

Resources for Optimal Care of the Injured Patient 2006

Chapter	Level II Requirement by Chapter
2	2-1 Surgical commitment is essential for a properly functioning trauma center.
2	2-7 (6-6) It is expected that the trauma 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 ED arrival time. The program must demonstrate that the surgeon's presence is in compliance at least 80% of the time.
2	2-8 (6-4) The trauma surgeon on call must be dedicated to the trauma center while on duty.
5	5-1 The hospital has the commitment of the institutional governing body and the medical staff to become a trauma center.
5	5-12 Seriously injured patients are admitted or evaluated by an identifiable surgical service staffed by credentialed providers.
5	5-13 There is sufficient infrastructure and support to the trauma service to ensure adequate provision of care.
5	5-4 The multidisciplinary trauma program continuously evaluates its processes and outcomes to ensure optimal and timely care.
5	5-5 The trauma medical director is either a board-certified surgeon or an ACS Fellow.
5	5-6 The trauma medical director participates in trauma call.
6	6-4 The trauma surgeon on call must be dedicated to the trauma service while on duty. (Refer to CD 2-8)
6	6-6 An attendance threshold of 80% must be met for trauma surgeon presence in the emergency department. (Refer to CD 2-7)
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.
8	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 the FAQ, http://www.facs.org/trauma/faq_answers.html
8	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.
8	8-5 An attending neurosurgeon is promptly available to the hospital's trauma service when neurosurgical consultation is requested.
8	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.
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.
9	9-4 There is an orthopaedic surgeon who is identified as the liaison to the trauma program.
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.
11	11-1 Anesthesiology services are promptly available for emergency operations.

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11	11-2 Anesthesiology services are promptly available for airway problems.
11	11-3 There is an anesthesiologist liaison designated to the trauma program.
11	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.
11	11-7 Anesthesia services are available 24 hours a day and present for all operations.
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.
11	11-9 In a center without anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management.
11	11-11 All anesthesiologists taking call have successfully completed an anesthesiology residency.
11	11-12 The anesthesia liaison has been identified.
11	11-17 There is a mechanism for providing additional staff for a second operating room when the first operating room is occupied.
11	11-18 The operating room is adequately staffed and immediately available. Refer to the FAQ, http://www.facs.org/trauma/faq_answers.html
11	11-20 The operating room has the essential equipment.
11	11-21 Trauma centers have the necessary equipment for a craniotomy.
11	11-24 The PACU has qualified nurses available 24 hours per day as needed during the patient's post-anesthesia recovery phase.
11	11-26 (I, II, III) The PACU has the necessary equipment to monitor and resuscitate patients.
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.
11	11-36 Conventional radiography and CT are available in all trauma centers 24 hours per day.
11	11-37 There is an in-house radiographer at Level I and II trauma centers. Refer to the FAQ, http://www.facs.org/trauma/faq_answers.html
11	11-40 Conventional catheter angiography and sonography are available 24 hours per day.
11	11-46 The trauma surgeon remains in charge of patients in the ICU.
11	11-47 Physician coverage of critically ill trauma patients must be promptly available 24 hours per day.
11	11-48 Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients.
11	11-53 The trauma service retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level.
11	11-54 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.
11	11-58 A qualified nurse is available 24 hours per day to provide care during the ICU phase.
11	11-60 The ICU has the necessary equipment to monitor and resuscitate patients.

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11	11-61 Intracranial pressure monitoring equipment is available.
11	11-70 A respiratory therapist is available to care for trauma patients 24 hours per day.
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.
11	11-76 The blood bank must be capable of blood typing and cross matching.
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.
11	11-78 The capability for coagulation studies, blood gases, and microbiology must be available 24 hours a day.
12	12-2 The hospital must provide physical therapy services.
12	12-6 Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services must be available during the acute phase of care in Level I and II trauma centers.
13	13-2 The PIPS process demonstrates the appropriate care or response by providers.
15	15-1 Trauma registry data are collected and analyzed.
16	16-27 The performance improvement program must be consistently functional, with structure and process. (NEW)

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