American College of Surgeons
Consultation/Verification Program
Reviewer Reference Guide of Suggested Classification

Pediatric Level II	Chapter	CD	Requirement by Chapter	
http://www.facs.org/trauma/verifivisitoutcomes.html				
•	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	TYPE II
•	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 CD10-4	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	10-17	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	See 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	10-24	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	See 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

In addition to the Level II Trauma Center requirements, the above must be met.