B-RAC Regional Trauma System Plan
Trauma Service Area - B

B-RAC MISSON:

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/2011	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

The mission of the B-RAC is to extend trauma care to the citizens of West Texas and all persons requiring trauma care in a fiscally responsible manner by working with entities and services either directly or indirectly involved in their care to improve health, of life and services while decreasing trauma related mortality and morbidity.

B-RAC GOALS: The primary goals of the B-RAC include but are not limited to:

1. The development of a Trauma System Plan for TSA-B, in accordance with the Texas Department of State Health Services guidelines for comprehensive system development with submission of the plan to the Texas Department of State Health Services as required by the Trauma Rules.
2. Decreasing morbidity and mortality resulting form trauma.
3. Assisting member organizations in attaining trauma designation at the level appropriate to resources available within their immediate service area.
4. Providing a forum to resolve conflict among members regarding trauma care and encourage activities designed to promote cooperation between member organizations.
5. Seeking ways to improve funding of trauma care providers within the counties served by TSA-B.
6. Increasing public awareness of the methods to access the trauma care system and trauma prevention.
7. Enhancing communication between healthcare providers and facilitate the transport of patients to appropriate facilities by utilization of the most effective mode of transport.
8. Developing within TSA-B, a comprehensive, standardized method of evaluating and improving care through:
    a. quality improvements activities
    b. education, injury prevention programs and certification programs
9. Re-evaluate the B-RAC on a yearly basis to ensure that all appropriate entities have been invited to participate; re-evaluate the Trauma System plan and update as necessary; annual regional need assessment and annual review of bylaws.
10. Demonstrate financial accountable and fiscal stewardship with defined operational duties of leadership positions, paid positions, committee and input; responsibilities and limitations for budget creation, signing of contracts and the conducting of daily business.

FISCAL ACCOUNTABILITY AND FINANCIAL STEWARDSHIP

The Executive Board of the B-RAC will develop an annual budget. Final approval of the budget will be made by the General Membership. A line item accounting of expenses will be presented at each General Membership meeting and Executive Board meeting. An annual audit will be conducted.

The annual budget will flow a standardized accounting format and will comply with DSHS requirements for reporting. The prioritized needs as identified by the need assessment and regional system planning will be supported in the budget.
A quarterly report will be provided to the Executive Board and General Membership reflecting the status of all B-RAC income, expenses (line item) and status of all state contract funds.
The Executive Board will approve the annual budget, annual dues, if applicable, and final acceptance through a general membership vote. The fiscal year of the organization will be September 1st through August 31st.

ANNUAL REVIEW OF TRAUMA SYSTEM PLAN AND BYLAWS

The B-RAC Executive Director will make an annual review of the Trauma System plan and bylaws. This review will be submitted to DSHS and the Executive Board and general Membership of the B-RAC as required.

ANNUAL REGIONAL NEEDS ASSESSMENT

An annual needs assessment will be completed by the B-RAC Executive Director. This information will be submitted to DSHS for their review. The needs assessment will be distributed to all B-RAC participating organizations. Data from the needs assessment will provide the basis for regional planning, prioritizing and distributing of regional resources. The results of the need assessment will be presented to the Executive Committee and General membership for their review. Changes in the B-RAC Trauma System Plan will be generated and determined from the results of this needs assessment.

REGIONAL CHARACTERISTICS-yearly review

The demographics of the B-RAC area will be reviewed on a yearly basis. These areas will include but not be limited to:

Age-related characteristics
Service area population with percentage of persons over 65 years of age and under 12 years of age
Age-specific equipment and supply needs within the region
Rehabilitative services
Education and training needs
Disaster management including decontamination, PPE and education needs
Injury prevention needs- including community specific needs and special injury patterns within communities

Data collection- methods to improve data collection and needs within each service area

REGIONAL DATA REPORTING

The B-RAC will provide essential materials and access for regional trauma data reporting. The server will be located in an easily accessible and secure location. The B-RAC Executive Director will make the coordination of PHEMS reports and hospital data. Regional reporting will be made to DSHS as outlined within their reporting criteria.

SYSTEM PLAN ACCESS

A copy of the B-RAC Trauma System Plan will be located on the B-RAC website. Notices of changes will be distributed to each organization/entity within 30 days when changes have been made.

B-RAC COMMUNICATIONS

The Executive Director of the B-RAC will establish and e-mail membership list and list of all members of the General Membership as well as a list of committee members that will be updated on an annual basis. Communications related to meetings, information/alerts, disaster management and other areas will be communicated via this mode to all e-mail participants.

DSHS REVIEW

B-RAC will provide the following to DSHS. The annual summary report will be compiled by the Director and submitted to DSHS as outlined below.

1. Schedule of all Executive Board and General Membership meetings and notification no less than 7 days prior to called meeting.
2. Minutes of meetings, including list of attendees and organizations they represent within 30 days for approval.
3. Any major changes in the B-RAC. These include changing leadership, bylaws revisions and other reviews of policy and procedure.
4. Any B-RAC leadership changes no less than 7 days after the change. A copy of revisions to bylaws and other changes will be submitted to DSHS no less than 30 days after approval.
5. Annual report to DSHS at conclusion of fiscal year. Include: short and long term objectives for the RAC and any changes to B-RAC operations.
6. Any other information requested by DSHS as related to B-RAC activities.

EDUCATION AND TRAINING

The B-RAC will develop, coordinate and schedule educational opportunities in response to RAC membership learning needs assessments. These programs will address learning and skills that are identified through the regional Performance Improvement / Patient Safety (PIPS) program. Educational offerings will be developed to address continuum of care, injury prevention, and programs that are consistent with systems development. Education to all members will be offered and the Executive Director will provide documentation of this. Written documentation will be in place.

EMERGENCY/DISASTER PREPARATION

A written disaster plan will be in place for the region. Coordination of services provided by all providers will be reflected within this plan. The plan will address availability of resources, standard planning components, threat analysis, resource assessment, and hospital/pre-hospital resources. This plan will be fully integrated with hospital and regional/city plans. Centralized coordination will be in place. These efforts will be coordinated through the Regional Preparedness committee, local Emergency Preparedness groups and DSHS.

REGIONAL PERFORMANCE IMPROVEMENT

An established plan for monitoring system performance is in place. The PIPS committee of the RAC directs this plan. A review of mortality and morbidity within the RAC is addressed. Specific goals and objectives are in place. The plan is reviewed yearly and new indicators are put in place. The Executive Director of the B-RAC keeps minutes. Sign in rosters are also in place.

A regional data collection registry will be in place. The data generated from this registry will provide and overview of the trauma issues within the TSA.

Coordination of PIPS activities related to skill competence or identified areas of need will be directed from the PIPS committee to Educators and the Medical Directors. RAC PIPS is multidisciplinary in nature. Confidentiality agreements are in place to ensure patient and service confidentiality.

Case reviews related to trauma are in place. The reviews are done at the regional level with EMS and at the PIPS Committee level. These allow for the sharing of information, review of patient outcomes. Outcomes related to trauma will be coordinated through the Injury Prevention committee, DSHS Dept. of Epidemiology and regional trauma registry data.

A regional review of appropriateness of patients treated within facilities will be made and presented to the PIPS committee. This information includes data related to types of patients, patients transferred and length of stay in referring facilities. Issues related to care from tertiary care perspectives would be presented as they occur.

PIPS committee will incorporate pediatric issues and concerns as well as registry and injury prevention specific for this TSA.

PEDIATRIC COMMITMENT AND QUALITY OF CARE REVIEW

It is recognized that Pediatric Trauma is the leading cause of death in children. The B-RAC will include pediatric assessment, quality review and injury prevention initiatives related to pediatric trauma. Education opportunities, regional assessment and quality review may include but is not limited to:

Child Fatality Review Teams
Quality Improvement activities including car passenger safety seat inspections and installations
Timelines and appropriateness of pediatric trauma transfers
General pediatric care provided to the critically ill and injured child.
Develop and implement “accepted” standards of care related to pediatric patient care as outlined by the Pediatric Subcommittee of GETAC.

INTRODUCTION

Texas Trauma Service Area (TSA) B consists of 22 counties with a population of 400,000+ persons. The largest of these counties in Lubbock, which serves as the geographic "hub" for the TSA. There are 18 hospitals within the TSA. UMC is a Level I trauma facility and Covenant Medical Center (CMC) is a Level II trauma center and Covenant Women and Childrens' Hospital. There are 12 hospitals that have received Level IV trauma designation.

There are 55 EMS services including air medical within TSA-B. The majority function under protocols and standards developed and implemented by the South Plains Emergency Medical Services (SPEMS) organization, while some act as independent licensed services. EMS services are represented in the Regional Advisory council (RAC) of TSA-B. The services provided by EMS range from paramedic to first responders and are a mixture of paid and volunteer services. (see attachment for list of services)

Referral patterns are from the rural facilities and region to the tertiary care centers located in Lubbock. Patient flow is via ground or air medical services. Patient referrals to tertiary care centers are through direct referrals and/or scene transports. The coordination of care and services is instrumental in the provision of safe and efficient trauma care. Rural facilities EMS providers, tertiary care centers, SPEMS and other interested agencies work in this coordination to provide optimal care to the trauma population.

A network has been developed through trauma development. This network allows for the sharing of ideas, implementation of better and improved trauma systems care and improved patient care. The tertiary care centers provide assistance to regional facilities and trauma coordinators in trauma care issues, education and preparation for trauma designation, as well as providing resources to EMS services when needed. There is an Executive Director is in place to oversee daily operations, committees, documentation, financial aspects and general duties for the TSA-B. This Executive Director works with EMS services, the community and hospitals in providing guidance and oversight on the RAC.

RAC COMPONENTS AND COMPONENT ISSUES SYSTEM ACCESS OBJECTIVES:

The system Access component of the B-RAC plan will:

1. Provide overview of the current 911 and enhanced 911 system in place
2. Define the communication network with in the TSA
3. Describe strengths, weaknesses, current resources, and long term objectives for system Access.

RESOURCES: Resources currently available include 911 basic, 911 enhanced, Automatic Number Identification(ANI) and Automatic Location Identification (ALI) which are available in enhanced 911 only. All systems are enhanced 911 with different levels of service. There are dedicated trunk lines which allow direct routing of emergency calls. Routine is based on the telephone exchange area, not municipal boundaries There are no basic 911 systems within the South Plains region.

CURRENT WORK: Primary emergency communication systems for public access is Enhanced 911. The emergency communication systems were implemented providing citizens access to emergency communication to municipalities and counties (incorporated and unincorporated) in the TSA. 911 calls are routed to the local telephone company central office and then a telephone number or ANI is attached to the voice and sent to PSAP (Public Safety Answering Point). With ALI and SR, the call is sent to the telephone central office and the computer (911 Database) assigns an address to the phone number, then routes the call to the designated PSAP.

ANI is a system capability that enables an automatic display of the seven-digit number of the telephone used to place the 911 call. ALI enables automatic display of the calling party's name, address and other information.

Alternate routing (AR) is a selective routing feature, which allows 911 calls to be routed to a designated alternative location if all incoming 911 lines are busy.

Selective routing (SR) is a telephone system that enables 911 calls from a defined geographical area to be answered at a pre-designated PSAP (public Safety Answering Point).

COMMUNICATIONS NETWORK

The South Plains Association of Governments administers the South Plains 911 Emergency Communications Systems. The communications system includes the following counties:

Bailey (ALI)	Floyd (ALI)	Crosby (PC/ALI)
Hockley(ALI)	Dickens (PC/ALI)	Hale (ALI)
Motley (ALI)—	Floyd Terry (ALI)	Kent (PC/ALI)-Dickens
King (PC/ALI)-Dickens	Stonewall (PC/ALI)-Dickens	Yoakum (ALI)
Cochran (PC/ALI)	Lamb (ALI)	Garza (PC/ALI)
Lynn (PC/ALI)		

The Lubbock Communications District (LECD) administers the emergency communications system for the city of Lubbock, Lubbock County and the cities of Abernathy and Plainview.

The LECD contingency plan for the 911 systems includes redundancy of all communication links, with alternate routing capabilities for either system overflow or evacuation of any of the communication center; Each center is equipped with an emergency backup power source and ring down circuits connection each 911 answering point. Connectivity is available through the cellular network, as well as radio communication.

All coin operated telephones in the South Plains region are programmed to offer free 911 access.

Public education has been implemented to target all residents. Curriculums, videos and other public education materials are available for use in educating the public to the 911 system.

LONG TERM OBJECTIVES: 1. To provide 911 access with enhancements are financially available to the citizens, communities and services within the ~~South Plains~~ TSA-B.

COMMUNICATIONS

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/11	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

OBJECTIVES:

1. To provide communication access to EMS providers, hospitals and the public.
2. Define communication centers and dispatch centers for TSA-B
3. Describe educational requirements for the persons providing dispatch

RESOURCES:

LUBBOCK DISPATCH CENTER: Lubbock County EMS maintains an emergency dispatch system. All dispatch personnel are verified by the Texas Department of Health (DSHS) as Paramedics and/or Emergency Medical Technicians (EMT). All dispatch personnel are trained in Medical Priority for pre-arrival instructions. This dispatch center is classified as the Regional Communication Center for the B-RAC. A full communication manual is in place and outlines review procedures, frequency of reviews and other aspects related to ensuring quality care through this center.

There is formal training conducted at UMC. Medical Priority Dispatch Pre-arrival Instructions are used. APCO Institute Criteria Based Dispatch Guide Cards are also utilized.

CURRENT WORK:

There are ultra frequency (450-470 MHz) radio capabilities in Lubbock County and throughout the (Trauma Service Area–B) TSA-B. Within the radio band, ten paired sets of frequencies are reserved for EMS communications and nave been assigned. Duplex multiplex four-channel equipment is operational for ambulance- to- dispatch, an ambulance-to- hospital and hospital-to-hospital. Aeromedical capabilities are also available.

LONG TERM OBJECTIVES:

1. Continue discussions with City of Lubbock on integration of services with multi-agency responses.
2. Upgrade communications systems to meet growing needs of the TSA-B.

MEDICAL OVERSIGHT/MEDICAL CONTROL

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/11	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

OBJECTIVES:

1. To provide medical leadership for trauma care provided throughout the South Plains.
2. To describe the Quality Management process for trauma patient care review through the continuum
3. To determine medical direction and protocols for utilization by EMS services within TSA-B.

NEED ANALYSIS:
An ongoing assessment is done by the EMS services through revisions of protocols for trauma care. This direction is overseen by the Medical Director of SPEMS with assistance from the SPEMS office staff. Quality Management sets up yearly indicators for review based on statistical data and findings from meetings.

RESOURCES:
EMS MEDICAL OVERSIGHT: TSA-B is both urban and rural. The Medical Director for SPEMS is Dr. Joe Sasin, Board Certified and experienced in trauma care in both the pre-hospital and hospital arena.

Medical Direction is provided at both a regional and local level to EMS services that request this service. Protocols are reviewed and revised yearly. Education is provided on these revisions via a structured action plan.

Continuing education and EMS PIPS review is conducted by trained provider personnel under the direction of the Medical Director. These reviews are scheduled at least monthly in areas of the region covered by SPEMS. This includes skill performance, practice and run reviews.

EMS Medical Direction participates in continuing education and outreach programs. It also participates in protocol, bypass and diversion decisions and emergency disaster preparedness. Specific reviews are made at the regional level on scene times, PIPS issues, and issues specific to that service.

EMS run report data is collected and submitted through an established system to the DSHS registry department. Data sets have been developed.

Field command is defined within the Disaster/Mass Casualty portion of the EMS system. A regional plan is being addressed though cooperative efforts with EMS, hospitals, and City of Lubbock and the Texas Department of State Health Services.

HOSPITAL MEDICAL OVERSIGHT: Triage, patient delivery decisions, treatment and transfer protocols specific for hospitals are integrated into the TSA-B trauma plan. These include both pre-hospital and hospital information. These portions of each facilities trauma plan outline the role that they play in the stabilization, resuscitation, admission, and/or transfer of patients within our TSA. Each facility maintains a trauma manual, which references each of these areas.

Medical oversight for the trauma programs within each facility is defined with a Medical Director responsible for trauma. Medical oversight to regional facilities via EMS is the responsibility of the Emergency Department physician and/or regional EMS protocols.

LONG TERM OBJECTIVES:

1. Continue to provide quality EMS services to the citizens of TSA-B based on protocols, guidelines, review and quality improvement activities
2. Provide optimal care medical direction through hospitals and EMS services to ensure quality trauma care

PREHOSPITAL TRIAGE CRITERIA

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/11	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

OBJECTIVES:

1. To provide optimal treatment to trauma patients by ensuring that the right patient goes to the right facility in the right amount of time
2. To provide a framework for pre-hospital providers to make informed decisions related to patient presentation and ultimate disposition.
3. To describe the anatomic, physiologic, mechanism of injury and co-morbid factors in the decision making process for patient triage and disposition.

NEEDS ANALYSIS:

Pre-hospital triage criteria are reviewed in protocol review and revision a yearly basis. The standard for these is based on the "Optimal Care" Guidelines developed by the American College of Surgeons Committee on Trauma and the Emergency Physicians Medical Association.

Current resources include SPEMS protocols for all levels of pre-hospital care. These protocols are based on nationally recognized standards of care. Coordination and standardization of pre-hospital care is provided by the Texas Department of State Health Services, Bureau of Emergency Management through established regulatory mechanisms. Protocol updates are provided to all pre-hospital providers.

CURRENT WORK:
Established pre-hospital triage decisions are contained within this document. Case reviews are done to analyze and evaluate specific patient care situations and provide recommendations to service providers.

Hospitals are notified via established radio and communications systems of incoming trauma patients.

LONG TERM OBJECTIVES:

1. To provide current up-to-date information to pre-hospital providers to triage trauma patients appropriately.
2. To continue to monitor, revise and review pre-hospital triage protocols and make changes accordingly.

DIVERSION POLICIES

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/11	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

OBJECTIVES:

1. To develop a hospital plan for diversion of trauma patients.
2. To ensure that communication is in place when diversion from a facility occurs.
3. To provide a written plan with review when diversion within a facility occurs.

RESOURCES:

Resources for diversion policy development were within the network of Trauma Coordinators within the State of Texas.

CURRENT WORK:

Each hospital within the TSA that is designated has a written diversion policy.
The policy includes but is not limited to:

1. Designated person to place facility on diversion
2. Procedure for placing facility on diversion
3. Reasons for diversion which include:
    a. trauma surgeon no available
    b. internal disaster
    c. specialty surgeon not available
    d. specialty equipment not available
4. Record keeping related to why diversion occurred
5. Ability to opening of critical care beds
6. Mass Casualty protocol and how to activate region wide plan
7. Diversions must be reported through the RAC PIPS committee monthly.

LONG TERM OBJECTIVES:

1. Provide mechanism for reporting and reviewing hospital diversions with TSA-B to ensure proper patient disposition.
2. Describe role that diversions play in future planning within TSA-B.

BYPASS POLICIES

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/11	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

OBJECTIVES:

1. To provide guidelines for pre-hospital providers to bypass facilities
2. To describe exceptions to bypass guidelines
3. To ensure that all participating members of TSA-B are aware of bypass guidelines

RESOURCES:

Resources utilized in the determination of bypass guidelines were the American College of Surgeons Committee on Trauma, American College of Emergency Physicians and DSHS.

CURRENT WORK:

Transport protocols must ensure that patients who meet triage criteria for activation of the regional trauma system will be transported directly to an appropriate trauma facility rather than to the nearest hospital except under the following circumstances:

1. If unable to establish and/or maintain an adequate airway, or in the case of traumatic cardiac arrest, the patient should be taken to the nearest acute facility for stabilization.
2. If expected transport time is excessive (greater than 25 minutes) or if a lengthy extrication time (greater than 15 minutes) is expected, consider contacting air medical services.
3. A rendezvous with other ground transport or air medical service may occur on hospital property or other secure area. If hospital staff provide medical assistance to patient(s) waiting rendezvous outside their facility, then the following would apply:
    a. The receiving hospital should be notified of the assistance that was provided.
    b. Assistance rendered, by whom, the patient response and reasons for assistance should be documented on the EMS run report and/or transporting service report.
    c. It is expected that the assistance rendered will not delay patient transport to a tertiary care center.
    d. The hospital must follow all provisions of the COBRA/EMTALA rules when providing assistance.
4. A level III or IV facility may be considered for immediate evaluation and stabilization if expected transport time to a lead facility is excessive (greater than 25 minutes)

5. Medical control may order bypass in any of the above situations as appropriate, such as when a facility is unable to meet hospital resource criteria or when there are patients in need of specialty care.

NOTE: If there is any question regarding whether to bypass a facility on-line medical control should be consulted for the final decision. RAC facility triage criteria for bypass should be considered.

CONSIDERATIONS: Criteria for consideration for air medical transport of trauma patients include but are not limited to:

1. Lengthy extrication and patient injury severity.
2. Mechanism of injury
    a. structural intrusion into patient space in vehicle
    b. patient ejection form vehicle
    c. death in same vehicle
    d. pedestrian struck at greater than 20 mph
    e. unrestrained patient with overturned vehicle
    f. motorcyclist thrown from bike at greater than 29 mph
    g. front bumper displaced to rear by more than 30 inches or front axle displaced to the rear
    h. fall greater than 20 feet in adult and more than 1.5 times the pediatric patient height
    i. penetrating injury between mid thigh and the head
    j. amputation or near amputation with possible timely reimplantation
    k. scalping or degloving injury
    l. severe hemorrhage. Patients with BP less than 90 systolic after initial volume resuscitation and those requiring ongoing blood or fluid for stabilization
    m. 2nd and 3rd degree burns greater than 15% or major burns to face, hands, feet, perineum or associated airway or inhalation injury.
    n. Patient with injury or potential injury to spinal cord, spinal column or neurological deficit.
    o. Injuries to face or neck which might result in an unstable or potentially unstable airway and might require invasive procedure to stabilize the airway.
    p. Altered objective ranking score for trauma (i.e. RTS,TS,CRAMS, etc.)
    q. Child less than 5 with trauma injuries
    r. Age greater than 55 and multiple trauma injuries, with or without co-morbid factors such as diabetes, heart disease, etc.
    s. Respiratory rate greater than 30 or less than 10 in adult trauma patient. Heart rate greater than 120 or less than 60.

LONG TERM OBJECTIVES:

1. To provide guidelines for facility bypass
2. To provide bypass overrides related to patient stability.
3. To review facility bypass at PIPS level and address issues and problems related to bypass.

FACILITY TRIAGE CRITERIA

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/11	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

OBJECTIVES:

1. To categorize patient and determine facility transport and/or transfer
2. To specify facility action plan for determination of patient transport and/or transfer
3. To include pediatric and burn criteria for patient transport and/or transfer

RESOURCES:
Resources utilized include physical plant review, staffing issues, and physician availability and specialty, and equipment capabilities. Resources in determination included the American College of Surgeons Committee on Trauma guidelines.

CURRENT WORK:
Patients are categorized into critical and urgent categories for this decision scheme. This assists facilities in determining which trauma patients should be transferred. It includes the facilities that should admit patients and those that should stabilize and transfer. Hospitals present transfer data at the RAC QM meeting to review types of patients being transferred as well as patients with extended lengths of stay within their facility (greater than 2 hours from arrival to disposition).

Interfacility transports are made to tertiary care centers for definitive and specialized care. Transfer to the appropriate facility is based on this criteria.

Written transfer agreements are in place. Regional transports into the tertiary care centers can be facilitated through the regional transfer line.

LONG TERM OBJECTIVES:

1. To monitor appropriateness of transfers from regional facilities
2. To review timeliness of transfers from regional facilities
3. To ensure appropriate transfers to tertiary care centers

TRAUMA SERVICE AREA--- B Regional Trauma Treatment Protocols

Date Reviewed:	Date Revised
7/18/06	
6/29/08	
4/19/11	4/19/11
07/17/2012	
07/16/2013	
07/21/2015	
06/26/2017	

PURPOSE:
The purpose of this document is to categorize the components of regional trauma treatment protocols for designated trauma facilities. Each hospital is responsible for the completion of these protocols and standard of care. This document will serve as a listing of essential criteria that is required for each trauma service.

COMPONENTS:
The following are essential criteria for treatment as defined by the Texas Department of State Health Services. These components are integrated into hospital quality improvement and educational activities for every designated trauma facility in TSA-B.

1. Assessment, resuscitation, and stabilization
2. Education and skill assessment
3. Appropriateness and quality care reviews
4. Participation in RAC PIPS process

PROTOCOL:
Every designated facility will have the following in place. These guidelines provide and overall summary of activities. The methods of implementation will be determined by each individual hospital and will be documented within their trauma service PIPS plan. A manual of existing and working protocols will be in place at each designated facility and readily available for nursing, medical and verification reviewer.

1. Assessment, resuscitation and stabilization of trauma patients. All persons providing medical and nursing care of trauma patients will meet established guidelines from DSHS. These may include but are not limited to:
    a. ATLS, BTLS, PHTLS, TNCC and PEPP
    b. ATLS and mandated by DSHS and American College of Surgeon Guidelines

Documentation of such certifications and/or requirements will be maintained by each facility and will be available for review at the time of verification review.

Ongoing education in these areas will be provided to nurses and physicians within the region in the form of outreach educational activities, conferences, etc.

2. Education and skill assessment—Each facility will provide educational opportunities for the staff caring for trauma patients (internal and /or external). The mechanism for this will be determined by each facility A record of these activities will be provided for review at the time of verification.

    a. Treatment guidelines, policies/procedure and standards of care for trauma patients will be in place at each designated facility. These guidelines will be reviewed at the time of redesignation and will be updated to meet current standards of care per each hospitals policy.

    These will include but will not be limited to:

    1. multiple trauma patients
    2. activation criteria
    3. trauma team composition
    4. care of head injured patients
    5. care of the pediatric trauma patient
    6. hypothermia
    7. massive transfusion
    8. hospital admission and transfer criteria
    9. specific equipment/procedures related to trauma care
        a. chest tube insertion
        b. crichothyrotomy
        c. blood and fluid warmers

3. Appropriateness and quality care review

    Appropriateness and quality care reviews will be done by each designated facility. These reviews will be determined within their facility. Chart audits of nursing, physician and ancillary care will be done. The quality improvement "loop closure" mechanism will be used. The methods for this completion will be determined through a variety of mechanisms, which might include:

    a. chart audits
    b. multidisciplinary team PIPS meetings
    c. physician and medical staff reviews
    d. regional quality reviews
    e. interstate quality reviews

A formal PIPS plan for this review and the overall review by the medical director for appropriateness and quality of care will be in place in each designated facility. This review will be viewed as protected.

4. Participation in RAC PIPS activities will follow established meeting requirements as determined in the B-RAC plan.