented.	TYPE II
•	6	6-11	6-11 All general surgeons on the trauma team have successfully completed the ATLS® course at least once.	TYPE II
•	6	6-12	6-12 The trauma medical director has documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.	TYPE II
•	6	6-13	6-13 Other trauma surgeons who take trauma call have documented 16 hours annually or 48 hours in the past 3 years of trauma-related CME or an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	TYPE II
•	6	6-14	6-14 The trauma medical director is a member of and participates in regional or national trauma organizations.	TYPE II
•	7	7- 1	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
•	7	7- 2	7-2 Emergency department physicians must be present in the emergency department at all times.	TYPE I

•	7	7- 4	7-4 In institutions in which there are emergency medicine residency training programs, supervision is provided by an in-house attending emergency physician 24 hours per day.	TYPE II
•	7	7-5	7-5 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the director of trauma services.	TYPE II
•	7	7- 6	7-6 An emergency physician is board-certified or meets the Alternate Pathway.	TYPE II
•	7	7- 7	7-7 Emergency physicians on the call panel are regularly involved in the care of injured patients.	TYPE II
•	7	7- 8	7-8 A representative from the emergency department participates in the pre-hospital PIPS program.	TYPE II
•	7	7- 9	7-9 A designated emergency physician is available to the trauma director for PIPS issues that occur in the emergency department.	TYPE II
•	7	7-10	7-10 There is emergency physician participation with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee (dealing with systems issues).	TYPE II
•	7	7-11	7-11 The emergency medicine representative or designee to the multi-disciplinary peer review committee attends a minimum of 50% of these meetings.	TYPE II
•	7	7-12	7-12 The emergency physician liaison representative has the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME	TYPE II
•	7	7-13	7-13 Other emergency physicians who take trauma call have the documented 16 hours annually or 48 hours in 3 years of trauma-related CME, or participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	TYPE II
•	7	7-14	7-14 There are emergency physicians who have successfully completed the ATLS® course.	TYPE II
•	7	7-15	7-15 The physicians who are not board certified in emergency medicine who work in the emergency department are current in ATLS®.	TYPE II
•	8	8- 1	8-1 A neurosurgical liaison is designated.	TYPE I
•	8	8- 2	8-2 Neurotrauma care is promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head and spine injuries when necessary. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE I
•	8	8- 3	8-3 The hospital provides an on-call neurosurgical backup schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed.	TYPE I

•	8	8- 4	8-4 There is a PIPS review of all neurotrauma patients who are diverted or transferred.	TYPE II
•	8	8- 5	8-5 An attending neurosurgeon is promptly available to the hospital's trauma service when neurosurgical consultation is requested.	TYPE I
•	8	8- 9	8-9 The neurosurgeons who care for trauma patients are board-certified or meet the Alternate Pathway.	TYPE II
•	8	8-10	8-10 Qualified neurosurgeons are regularly involved in the care of head - and spinal cord- injured patients and are credentialed by the hospital with general neurosurgical privileges.	TYPE I
•	8	8-11	8-11 The neurosurgery service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.	TYPE II
•	8	8-12	8-12 The neurosurgeon representative attends a minimum of 50% of the multidisciplinary peer review committee meetings.	TYPE II
•	8	8-13	8-13 The neurosurgeon liaison representative has documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.	TYPE II
•	8	8-14	8-14 Other neurosurgeons who take trauma call have the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME, and participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	TYPE II
•	9	9- 1	9-1 Physical and occupational therapists and rehabilitation specialists are present.	TYPE II
•	9	9- 2	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- 3	9-3 A mechanism to ensure operating room availability without undue delay for patients with semiurgent orthopaedic injuries is present.	TYPE II
•	9	9- 4	9-4 There is an orthopaedic surgeon who is identified as the liaison to the trauma program.	TYPE I
•	9	9- 5	9-5 Plastic surgery, hand surgery, and spinal injury care capabilities are present at Level I trauma centers.	TYPE I
•	9	9- 6	9-6 Orthopaedic team members have dedicated call at their institution and have a backup call system.	TYPE II
•	9	9- 7	9-7 An orthopaedic team member is promptly available in the trauma resuscitation area when consulted by the surgical trauma team leader for multiply injured patients.	TYPE II
•	9	9- 8	9-8 The design of the backup call system, the responsibility of the orthopaedic trauma liaison, has been approved by the trauma program director.	TYPE II

•	9	9- 9	9-9 Level I and II centers provide sufficient resources, including instruments, equipment, and personnel, for modern musculoskeletal trauma care, with readily available operating rooms for musculoskeletal trauma procedures.	TYPE I
•	9	9-12	9-12 The orthopaedic service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.	TYPE II
•	9	9-13	9-13 The orthopaedic trauma liaison or representative attends a minimum of 50% of the multidisciplinary peer review meetings.	TYPE II
•	9	9-14	9-14 Orthopaedic surgeons who care for injured patients are board certified or meet the Alternate Pathway.	TYPE II
•	9	9-15	9-15 The orthopaedic surgeon has privileges in general orthopaedic surgery.	TYPE II
•	9	9-16	9-16 The orthopaedic surgical liaison to the trauma program at Level I and Level II centers has documented at least 16 hours annually or 48 hours in years of verifiable, external trauma-related CME.	TYPE II
•	9	9-17	9-17 The orthopaedic trauma team member has documentation of the acquisition of 16 hours of CME per year on average and has participated in an internal educational process conducted by the trauma program and the orthopaedic liaison based on the principles of practice-based learning and the PIPS program.	TYPE II
•	10	10- 1	10-1 Hospitals that pursue verification as pediatric trauma centers must meet the same resource requirements as adult trauma centers, in addition to pediatric resource requirements (Table 1)	TYPE II
•	10	10- 2	10-2 A Level I pediatric trauma center must annually admit 200 or more injured children younger than 15 years.	TYPE I
•	10	10- 4	10-4 and 10-5 All pediatric trauma centers must have a pediatric trauma program manager or coordinator and a pediatric trauma registrar.	TYPE I
•	10	10- 5	Refer to CD10-4	TYPE II
•	10	10- 6	10-6 In a Level I pediatric trauma center, the pediatric trauma program manager or coordinator must be dedicated to the pediatric trauma service.	TYPE II
•	10	10- 7	10-7 All pediatric trauma centers must have a pediatric trauma PIPS program.	TYPE I
•	10	10- 8	10-8 All pediatric trauma centers must have the following programs: pediatric rehabilitation, child life and family support programs, pediatric social work, child protective services, pediatric injury prevention, community outreach, and education of health professionals and the general public in the care of pediatric trauma patients.	TYPE II

•	10	10- 9	10-9 A pediatric trauma center must have identifiable pediatric trauma research.	TYPE II
•	10	10-10	10-10 A Level I pediatric trauma center must have at least 2 surgeons who are board-certified or board-eligible in pediatric surgery by the American Board of Surgery	TYPE I
•	10	10-11	10-11 and 10-12 There must be 1 board-certified or board-eligible orthopaedic surgeon and 1 board-certified or board-eligible neurosurgeon on staff who have had pediatric fellowship training.	TYPE I
•	10	10-12	Refer to CD 10-11	TYPE I
•	10	10-13	10-13 and 10-14 There must be 1 additional board-certified or board-eligible orthopaedic surgeon and 1 additional board-certified or board-eligible neurosurgeon identified with demonstrated interests and skills in pediatric trauma care.	TYPE II
•	10	10-14	Refer to CD 10-13	TYPE II
•	10	10-15	10-15 There must be 2 physicians who are board-certified or board-eligible in pediatric critical care medicine or in pediatric surgery and surgical critical care by the American Board of Surgery.	TYPE I
•	10	10-16	10-16 There must be 2 physicians who are board-certified or board-eligible in pediatric emergency medicine.	TYPE II
•	10	10-17	10-17 and 10-18 The pediatric intensive care unit and the pediatric section of the emergency department must be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas.	TYPE II
•	10	10-18	Refer to CD 10-18	TYPE II
•	10	10-22	10-22 and 10-23 In a Level I pediatric trauma center, the pediatric trauma medical director must have successfully completed board examinations in general surgery and be board-certified or board-eligible in pediatric surgery.	TYPE I
•	10	10-23	Refer to CD 10-22	TYPE I
•	10	10-24	10-24 There are non-pediatric trained surgeons serving on the pediatric panel with proper qualifications: (1) credentialed by the hospital to provide pediatric trauma care, (2) members of the adult trauma panel, (3) the pediatric trauma medical director has agreed to their having sufficient training and experience in pediatric trauma care, and (4) their performance has been reviewed by the pediatric PIPS program.	TYPE I

•	10	10-25	10-25 For Level I and II pediatric trauma centers, it is expected that the trauma surgeon be in the emergency department on patient arrival, with adequate advance notification from the field. The maximum acceptable response time is 15 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80% attendance threshold must be met for the highest level of activation.	TYPE I
•	10	10-26	10-26 The trauma surgeon is expected to be present in the operating room for all trauma operations. A mechanism for documenting this presence is essential.	TYPE II
•	10	10-27	10-27 The program must make specialty-specific pediatric education available for other specialists (anesthesiology, neurosurgery, orthopaedic surgery, emergency medicine, radiology, and rehabilitation).	TYPE II
•	10	10-28	10-28 An organized pediatric trauma service led by a pediatric trauma medical director must be present.	TYPE I
•	10	10-29	10-29 Full-service general hospitals providing comprehensive care for adults and children historically have provided the majority of adult and pediatric trauma care in urban and suburban areas. Hospitals that seek verification as an adult and pediatric trauma center must meet the criteria for the verification level sought in each type of center.	TYPE II
•	10	10-30	10-30 and 10-31 Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating its capability to care for the injured child: the trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body , there must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program.	TYPE II
•	10	10-31	Refer to CD 10-30	TYPE II
•	10	10-32	10-32 For adult trauma centers admitting fewer than 100 injured children younger than 15 years must review the care of injured children through their PIPS programs.	TYPE II
•	10	10-33	10-33 There must be a multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from pediatric/general surgery, orthopaedic surgery, neurosurgery, emergency medicine, critical care medicine, and anesthesia to improve trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses.	TYPE I

•	10	10-34	10-34 Attendance by the required representatives to at least 50% of the multidisciplinary peer review meetings must be documented, and all pediatric and general surgeons on the trauma panel treating children must attend at least 50% of the multidisciplinary peer review meetings.	TYPE II
•	10	10-35	10-35 In Level I and II pediatric trauma centers, the pediatric trauma medical director and the liaisons from neurosurgery, orthopaedic surgery, emergency medicine, and critical care medicine must each accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external CME, of which at least 12 hours (in 3 years) must be related to clinical pediatric trauma care.	TYPE II
•	11	11- 1	11-1 Anesthesiology services are promptly available for emergency operations.	TYPE I
•	11	11- 2	11-2 Anesthesiology services are promptly available for airway problems.	TYPE I
•	11	11- 3	11-3 There is an anesthesiologist liaison designated to the trauma program.	TYPE I
•	11	11- 4	11-4 Anesthesia services in Level I trauma centers are available in-house 24 hours a day.	TYPE I
•	11	11- 5	11-5 When anesthesiology chief residents or CRNAs are used to fulfill availability requirements, the staff anesthesiologist on call is (1) advised, (2) promptly available or all times, and (3) present for all operations.	TYPE I
•	11	11- 6	11-6 The availability of the anesthesia services and the absence of delays in airway control or operations is documented by the hospital PIPS process.	TYPE II
•	11	11-11	11-11 All anesthesiologists taking call have successfully completed an anesthesiology residency.	TYPE I
•	11	11-12	11-12 The anesthesia liaison has been identified.	TYPE I
•	11	11-13	11-13 The anesthesia resident participates in the trauma PIPS process.	TYPE II
•	11	11-14	11-14 The anesthesiology representative or designee to the trauma program attends at least 50% of the multidisciplinary peer review meetings.	TYPE II
•	11	11-15	11-15 The operating room is adequately staffed and immediately available. In a Level 1 trauma center, this criterion is met by having a complete operating team in the hospital at all times, with individuals who are dedicated only to the operating room. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE I
•	11	11-16	11-16 The operating room team is fully dedicated to the duties in the operating room and does not have functions requiring its presence outside the operating room.	TYPE II

•	11	11-17	11-17 There is a mechanism for providing additional staff for a second operating room when the first operating room is occupied.	TYPE I
•	11	11-20	11-20 The operating room has the essential equipment.	TYPE I
•	11	11-21	11-21 Trauma centers have the necessary equipment for a craniotomy.	TYPE I
•	11	11-23	11-23 The trauma center has cardiopulmonary bypass and an operating microscope available 24 hours per day. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	11	11-24	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	11-25	11-25 The PACU is covered by a call team from home with documentation by the PIPS program that PACU nurses are available and delays are not occurring.	TYPE II
•	11	11-26	11-26 (I, II, III) The PACU has the necessary equipment to monitor and resuscitate patients.	TYPE I
•	11	11-27	11-27 The PIPS process ensures that the PACU has the necessary equipment to monitor and resuscitate patients.	TYPE II
•	11	11-28	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	11-29	11-29 Diagnostic information is communicated in a written form and in a timely manner.	TYPE II
•	11	11-30	11-30 Critical information is verbally communicated to the trauma team.	TYPE II
•	11	11-31	11-31 Final reports accurately reflect communications, including changes between preliminary and final interpretations.	TYPE II
•	11	11-32	11-32 Changes in interpretation are monitored through the PIPS program.	TYPE II
•	11	11-33	11-33 There is at least 1 radiologist appointed as liaison to the trauma program.	TYPE II
•	11	11-34	11-34 Radiology participates in the trauma PIPS program by at least being involved in protocol development and trend analysis that relate to diagnostic imaging.	TYPE II
•	11	11-35	11-35 The trauma center has 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.	TYPE II
•	11	11-36	11-36 Conventional radiography and CT are available in all trauma centers 24 hours per day.	TYPE I

•	11	11-37	11-37 There is an in-house radiographer at Level I and II trauma centers. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE I
•	11	11-38	11-38 In a Level I trauma center, there is an in-house CT technologist.	TYPE I
•	11	11-40	11-40 Conventional catheter angiography and sonography are available 24 hours per day.	TYPE I
•	11	11-41	11-41 MRI capability is available 24 hours per day at Level I trauma centers.	TYPE II
•	11	11-42	11-42 The PIPS program documents the appropriate timeliness of the arrival of the MRI technologist.	TYPE II
•	11	11-43	11-43 There is a surgically directed ICU physician team.	TYPE I
•	11	11-44	11-44 The surgical director or coordinator of the ICU has the appropriate training and experience for the role.	TYPE II
•	11	11-46	11-46 The trauma surgeon remains in charge of patients in the ICU.	TYPE I
•	11	11-47	11-47 Physician coverage of critically ill trauma patients must be promptly available 24 hours per day.	TYPE I
•	11	11-48	11-48 Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients.	TYPE I
•	11	11-50	11-50 The surgical director of the ICU must have obtained critical care training during residency or fellowship and must have expertise in perioperative and post-injury care of injured patients.	TYPE II
•	11	11-51	11-51 The surgical director of the ICU must have added certification in surgical critical care from the American Board of Surgery or must have fulfilled the Alternate Pathway for critical care. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	11	11-53	11-53 The trauma service retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level.	TYPE I
•	11	11-54	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	11-55	11-55 The patients in Level I facilities have in-house physician coverage for ICU at all times. **Refer to FAQ FOR 11.56, http://www.facs.org/trauma/optimalcare.pdf**	TYPE I
•	11	11-58	11-58 A qualified nurse is available 24 hours per day to provide care during the ICU phase.	TYPE I
•	11	11-59	11-59 The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU.	TYPE II
•	11	11-60	11-60 The ICU has the necessary equipment to monitor and resuscitate patients.	TYPE I

•	11	11-61	11-61 Intracranial pressure monitoring equipment is available.	TYPE I
•	11	11-63	11-63 Level I facilities must have a full spectrum of surgical specialists available. (orthopaedic surgery, neurosurgery, cardiac surgery, thoracic surgery, hand surgery, microvascular surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology)	TYPE I
•	11	11-66	11-66 In a Level I trauma center, medical specialists on staff must include: cardiology, infectious disease, pulmonary medicine, and nephrology and their respective support teams (for example, respiratory therapy, dialysis team, and nutrition support).	TYPE II
•	11	11-70	11-70 A respiratory therapist is available to care for trauma patients 24 hours per day.	TYPE I
•	11	11-72	11-72 Acute hemodialysis is available.	TYPE II
•	11	11-75	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	11-76 The blood bank must be capable of blood typing and cross matching.	TYPE I
•	11	11-77	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	11-78 The capability for coagulation studies, blood gases, and microbiology must be available 24 hours a day.	TYPE I
•	12	12- 1	12-1 In Level I and II trauma centers, rehabilitation services must be available within its physical facilities or to a freestanding rehabilitation hospital, through a transfer agreement.	TYPE II
•	12	12- 2	12-2 The hospital must provide physical therapy services.	TYPE I
•	12	12- 3	12-3 The hospital must provide social services.	TYPE II
•	12	12- 4	12-4 The hospital must provide occupational therapy services.	TYPE II
•	12	12- 5	12-5 The hospital must provide speech therapy services.	TYPE II
•	12	12- 6	12-6 Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services are available during the acute phase of care.	TYPE II
•	15	15- 1	15-1 Trauma registry data are collected and analyzed.	TYPE II
•	15	15- 2	15-2 The data are submitted to the National Trauma Data Bank. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	15	15- 3	15-3 The trauma center uses the registry to support the PIPS process.	TYPE II
•	15	15- 4	15-4 The trauma registry has at least 80% of the trauma cases entered within 60 days of discharge	TYPE II

•	15	15- 5	15-5 The trauma program ensures that trauma registry confidentiality measures are in place.	TYPE II
•	15	15- 6	15-6 There are strategies for monitoring data validity for the trauma registry.	TYPE II
•	16	16- 1	16-1 The trauma center demonstrates a clearly defined PIPS program for the trauma population.	TYPE II
•	16	16- 2	16-2 The PIPS program is supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement.	TYPE II
•	16	16- 3	16-3 The program is able to demonstrate that the trauma registry supports the PIPS process.	TYPE II
•	16	16- 4	16-4 The process of analysis includes multidisciplinary review.	TYPE II
•	16	16- 5	16-5 The process of analysis occurs at regular intervals to meet the needs of the program.	TYPE II
•	16	16- 6	16-6 The results of analysis define corrective strategies.	TYPE II
•	16	16- 7	16-7 The results of analysis and corrective strategies are documented.	TYPE II
•	16	16- 8	16-8 The trauma program is empowered to address issues that involve multiple disciplines.	TYPE II
•	16	16- 9	16-9 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	TYPE II
•	16	16-10	16-10 The trauma program has a medical director with the authority and administrative support to lead the program.	TYPE II
•	16	16-11	16-11 The trauma medical director has sufficient authority to set the qualifications for the trauma service members.	TYPE II
•	16	16-12	16-12 The trauma medical director has sufficient authority to recommend changes for the trauma panel based upon performance reviews.	TYPE II
•	16	16-13	16-13 Identified problem trends undergo multidisciplinary peer review by the Trauma Peer Review Committee.	TYPE II
•	16	16-14	16-14 The trauma center is able to separately identify the trauma patient population for review.	TYPE II
•	16	16-15	16-15 There is a process to address trauma program operational issues.	TYPE II
•	16	16-16	16-16 There is documentation reflecting the review of operational issues and, when appropriate, the analysis and proposed corrective actions.	TYPE II
•	16	16-17	16-17 The process identifies problems.	TYPE II
•	16	16-18	16-18 The process demonstrates problem resolution (loop closure).	TYPE II

•	16	16-19	16-19 There is a trauma multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia.	TYPE II
•	16	16-20	16-20 The attendance by the trauma medical director and the specialty representatives is at least 50%.	TYPE II
•	16	16-21	16-21 The core general surgeon attendance at the trauma peer review committee is at least 50%.	TYPE II
•	16	16-22	16-22 In circumstances when attendance is not mandated (non-core members), the trauma medical director ensures dissemination of information from the trauma peer review committee.	TYPE II
•	16	16-23	16-23 The trauma medical director documents the dissemination of information from the trauma peer review committee.	TYPE II
•	16	16-24	16-24 Evidence of appropriate participation and acceptable attendance is documented in the PIPS process.	TYPE II
•	16	16-25	16-25 Deaths are systematically categorized as preventable, non-preventable, or potentially preventable. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf -- New nomenclature (Effective January 2012)**	TYPE II
•	16	16-26	16-26 When a consistent problem or inappropriate variation is identified, corrective actions are taken and documented.	TYPE II
•	16	16-27	16-27 The performance improvement program must be consistently functional, with structure and process.	TYPE I
•	17	17- 1	must be consistently functional, with structure and process. (16.27)	TYPE II
•	17	17- 2	17-2 The trauma center provides some means of referral and access to trauma center resources.	TYPE II
•	17	17- 3	17-3 The trauma center is involved in prevention activities, including public educational activities.	TYPE II
•	17	17- 4	17-4 The Level I trauma center provides and participates in an ATLS® course at least annually. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II

•	17	17- 5	17-5 A Level I trauma center must provide a continuous rotation in trauma surgery for senior residents (PGY 4 or higher) that is part of an Accreditation Council for Graduate Medical Education- accredited program in any of the following disciplines: general surgery, orthopaedic surgery, or neurosurgery; or support an acute care surgery fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma. F**or Pediatric Level I trauma centers – it is PGY 3 or higher) Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE I
•	17	17- 6	17-6 The hospital provides a mechanism for trauma-related education for nurses involved in trauma care.	TYPE II
•	17	17- 7	17-7 All general surgeons and emergency medicine physicians on the trauma team have successfully completed the ATLS® course at least once.	TYPE II
•	17	17- 8	17-8 The trauma director and liaison representatives from neurosurgery, orthopaedic surgery, and emergency medicine have accrued an average of 16 hours annually or 48 hours in 3 years of trauma related CME. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	17	17- 9	17-9 Other general surgeons, neurosurgeons, orthopaedic surgeons, and emergency medicine specialists who take trauma call have acquired 16 hours of CME per year on average or participated in an internal educational process.	TYPE II
•	18	18- 1	18-1 The trauma center participates in injury prevention.	TYPE II
•	18	18- 2	18-2 The trauma center has a prevention coordinator with a demonstrated job description and salary support.	TYPE II
•	18	18- 3	18-3 The trauma center demonstrates the presence of prevention activities that center on priorities based on local data.	TYPE II
•	18	18- 4	18-4 The trauma center demonstrates collaboration with or participation in national, regional, or state programs.	TYPE II
•	18	18- 5	18-5 The trauma center has a mechanism to identify patients who are problem drinkers.	TYPE II
•	18	18- 6	18-6 The trauma center has the capability to provide intervention or referral for patients identified as problem drinkers. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	19	19- 1	19-1 The Level I trauma center meets either the minimum of 20 peer-reviewed articles published in Journals included in *Index Medicus* in 3 years or the criterion of 4 of 7 scholarly activities as listed in the chapter and 10 peer-reviewed articles published in journals included in *Index Medicus/Medline* in 3 years.	TYPE II
•	19	19- 2	19-2 The research resulted from work related to the trauma center.	TYPE II

•	19	19- 3	19-3 The articles include authorship or co-authorship by a member of the general surgery trauma team.	TYPE II
•	19	19- 4	19-4 Of the 20 articles there is at least 1 that includes authorship or co-authorship by members of the general surgery trauma team and at least 1 each from 3 of 6 disciplines: neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, and rehabilitation. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	19	19- 5	19-5 The trauma center meets the alternative criteria for research: *10 peer-reviewed articles published in journals included in *Index Medicus* resulting from work in the trauma center with at least 1 authored or coauthored by members of the general surgery trauma team and at least 1 each from 3 of 6 disciplines (neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, and rehabilitation). AND * 4 of 7 scholarly activities as stated in Chapter 19, Trauma Research & Scholarship. **Refer to FAQ, http://www.facs.org/trauma/optimalcare.pdf**	TYPE II
•	19	19- 6	19-6 The administration of the trauma center demonstrates support of the research program.	TYPE II
•	20	20- 1	20-1 The hospital meets the disaster-related requirements of JCAHO.	TYPE II
•	20	20- 2	20-2 A trauma panel surgeon is a member of the hospital's disaster committee.	TYPE II
•	20	20- 3	20-3 Hospital drills that test the individual hospital's disaster plan are conducted at least every 6 months.	TYPE II
•	20	20- 4	20-4 The trauma center has a hospital disaster plan described in the hospital disaster manual.	TYPE II
•	21	21- 1	21-1 The trauma center has an established relationship with a recognized OPO.	TYPE II
•	21	21- 2	21-2 There are written policies for triggering notification of the OPO.	TYPE II
•	21	21- 3	21-3 The PIPS process reviews the organ donation rate.	TYPE II
•	21	21- 4	21-4 There are written protocols for declaration of brain death.	TYPE II

PIPS	Performance Improvement and Patient Safety
Core Group	Definition of Core = Those surgeons identified by the trauma medical director who participate in the Trauma Multidisciplinary Peer Review Committee meetings and take 60% of the trauma call.