ANYTOWN TRAUMA CENTER
TRAUMA PROTOCOLS

TITLE: TRAUMA TEAM ACTIVATION PROTOCOL

PURPOSE:

The purpose of the protocol is to establish guidelines for trauma team activation and define the members of the responding trauma team to facilitate the resuscitation and management of critical or seriously injured patients who require rapid, organized resuscitation, evaluation and stabilization to promote optimal outcomes. It also serves to provide triage guidelines for adult and pediatric patients.

PROCESS:

1. TRAUMA TEAM ACTIVATION PROTOCOL
   A. The criteria for activation of the trauma team is clearly defined and posted at the Emergency Department triage desk, by the EMS communication station and in the resuscitation rooms.
   B. The trauma team may be activated prior to arrival based on the EMS communication and their assessment.
   C. The trauma surgeon, emergency medicine physician, emergency department charge nurse/ house supervisor, emergency department nurses and the Trauma Program Manager may activate the trauma team.
   D. The person calling the trauma activation will initiate the trauma page to group page the trauma team and will specify the MOI, BP, HR, ETA and level of activation required and age if available.
   E. If the trauma team members are present in the emergency department and alert is still communicated to ensure everyone is notified.
   F. Trauma team member notification and arrival times will be documented on the trauma flow sheet (paper or electronic).
   G. Trauma team members will sign-in when they arrive.
   H. Trauma team members will be activated for all patients who meet the following criteria:
      1. Level 1 trauma activation (major): life threatening injuries and/or unstable vital signs, limb-threatening or disability threatening injury
      2. Level II trauma activation: significant injuries identified or significant mechanism of injury with a BP greater than 90 and awake patient
      3. Level III trauma activations: Isolated, single system injuries requiring surgical specialty evaluation for admissions or operative intervention.

II. TRAUMA TEAM ACTIVATION CRITERIA

A. Review Trauma Team Activation Guidelines. (Define for your center based on CDC criteria and regional standards in collaboration with EMS providers)
## III. TRAUMA RESPONSE TEAMS PER LEVEL OF TRAUMA ACTIVATION AND RESPONSE TIME REQUIREMENTS (FROM ACTIVATION).

### A. Level I Trauma Activation

<table>
<thead>
<tr>
<th>Role</th>
<th>Time Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Surgeon*</td>
<td>≤ 15 minutes</td>
</tr>
<tr>
<td>Emergency Department Physician</td>
<td>≤ 10 minutes</td>
</tr>
<tr>
<td>ED nurses assigned resuscitation room* (at least 2 initially)</td>
<td>On arrival</td>
</tr>
<tr>
<td>Charge Nurse or house supervisor</td>
<td>≤ 10 minutes</td>
</tr>
<tr>
<td>Radiology Technician</td>
<td>≤ 10 minutes</td>
</tr>
<tr>
<td>Blood Bank and Respiratory</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Chaplain (as requested)</td>
<td>As needed</td>
</tr>
<tr>
<td>Trauma Program Manager as available</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

### B. Level II Trauma Activation

<table>
<thead>
<tr>
<th>Role</th>
<th>Time Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Surgeon</td>
<td>≤ 30 minutes</td>
</tr>
<tr>
<td>Emergency Department Physician</td>
<td>≤ 10 minutes</td>
</tr>
<tr>
<td>ED Nurse assigned to Resuscitation Rooms</td>
<td>On arrival</td>
</tr>
<tr>
<td>Trauma Program Manager</td>
<td>As Needed</td>
</tr>
</tbody>
</table>

### C. Level III Trauma activation

<table>
<thead>
<tr>
<th>Role</th>
<th>Time Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Physician</td>
<td>≤ 30 minutes</td>
</tr>
<tr>
<td>ED Nurse</td>
<td>On Arrival</td>
</tr>
<tr>
<td>Trauma Program Manager*</td>
<td>As Needed</td>
</tr>
</tbody>
</table>

A Trauma Activation may be activated and on EMS communication and upgraded (upon completion of primary survey) and can be done by any member of the trauma team depending upon patient’s condition related to Trauma Team Activation during primary or secondary assessment.
ANYTOWN TRAUMA CENTER
TRAUMA PROTOCOLS

TITLE: TRAUMA TEAM RESUSCITATION PROTOCOL

PURPOSE:

A trauma team is defined as the emergency medicine physician, the assigned emergency department nurse, radiology tech, respiratory tech, blood bank, charge nurse/house supervisor, chaplain, security and the trauma surgeon on call. Individuals have specific training and skills to meet the critical or seriously injured patient’s needs and system knowledge to expedite patient definitive care or transfer. Each individual has been educated on their role in a trauma resuscitation and has the defined competencies and educational requirements to ensure optimal care is provided to each patient.

PROCESS:

TRAUMA TEAM COMPOSITION

A. Trauma (General) Surgeon: Surgeon on-call responds to the Emergency Department according to the trauma activation criteria and is responsible for directing resuscitative efforts, diagnostic priorities, interventions, plan of care to definitive.

B. Expectations of the trauma surgeon include the following:

1. Collaborates with the assigned emergency department nurse to ensure that the team is assembled and prepared for the patient’s arrival.
2. Responsible for the overall trauma management and resuscitation of the patient, including the primary and secondary survey, establishes and communicates the priorities of care to the trauma team, directs diagnostic priorities, and addresses patient safety concerns.
3. Facilitates communication with the EMS personnel and the EMS time-out.
4. Assists and addresses interventions as needed.
5. Responsible for contacting and coordinating consulting services as appropriate.
6. Orders all diagnostic tests, determines radiological sequences of studies after the initial film series.
7. Collaborates with the emergency department RN and chaplain to ensure the family is updated on the patient’s condition.
8. Responsible for physician documentation related to the resuscitation, history and physician following regulatory guidelines.
9. If surgical intervention is needed, notifies OR personnel or directs and coordinates transfer for definitive care following the EMTALA regulations.
10. Writes orders to direct the disposition of the patient.
11. Notifies the trauma program manager or trauma medical director of any problem or trauma performance improvement needs.

B. **ED Physician**: The ED Physician will respond prior to or immediately on patient arrival and is responsible for directing the trauma resuscitation until the surgeon’s arrival.
C. The expectations of the emergency physician include the following:
   1. Activates the Trauma Team for patients who meet the established Trauma Team Activation criteria.
   2. Acts as the Team Leader until the General Surgeon arrives.
   3. Evaluates the patient’s airway status and makes appropriate interventions to secure a definitive airway, while preventing cervical spine movement.
   4. Completes the primary survey, communicating the following to the Team - airway, breathing, and circulation and presenting neurological assessment.
   5. Directs the administration of all paralytic agents for rapid sequence intubation.
   6. Defines resuscitation priorities and diagnostic intervention if the trauma surgeon is not present.

D. **Primary Emergency Nurse:** The primary emergency department RN assigned to the trauma resuscitations has the educational knowledge and skills credentialing to care for the critical or seriously injury patients (TNCC & ATCN, ENPC). Primary role is to ensure ABCs and to assist with interventions necessary for the primary survey to include IV access, fluid / blood product resuscitation efforts, disability assessments and needed interventions and maintain patient warmth. The primary trauma nurse will assist in coordinating the care and monitoring for diagnostic evaluation and interventions needed as defined by the secondary survey.

   1. **EXPECTATIONS**
      a. Responsible for Trauma Team activation and will function as primary resuscitation nurse.
      b. Charged with preparing the room prior to patient(s) arrival, ensuring the room is warm and equipment prepared, trauma flow sheet is readily available for documentation.
      c. Will perform the trauma nursing primary and secondary assessment and immediate nursing interventions.
      d. Addresses serial vital signs, cardiac monitoring and pulse-ox monitoring.
      e. Responsible for all reassessments and documentation of interventions.
      f. Will administer all medications or delegate to the second trauma nurse.
      g. Responsible for IV (2 large-bore 14g)
      h. Responsible for obtaining blood specimen for laboratory analysis.
      i. Manages blood/fluid warmer/infuser devise.
      j. If Foley catheter is indicated, inserts and obtains urine specimen for Laboratory testing.
      k. Assists the physician as needed in patient assessment.
      l. Responsible for documenting all vital information on the trauma flow sheet (paper/electronic).
      m. Communicates with family to provide updates.
      n. Responsible for remaining with unstable patients when out of the ED (i.e. CT scan).
      o. Will give patient report to receiving unit or receiving facility if the patient is transferred to a higher-level trauma facility.
E. **Emergency Department Secondary RN:** This RN will be primarily responsible for assisting with emergency and diagnostic procedures, and ongoing monitoring of the patient’s status and response to interventions.

1. **EXPECTATIONS**
   a. Assists with the transfer of the patient to the ED stretcher, and the removal of clothing.
   b. Obtains the patient’s initial set of vital signs, including a temperature (rectal/core recommended) and communicates to the team.
   c. Ensures that NBP cuff is applied.
   d. Ensures patient warming measures are in place.
   e. Assists in establishing IV (2 large-bore) access.
   f. Once airway is established, places NGT/OGT, if indicated.
   g. Prepares procedure trays and assists physicians as needed.
   h. Continues to obtain serial vital signs, neurological assessments and extremity neurovascular assistance as patient condition warrants.
   i. Assists with the immobilization of fractures, and management of soft tissue injuries, reassessing extremity.
   j. Assists with the transport or transfer of the patient as needed.

F. **Respiratory Therapist:** A respiratory therapist will respond to assist with airway assessments/interventions and ventilation, assists with blood gas Procurement/analysis.

   1. **EXPECTATIONS**
      a. Prepare airway and intubation equipment prior to the patient’s arrival, as indicated. Ensures CO2 detection is available.
      b. Assists the ED Physician with management of the airway and administration of oxygen. Provides assisted respiratory support if the patient’s respirations are absent or inadequate.
      c. Maintains manual immobilization of the cervical spine during intubation and all procedures (or delegates).
      d. Secures and reassesses tube placement throughout the resuscitation efforts.
      e. Monitors pulse oximetry and the patient’s response to interventions.
      f. Responsible for the mechanical ventilation during evaluation and stabilization of the patient, if indicated.
      g. Assists with transfer of any intubated patient to radiology, CT Scan, OR or ICU.
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G. **Radiology Technologist**: One Radiology Technician will respond within 10 minutes of paging to the Emergency Department to complete radiologic studies as requested by the Trauma Team.

1. **EXPECTATIONS**
   a. Positioning the patient for films and performing radiological procedures.
   b. Initial priority is a Blunt Trauma Panel (AP chest and AP pelvis) unless directed otherwise by the trauma surgeon or emergency physician.
   c. Develops films in a timely manner and delivers the films to the trauma room for the physician to review as soon as possible – if electronic pushes images to the radiologist for review.
   d. Will make copies of films if the patient is transferred to higher, level trauma facility, or facilitate electronic transfer if files as appropriate.

NOTE: The Operating Room staff will be initially notified by the Emergency Department and placed on alert of a potential trauma case. The Anesthesiologist or CRNA will assume responsibility for the airway upon arrival to the OR.

H. **Charge Nurse**: The charge nurse or house supervisor will notify the receiving department of the patient’s impending arrival and secure all admit beds.

1. **EXPECTATIONS**
   a. Coordinate patient disposition from the ED with receiving units.
   b. Ensure family needs are addressed
   c. Ensure support and care for the staff is available.
   d. Facilitate documentation for all trauma transfers to a higher level of care.

I. **Trauma Program Manager** (TPM). The TPM responds to the ED within 10 minutes of paging when in-house to provide supportive assistance to the trauma team as necessary. The TPM evaluates the resuscitation for variances and trauma center criteria compliance, and assists in the care of the trauma patient as appropriate. May function as a primary or secondary emergency department RN for the resuscitation.

J. All trauma team members are responsible for compliance to documentation standards.
ANYTOWN TRAUMA CENTER
TRAUMA PROTOCOLS

TITLE:  TRANSFER PROTOCOL

PURPOSE:

Patients meeting trauma activation protocol may require specialized trauma care beyond the capability of the resources available at our facility. These patients require transfer to a higher level of care. Decision to transfer the trauma patient is by the trauma surgeon or the emergency physician based on the individual’s injury, preexisting disease and hospital capabilities. Patients must be stabilized prior to transfer or stabilized to the best of our center’s capabilities.

PROCESS:

1. CRITERIA MEETING TRANSFER TO HIGHER LEVEL OF TRAUMA CARE
   
   A. Multisystem injury trauma patients with hypotension, or requiring ventilation or blood products.
   
   B. Central Nervous System Trauma
      1. Neurological injuries, paralysis, or lateralizing sign
      2. Spinal cord injuries with or without neurological deficit
      3. Traumatic brain injury
      4. Positive finding for acute injury by head CT
      5. Patients on anticoagulation therapy with head injuries
   
   C. Dislocations
      1. Vertebral column injury
         a. All Spine: Dislocations, facet subluxations and fracture/dislocations
         b. Difficult or unstable extremity dislocations/
   
   D. Pelvic Trauma
      1. Compound/open pelvic injury or pelvic visceral injury
      2. All pelvic ring disruption from high energy mechanism such as MVC, consider immediate transfer.
      3. For low energy mechanism such as geriatric fall from standing consult orthopedics
      4. Acetabular fractures
      5. High risk patients with pelvic trauma
         a. OB patients
         b. Patients on anticoagulation therapy
         c. Femoral head fractures with complex fracture patients
E. Burns
1. Partial thickness burns greater than 10% total body surface area (TBSA)
2. Burns of the face, hands, feet, genitalia, perineum, or major joins.
3. Third degree burns in any age group.
4. Electrical burns, including lighting injury.
5. Chemical burns.
6. Inhalation injury
7. Burn injury in patients with preexisting medical disorders that could complicate management, prolonged recovery, or affect mortality.

8. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.

9. High risk population children under five years individuals over fifty and preexisting medical conditions.

10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

E. Specialized Injuries
1. Any pediatric patient (<16 years old) with multi-system trauma requiring organ system support, mechanical ventilation, requiring critical care (ICU)/intermediate care (IMU), or potential operative intervention shall be transferred to a higher level of care.
2. Any patient with injury requiring specialty surgical services not available at our hospital.
3. Patients who require specialized rehabilitation services or psychological support.

F. Cardiovascular
1. Any patient with suspected great vessel or cardiac injury
G. Any patient with requiring inpatient psychiatric care or behavioral health services needs.

II. Trauma Guidelines

A. Medical Staff
   1. Provides Medical Screening Exam
   2. Completes primary survey and orders stabilizing interventions
   3. Determines need for higher level of care
   4. Contacts charge nurse to initiate a trauma transfer if meets transfer criteria
   5. Responsible for the two doctor communication and acceptance of transfer.
   6. Responsible for the documentation and orders for transfer to a higher level of care.
   7. Responsible to sign the Memorandum of Transfer document (MOT).

B. Charge Nurse
   1. Completes MOT and addresses required signatures.
   2. Obtain Medical Record documentation to include into and imaging studies for all patients’ transfers.
   3. Communicates with family regarding transfer.
   4. Ensures report to receiving facility is completed.
   5. Addresses all regulatory issues regarding transfer.
TITLE: TRAUMA ADMISSIONS TO THE ICU GUIDELINES

PURPOSE: To provide guidelines for trauma patient admission to the ICU

PROCESS: All trauma patients admitted to the ICU must meet the admission criteria for ICU

1. All trauma patients needing ICU care must be admitted to the trauma surgeon for a minimum of 24 hours.
2. Intensivist consult should be ordered by the primary trauma surgeon as deemed necessary.
3. Trauma patients need to be identified by the ICU staff.
4. Orders must be written by the primary trauma surgeon or signed off by the trauma surgeon if written by a consulting team.
5. Nursing ensures that orders written by consulting services are approved by the admitting trauma surgeon.
6. Once the patient no longer meets ICU admission criteria, the patient will be transferred to the appropriate unit by the trauma surgeon.
ANYTOWN TRAUMA CENTER
TRAUMA PROTOCOLS

TITLE: TRAUMA SERVICE ADMISSION GUIDELINES

PURPOSE:

Guidelines for the admission of trauma patients to Anytown Trauma Center are documented.

PROCESS:

1. DEFINITIONS

   A. Trauma is defined as a physical injury, wound or shock caused by an external force.

1. ADMISSION GUIDELINES

   A. All multi-system trauma patients must be admitted to a trauma surgeon, if not transferred.
   B. Single system injury patients without significant comorbidities may be admitted to a specialty surgical service (i.e. fractured femur may be admitted to Orthopedics).
   C. A multi-system trauma patient must be admitted to the trauma surgeon for a minimum of 24 hours for observation and evaluation. If a single organ system injury remains as the primary problem after 24 hours, the patient may be transferred surgical specialty service or continuation of care.
   D. Non-surgical admissions
      1. Appropriate admission criteria may include:
         a. Drowning
         b. Drug over dose
         c. Hanging – if CT neck and CTA neck negative for bony or vascular injury
         d. Patients with complex preexisting disease and injury that does not require surgical intervention.
      2. Any patient with an injury meeting trauma activation protocol being considered for admission to the hospital, must be cleared by the trauma surgeon prior to admission.
   E. Exclusions (to non-surgical admissions):
      1. Traumatic injuries requiring admission to an ICU or IMU
      2. All rib fractures
      3. Solid organ injury
      4. Pelvic fracture with retroperitoneal hematoma or in a patient on anticoagulation
      5. Pregnancy ≥20 weeks with trauma injuries
      6. Penetrating trauma
      7. Age <16
      8. Patients meeting trauma transfer guidelines.
   F. Physician is responsible for determining the need for admission to the observation/Inpatient setting.
   G. Physician has to complete order / referral for admission.
H. Physician writes appropriate admission/observation orders
I. Physician orders the specialty service consultation.
J. Physician assures patient has a disposition prior to 23 hour observation period as appropriate.
ANYTOWN TRAUMA CENTER
TRAUMA PROTOCOLS

TITLE: TRAUMA MEDICAL DIRECTOR JOB DESCRIPTION

PURPOSE:

The Trauma Medical Director has the authority and oversight for all trauma patient management activities. In this capacity, the trauma medical director report to the Chief Medical Officer. The Trauma Medical Director develops and monitors the trauma management protocols and trauma procedures to ensure optimal outcomes, patient safety, and compliance to trauma center verification/designation.

PROCESS:

1. RESPONSIBILITIES

A. Direct the care of the injured patient through established trauma management protocols based on evidence based practice.
B. Coordinate the medical specialties required in the care of the trauma patients.
C. Develop and implement the trauma protocols, guidelines and procedures pertaining to trauma management and coordination of care.
D. Coordinate trauma education for the trauma center, associated surgical and medical services and nursing service.
E. Service as chairperson of the Trauma Operations Committee and the Trauma Peer Review Committee.
F. Interfaces with hospital administration to ensure optimal outcomes, administrative activities required by trauma center criteria are met, and is responsible the development of the trauma capital budget request and operating budgets in collaboration with the trauma program manager.
G. Develops and monitors credentialing standards for members of the trauma physician team and liaisons.
H. Ensures and monitors the quality of care, performance improvement initiatives, and compliance to trauma protocols.
I. Collaborates with the Trauma Program Manager, the Emergency Department Manager and Emergency Medical Director to monitor and review trauma performance improvement activities to define opportunities for improvement.
J. Consults with Chief of Staff and Administration regarding quality care issues, adverse outcomes and identified opportunities for improvement.
K. Responsible for the oversight of maintaining trauma verification/designation.
L. Leads the medical staff, nursing and ancillary departments in establishing protocols for the management of trauma patients in all phases of care.
M. Participates in a leadership capacity in the development and evaluation of the trauma center’s disaster response capabilities.
N. Attends and participates in Regional Trauma Advisory Council and acts as a liaison with area hospitals, physicians and Emergency Medical Services.

2. Qualifications
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A. MD license to practice medicine in the State of ____________.
B. Board Certified in General Surgery
C. Current certification as an ATLS Provider (ATLS Instructor preferred).
D. Member of the Medical Staff
E. Member of the surgical staff in good standing.
F. Board certified in Critical Care Medicine preferred.
G. Minimum of 10 trauma call shifts per month.
H. Completed specific trainings for trauma performance improvement
I. Complete specific training for Disaster Response.
J. Leadership skills necessary for collaboration and management of the Trauma Performance Improvement Program
K. Directly responsible for trauma physicians, credentialing, compliance to standards for all trauma physicians, liaisons and advanced practice providers.
L. Dedicated 16 hours of administrative time each month to the trauma medical director role.
M. Maintains a minimum of 16 hours of trauma related CME annually.
ANYTOWN TRAUMA CENTER
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TITLE: TRAUMA PROGRAM MANAGER JOB DESCRIPTION

PURPOSE:

The Trauma Program Manager is responsible for the oversight and authority of all trauma patient management; development, implementation, and maintenance of the trauma service; and consistent compliance of the ACS Trauma Center Verification Criteria.

PROCESS:

1. RESPONSIBILITIES
   A. The Trauma Program Manager will collaborate with the Trauma Medical Director to ensure in the following and provide direct leadership and management.
      1. Develop and maintain a concurrent Trauma Registry.
      2. Develop and implement the trauma protocols and guidelines for the trauma center.
      3. Develop and implement the trauma education program for all individuals involved in trauma care to include medical staff, nurses, EMS providers, allied health and the community.
      4. Develop, initiate, and monitor public education for the community.
      5. Develop and implement the Trauma Performance Improvement Program.
      6. Collaborate in the development implementation and monitoring of the element of the Trauma Center. These elements include, but are not limited to:
         a. Trauma Registry inclusion and utilization guidelines
         b. Trauma management protocols and guidelines
         c. Trauma education standards
         d. Trauma Performance Improvement & Patient Safety Plan
         e. Trauma injury prevention initiatives and documentation of activities
         f. Community outreach education and documentation of activities
         g. Diversion Protocol
         h. Transfer and admission guidelines
         i. Trauma Activation Protocol
         j. Trauma reporting dashboard and criteria
         k. Trauma disaster response protocols
         l. Collaboration with Nursing Department that interface with trauma patient population.
         m. Serves as a liaison with the community and regional EMS providers
         n. Participates in a leadership role in emergency management.

2. QUALIFICATIONS
   A. A registered nurse in the State of ________________, with Bachelor’s Degree.
   B. Minimum of 3 – 5 years of experience in the emergency department or critical care.
C. Experience commensurate with the trauma center level of verification.
D. Good interpersonal and communication skills.
E. Demonstrates leadership and management skills
F. Involved in professional organizations.
G. TNCC – I or, ATCN – 1 status
H. PALS or ENPC or ACLS Certification
I. Defined trauma related education: TOPIC, AAAM, ATS Trauma Coordinators Core Course
J. Trauma Outcomes and Performance Improvement Course required
K. Trauma Care after Resuscitation Course Completion
L. Must maintain 16 hours of continuing trauma education annually.
M. Must have a minimum of twenty hours of administrative dedicated time to oversee the trauma center criteria issues monthly

3. JOB RELATIONS

A. Reports to:
   1. CNO – Chief Nursing Officer

B. Supervised by:
   1. CNO/Designee

C. Employees Supervised:
   1. Trauma Registrar(s)
ANYTOWN TRAUMA CENTER
TRAUMA PROTOCOLS

TITLE: TRAUMA SURGEON LIAISONS AND ADVANCE PRACTICE PROVIDERS CREDENTIALING

PURPOSE:

The Trauma Medical Director (TMD) is responsible for the credentialing of each physician and advanced practice provider member of the trauma team. The TMD is required to credential each member of the trauma medical team at least annually, and has the authority to remove any physician who does not meet the credentialing requirements.

PROCESS:

1. TRAUMA SURGEONS
   A. Criteria for credentialing are based on the guidelines outlined in the American College of Surgeons document “Resources for Optimal Care of the Injured Patient: 2014” and will include:
      1. Board Certification or eligibility
      2. Current ATLS status
      3. Average of 16 hours of trauma related education/CME annually
      4. Trauma PI committee attendance, ≥50%, annually.
      5. Trauma Peer Review Committee attendance ≥50% annually
      6. 80% compliance to Trauma activation times annually.
      7. Complete PI request within five days of the request and provide written feedback.
      8. Participation in trauma education, injury prevention, outreach education program activities

2. EMERGENCY DEPARTMENT
   A. Credentialing requirements for ED physicians will include:
      1. Board certification or eligibility
      2. Proof of previous completion of an ATLS course.
      4. Minimum of 16 hours of trauma related education/CME annually (trauma liaison only)
      5. Attendance at trauma PI committee, ≥50%, annually
      6. Attendance at Trauma Peer Review committee ≥50%, annually
      7. Participation in disaster response plan development, revisions, and exercises.
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3. CREDENTIALING FOR ORTHOPEDIC LIAISON
   A. Credentialing requirements for orthopedic physicians will include:
      1. Board certification or eligibility.
      2. Minimum of 16 hours of orthopedic related education/CME annually
      3. Attendance Trauma PI committee, ≥50% annually
      4. Attendance at Trauma Peer Review Committee, ≥50% annually
      5. Participation in disaster response and disaster exercises

4. CREDENTIALING FOR ANESTHESIA LIAISONS
   A. Credentialing requirements for Anesthesia physicians will include:
      1. Board certification or eligibility
      2. Attendance at Trauma PI Committee, ≥50% annually.
      3. Attendance at Trauma Peer Review Committee ≥50% annually.

5. CREDENTIALING FOR ADVANCED PRACTICE PROVIDERS PARTICIPATING IN
   TRAUMA CARE
   A. Credentialing requirements for Advance Practice Providers.
      1. Current ATLS
      2. Minimum of 16 hours of trauma related education/CME annually
      3. Complete credentialing process outlined or specific role.
      4. Participate in disaster response activities.

The Trauma Medical director has the authority to add or remove members to the
trauma team panel.