



**Level IV Trauma Care Facility Self-Assessment Categorization Application**  
 Iowa Department of Public Health  
 Bureau of Emergency and Trauma Services  
 321 E. 12<sup>th</sup> St.  
 Des Moines, IA 50319-0075  
[www.idph.state.ia.us](http://www.idph.state.ia.us)

INSTRUCTIONS: This form may be completed and submitted using two different methods. You may print this form, complete by hand, and submit it to the address listed above. You may also fill this form out electronically. Save the file on your computer and submit it to the e-mail address listed below. PLEASE NOTE: In order to do this you will need to have Adobe Acrobat Reader 7.0 or higher installed on your computer.

Questions and comments can be directed to:  
 Margot McComas BSN, CCRN  
 State Trauma Coordinator  
 515-281-0443  
[margot.mccomas@idph.iowa.gov](mailto:margot.mccomas@idph.iowa.gov)

### Hospital Information

Date of Application			
Name of Facility			
Address			
City	State	Zip	
Hospital Administrator:		Email	Phone
Trauma Program Manager (TPM):		Email	Phone
Trauma Registrar (may also be TNC):		Email	
Trauma Medical Director (TMD)	TMD Board Certification	Email	Phone
Emergency Department Medical Director (may also be TMD):			
Orthopedic Liaison (if routinely available):			
Anesthesia Liaison (if routinely available):			
Radiology Liaison:			
Laboratory Liaison:			
ED Physician Liaison:			
Neurosurgical Liaison (if routinely available):			
Registrar Staff; Injury Prevention Staff; Other Support Staff			

## Hospital Statistics / Organization / Personnel

<b># of Acute beds in facility</b>		<b># of ED beds</b>	<b># of beds set up for Trauma</b>
<b>List all Physicians providing trauma care in ED and their board certification in the corresponding box</b>			
1.		2.	
3.		4.	
5.		6.	
7.		8.	
9.		10.	
<b>Provide ATLS Certificate with expiration for each Physician</b>			

<b>List all Advanced Practice Clinicians (ARNP, PA,) taking ED call and their specialty in the corresponding box</b>			
1.		2.	
3.		4.	
5.		6.	
7.		8.	
9.		10.	
<b>Provide ATLS Certificate with expiration date for each Advanced Practice Clinician</b>			

<b>Note: Submit call schedule for past three months listing all providers covering ED trauma call.</b>
Where is the provider call schedule posted:

<b>Emergency Department</b>	
<b>Total number of nurses on the ED roster:</b>	
<b>Number of ED nursing staff who are TNCC/ATCN verified:</b>	
<b>Please list required education below (ATLS, PALS, Etc.)</b>	
1.	2.
3.	4.
5.	6.

<b>Emergency Equipment Available in the Hospital</b>						
Airway control and ventilation equipment, including laryngoscopes, ET tubes, bag-valve-mask, pocket masks, and oxygen in all sizes.	Yes	No		Drugs necessary for emergency care	Yes	No
				Surgical sets for airway control, vascular access, chest tube placement	Yes	No
End-Tidal CO2 determination	Yes	No		Equipment for cervical spine immobilization	Yes	No
Pelvic Immobilizer and/or binder	Yes	No		Pediatric weight/length-based drug dosage and equipment system	Yes	No
Rapid Infuser System	Yes	No		Thermal control equipment for patients	Yes	No
Suction devices	Yes	No		Thermal control equipment for blood/fluids	Yes	No
Monitor-defibrillator	Yes	No				
IO	Yes	No				
IV Fluids and Large-bore IV catheters	Yes	No				

List all EMS Services transporting patients to the ED and their Medical Director in the corresponding box			
1.		2.	
3.		4.	
5.		6.	
Is continuing education required for EMS?		Yes	No
If Yes, please list required education below			
1.		2.	
3.		4.	
Is there a copy of state-approved protocols for each service on file?		Yes	No
Is there a list of services and their authorization levels, including state EMS field coordinator contact information on file?		Yes	No

Lab Department	Yes	No	24 Hour Coverage?	Yes	No
Hours staffed in-house					
Coverage when not in house					
Response time					
Standard analysis of blood, urine, micro sampling and other body fluids	Yes	No			
Is there availability of blood typing and cross matching at the facility	Yes	No			

Blood Products and Number of Units available								
A+	A-	B+	B-	AB+	AB-	O+	O-	FFP
Comprehensive blood bank or access to blood bank				Yes	No			
Coagulation Studies				Yes	No			
Blood gasses and pH determinations				Yes	No			
Microbiology				Yes	No			
Drug and Alcohol Screenings				Yes	No			

Radiology Department	Yes	No	24 Hour Coverage- Radiology Tech	Yes	No
Hours staffed in-house					
Coverage when not in use					
Response time					
Portable x-ray equipment	Yes	No	CT Scanner	Yes	No
Angiography	Yes	No	Sonography	Yes	No
24 Hour Image Reads			MRI		
Please explain the 24 hour image read process:					

**Note: If General/Trauma Surgery is routinely involved in the care of the trauma patient the following shall apply:**

<b>Surgical Department</b>	Yes	No
<b>OR-Registered nurses available 24 hours per day (in house or on call)</b>	Yes	No
<b>OR available for emergencies</b>	Yes	No
<b>PACU</b>	Yes	No
<b>PACU-Registered nurses available 24 hours per day (in house or on call)</b>	Yes	No

**If Yes, explain staffing on-call policy and monitoring of response time (OR and PACU):**

<b>Intensive Care Unit</b>		
<b>ICU</b>	Yes	No
<b>ICU Medical Director (provide name and credentialing)</b>	Name:	Board Certification:
<b>ICU Co-Medical Director (provide name and credentialing)</b>	Name:	Board Certification:
<b>ICU-Registered nurses available 24 hours per day (in house or on call)</b>	Yes	No

<b>Anesthesia coverage for on-call trauma cases</b>	Yes	No
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If Yes, explain coverage:

<b>Respiratory Therapy Services available:</b>	Yes	No
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<b>Rehabilitation Services</b>	Yes	No
<b>Physical Therapy</b>	Yes	No
<b>Occupational Therapy</b>	Yes	No
<b>Speech Therapy</b>	Yes	No
<b>Social Services</b>	Yes	No

<b>Submission of electronic data to the State Trauma Registry</b>	Yes	No	<b>Data Submission within 60 days after patient discharge (report to be pulled by IDPH)</b>	Yes	No
If No, explain:					

Answer the questions below based on the dates specified.	From:	To:
Number of ED visits during period noted above (includes pts DC to home):		
Number of <b>trauma</b> patients admitted to your facility during period noted above:		
Number of <b>trauma</b> patients transferred to a Level I/II/III trauma center during period noted above: <b>(based upon your facility definition of <u>trauma patient</u>)</b>		
Number of <b>trauma deaths</b> at your facility, including DOA's, in the last <b>three years</b> :		
Percent of autopsies performed on trauma deaths:		
How many trauma referrals were made to the regional organ procurement organization in the last 12 months:		
How many trauma patient donors in the last 12 months:		
Number of patients meeting trauma code activation criteria in the last year:		
Number of "Trauma Codes/Alerts" <u>activated</u> in the last year:		
Number of trauma patients meeting the definition for registry inclusion criteria: <b>(Registry inclusion criteria noted below)</b>		

## Iowa Inclusion/Exclusion Criteria

### Definition:

*At least one* of the following injury diagnostic codes as follows:

International Classification of Diseases, Tenth Revision (**ICD-10-CM**):

- **S00-S99 with 7th character modifiers of A, B, or C ONLY.** (Injuries to specific body parts - initial encounter)
- **T07** (unspecified multiple injuries)
- **T14** (injury of unspecified body region)
- **T20-T28 with 7th character modifier of A ONLY** (burns by specific body parts - initial encounter)
- **T30-T32** (burn by TBSA percentages)
- **T79.A1-T79.A9 with 7th character modifier of A ONLY** (Traumatic Compartment Syndrome - initial encounter)

**Excluding the following isolated injuries:**

**ICD-10-CM:**

- **S00** (Superficial injuries of the head)
- **S10** (Superficial injuries of the neck)
- **S20** (Superficial injuries of the thorax)
- **S30** (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
- **S40** (Superficial injuries of shoulder and upper arm)
- **S50** (Superficial injuries of elbow and forearm)
- **S60** (Superficial injuries of wrist, hand and fingers)
- **S70** (Superficial injuries of hip and thigh)
- **S80** (Superficial injuries of knee and lower leg)
- **S90** (Superficial injuries of ankle, foot and toes)
- **Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.**

**AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9):**

- Hospital admission as defined by your trauma registry inclusion criteria
  - **and/or:**
- Patient transfers via EMS transport (including air ambulance) from one hospital to another hospital (even if later discharged from the emergency department)
  - **and/or:**
- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status)

**ENTRY INTO THE REGISTRY MUST BE PERFORMED FOR:**

- Every Trauma Activation (even if later discharged from the emergency department)-regardless of presence of qualifying injury code

## Performance Improvement Program

Submit the form currently used for trauma audits by the PIPS Program as an attachment

Describe the process for review of hospital trauma patient care:  
(which charts are audited, by whom, and what happens to data obtained)

Describe the process for review of pre-hospital trauma patient care:  
(which charts are audited, by whom, and what happens to data obtained)

**Describe the process for morbidity and mortality review of trauma care for all trauma deaths:  
(who reviews the cases, what happens with the information obtained, are the deaths graded)**

**Describe the process for assuring and documenting occurrence resolution (loop closure):  
(what happens with issues identified and how is this documented as completed)**

**Describe the process for review of all trauma transfers to definitive care and transport activities:**

**Describe the Trauma Program's involvement within the Service Area the hospital belongs to:**

<b>Trauma Activation Protocol (when to activate, who responds)</b>	Yes	No
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**Submit a copy of Trauma Team Activation Protocol**

<b>Trauma Transfer Protocol</b>	Yes	No
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**Submit a copy of Trauma Transfer Protocol**

<b>Mass Casualty / Disaster Protocols</b>	Yes	No
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<b>Participation in Disaster Drills</b>	Yes	No
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**Submit a copy of the Hospital Disaster Plan and a List of Participation in Hospital Specific and Regional Disaster Drills**

<b>Transfer agreement with a Level I, II, or III) facility</b>	Yes	No
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**Does transfer agreement include the following specialties**

<b>Burn Care</b>	Yes	No	<b>Head/Spinal care</b>	Yes	No
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**Submit a copy of all transfer agreements on file**

<b>Two-way communication with EMS</b>	Yes	No
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<b>Explain types, locations, and concerns</b>	
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<b>Immediate phone contact with a Level I or II trauma center</b>	Yes	No
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<b>Which facility, any issues or concerns</b>	
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<b>Helicopter landing site available</b>	Yes	No
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<b>Explain location</b>	
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**Prevention & Public Education**

**Please describe your facility's public education program related to trauma: programs, outreach, facility and community activities, collaboration with other institutions, participation in community prevention activities, public education related to trauma, effectiveness of programs, etc.**

**Please list weaknesses and recommendations given at your last trauma designation site visit; and indicate how they have been addressed within your trauma program. (A copy of the last survey can be sent to you upon request).**

**Items that must be submitted with this application:**

- Policies
  - Burn Stabilization
  - Spinal Care
  - Trauma Activation/Alert
  - Transfer Protocol/Procedure
  - Bypass/Diversion
  - Organ Procurement
  - Brain Death Determination
  - Emergency Blood Release
  - Massive Transfusion
  - Credentialing
  - Policy Review
  - Disaster Plan with a spreadsheet of Hospital Specific and Regional Disaster Drills Listed
- TPM-list of active involvement in State, Regional, Service Area, or National Trauma Initiatives
- ATLS® certifications for all providers covering the ED (Physicians and Advanced Practice Clinicians)
- Call schedule for all providers covering the ED from the last three months
- PIPS Plan
- Trauma audit filters (forms) for PI process, to include both adult and pediatric filters
- Formal Job Description for TMD and TPM
- Trauma Specific Organizational Chart and Facility Organizational Chart
- Summary Report of trauma data obtained from ImageTrend for 12 months prior to submission of SACA
- Transfer agreements
- Spreadsheet of all trauma specific education and outreach provided to prehospital providers, hospital staff, and the community
- Trauma Care Facility Staff Resolution-Current written resolution supporting the Trauma Care Facility (TCF) from the hospital board and administration, CEO and Board President, Chief Nursing Officer, Trauma Program Manager, Trauma Medical Director, and ED Medical Director
- Peer Review Meeting Agendas to include attendance (12 months of meeting minutes)
- Trauma Committee/PI Committee meeting minutes to include attendance (12 months of meeting minutes)
- Outside Peer Review-If peer review is routinely outsourced, please provide documentation of process and loop closure.

This application was prepared by: \_\_\_\_\_ Date \_\_\_\_\_

I have read and understand the requirements for trauma level designation. All of the information in this application is truthful and accurate to the best of my knowledge.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Completed and signed application should be returned to:

**Iowa Department of Public Health**  
**Bureau of Emergency and Trauma Services**  
**State Trauma Coordinator**  
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