ALABAMA TRAUMA SYSTEM

Hospital Entry

ATCC (Alabama Trauma Communications Center)

Phone #: 1.800.359.0123 NEXTEL #: 154*132431*4
Southern LINC #: Fleet 55 Talk group 10 or Private 55*380

PROCEDURE: System Entry (CALL ATCC EARLY)

HOSPITAL ROLE

A – IDENTIFY

- You / Your organization
- Location of Trauma Scene
- Age & Sex of the patient(s)
- Reason for entry & MOI
- How did patient arrive at the hospital

B – Assessment

- A – Airway: is it clear, non patent, intubated
- B – RR Rate, Pulse Ox. Reading, symmetry
- C – Peripheral Pulses present or not? Pulse Rate
- D – GCSS (ATCC will score if needed) / Area(s) of Injury - why do you want to put the patient in the trauma system
- E – Any Environmental Issues – age, sex, co-morbids

C – Decisions

- Chose closest appropriate Trauma Center & request availability
- Chose Transportation type (air/ground)
- Estimate Time of transport
- Request patient ATCC ID #

TRANSPORT DECISION NOTES

- Transferring Doctor selects transport mode – air or ground
- Consult with ATCC, if transport assistance needed

ATCC ROLE

A – Listen to Caller

- Record the information
- Place the patient in ATS if entry criteria is met.

B –Record

- Request & record needed information for ATS & receiving hospitals
- Provide an ATCC # to the hospital.

C – Contact

- Contact the chosen available trauma hospital & provide the info.
- Link the Transferring & receiving doctors if patient is stable.
- Link the transferring and receiving Doctors upon request of either party as requested (stable or unstable).

D – Transport

- Assist transferring hospital w/locating transport agency, if requested.
- Monitor transport agency transport times & update receiving hospital

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ENTRY CRITERIA FOR HOSPITALS

Physiological

Systolic B/P: ADULT < 90mm (no radial pulse)

CHILD Age 6 or less <80mm (no radial pulse)

Resp. Distress:

Adult: < 10 or > 29

Newborn: < 20 or > 60

Child (3 or younger): < 20 or > 40

Child (4 or older): < 12 or > 29

HEAD TRAUMA: GCSS < 13

Any neurological changes in child 5 or less

BURN CRITERIA

*Partial thickness burn of < 10% of total body surface area.

*Burns that involve face, hands, feet, genitalia, perineum or major joints.

*3rd degree burns in any age group.

*Electrical burns, including lightning injury.

*Chemical burns

*Inhalation injury

*Burn injuries in patients w/pre-existing medical disorders that could complicate management, prolong recovery or affect mortality.

*Any patient w/burns & 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's condition may be stabilized initially in a trauma center before transfer to a burn center.

*Burned children in hospitals w/o qualified personnel or equipment for the care of children.

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

ANATOMICAL

*Flail Chest

*2 or more proximal long bone fractures

*Penetrating injury (high energy)
Head – Neck – Torso – Groin

*Combined trauma/burn > 15% or Burn Center Criteria

*Amputation
Proximal to wrist or ankle

*Paralyzed limb(s)

*Pelvic Fx / unstable pelvis demonstrated by x-ray

*Significant internal injuries found & hospital does not have needed resources.

NOTES

*If the patient does not meet physiologic criteria, then a Doctor to Doctor conversation must occur.

*Mechanism of Injury is not a reason for hospital entry of a trauma patient.

*ATCC will only assist in transfer of ATS patients.

Alabama EMS & Trauma System
Quality Assurance/ Quality Improvement Plan

Quality Assurance Plan

The mission of the quality assurance/quality improvement (QA/QI) plan is to assure optimal care of injured patients in the state of Alabama.

To accomplish this mission the QA/QI committee will continuously monitor the Statewide EMS & Trauma System utilizing system operation standards, system performance criteria, and data. The QA/QI process also includes development of system operation protocols, system performance standards, and system benchmarks. The process also includes the coordination of educational initiatives, system changes and enforcement as necessary.

QA/QI is made up of three component areas:

1) Standard Setting - the establishment of system operation protocols, system performance standards, and system benchmarks.
2) Quality Control - the "real time" operations of intervention by on-line medical direction, ADPH/OEMS&T, or the Alabama Trauma Communications Center (ATCC) to prevent sub-standard performance in any component of the ATS.
3) Quality Improvement - the use of system standards, quality control incidents, and data to determine the need for system change, provider education, or contract/regulatory action by the ADPH/OEMS&T.

The process is designed to allow all participants to recognize optimal as well as sub-standard performance. The process may use direct intervention, educational initiatives, system changes, and enforcement as necessary.

Alabama Trauma System QA/QI consists of the following:

1) Hospital
    A. Quarterly internal audits
    B. Alabama Trauma System Registry reports
    C. Participation in quarterly regional QA/QI committee meetings

2) Pre Hospital
    A. Air
        1. Internal Audits
        2. Participation in quarterly regional QA/QI committee meetings
        3. Participation in quarterly Aero-Medical QA/QI committee
    B. Ground
        1. Internal Audits
        2. Participation in quarterly regional QA/QI committee meetings
        3. Participation in quarterly Aero-Medical QA/QI committee

3) ATCC
    1. Assist all appropriate parties with their responsibilities as detailed in this plan.
    2. Provide Quality Control to assure ATS system operation protocols and ATS system performance standards are met with intervention as appropriate and incident reports made as necessary.

4) On-Line Medical Direction
    1. Provides on-line medical direction as necessary to assure compliance with ATS system operation protocols and ATS system performance standards.
    2. Provides incident reports as necessary to the appropriate RTAC(s).

5) System
   The Alabama Department of Public Health's Office of EMS and Trauma is responsible for direct oversight and operation of the QA/QI plan:
    A. Assumes responsibility and accountability for the implementation and ongoing activities of the QA/QI process.
    B. Establishes, maintains and provides guidance to STAC, RTAC, EMS Regional Staff and ATS QA/QI Committees.
    C. Integrates the QA/QI process into activities for all levels of participation within the ATS.
    D. Utilizes the QA/QI data to identify the need to make any changes to the ATS to ensure its success.
    E. Communicates and cooperates with appointed RTAC QA/QI committee members to operate their QA/QI plan.
    F. Reports all QA/QI plan activities to STAC and the State Committee of Public Health.
    G. Establishes and maintains a systematic QA/QI assessment process.
    H. Establishes a culture of excellence through leadership, education, communication and teamwork.
    I. Forwards complaints received at the State level to the Regional staff for follow-up according to steps I, II, III and IV of the Trauma System noncompliance process listed under **Regional Trauma Advisory Council: Number 8.**

Regional Trauma Advisory Council (Staffed by Regional EMS Agency)

1. Utilizes regional level quality assurance/improvement, data process to identify the need to maintain/change trauma system processes by reporting findings to OEMS&T.
2. Communicates and cooperates with the direct services providers, ADPH/OEMS & T staff and all appropriate trauma system personnel to ensure Trauma System information is shared including the return of outcome data to the prehospital agencies involved in each patients care.
3. Promotes, coordinates and conducts ongoing prehospital and hospital ATS education.
4. Follows up with direct services providers to ensure trauma processes are performed.
5. Participates in all levels of the QAQI process.
6. Meets quarterly with the ATS QA/QI committee to discuss ways to improve the ATS processes.
7. Receives all ATS QA/QI issues and then forwards to the ADPH/OEMS&T as well as State & Regional QI committees.

Non-Compliance Assurance

Reports **noncompliance** issues to the Regional Trauma Advisory Council as listed below for the ATS prehospital component:

I. **First Issue**

A. Minor issues (misunderstanding, not yet trained, etc.): Explanation of issue and remedial education, documentation by regional staff. These non compliance issues will be resolved on a regional level only. All information pertaining to non compliance issues is due within a 30 day time frame. Information not received in the 30 day time frame will become a B issue and forward to the State OEMS&T Compliance Officer for further review.

B. Issues where service or provider does not respond or is uncooperative: to be forwarded to the OEMS & T Compliance Officer. (For appropriate actions by Compliance Officer).

II. **Second Issue**-Verbal warning by regional staff. Issue will be forwarded to State OEMS & T Compliance Officer. State OEMS & T Compliance Officer will notify service provider and individual involved to schedule a face to face/verbal meeting (at the discretion of the Compliance Officer).

III. **Third Issue**-Verbal/written report will be forwarded to State OEMS & T Compliance Officer for investigation with possible licensure action taken.

IV. State OEMS & T Compliance Officer will report all outcomes from findings to RTAC via email. A summary will be provided to the STAC.

EMS & Trauma Regions Noncompliance:

All regional EMS Agency noncompliance issues related to trauma system issues will be handled by the Director of the Office of EMS & Trauma.

Hospital Noncompliance:

All hospital noncompliance trauma system issues will be processed according to the contractual agreement with the hospital ***(See Trauma System Contract for respective hospital).***

ATCC Noncompliance:

All ATCC noncompliance issues will be processed by the Director of the Office of EMS & Trauma and the ATCC Director.

RTAC QA/QI Committee Make Up

I. Representation-

Each RTAC QA/QI committee will have the following minimum trauma system components represented:

E911
ATCC
BLS First Responder
ALS First Responder
ALS Transport Provider
BLS Transport Provider (Only if BLS responds to 911 calls)
Trauma Hospital of each level in the Region
Community Hospital
Emergency Medicine
Emergency Nursing
Trauma Surgeon

General Surgeon
Orthopedic Surgeon (if level 1 or 2 in Region)
Neurosurgeon (if level 1 in Region)
Trauma Coordinator from each level hospital in the ATS Region

II. Membership

Each RTAC will determine and select the RTAC QA/QI membership to assure the above are represented. The Vice-Chair of the RTAC is to be the Chair of the RTAC QA/QI Committee.

III. Meetings

The RTAC QA/QI committee must meet at least once quarterly. All meetings will be advertised to ATS staff.

ATCC/Trauma System Issues QA/QI

Date: _____ **ATCC#:_____**

Occurrence Date: ____ Time:_____ **Region: _____**

Organizations Involved:

Region to Complete:
Non-Compliance Issue: **IA** ☐ **IB** ☐

ISSUES(S):

☐ Patient not entered into system.

☐ Patient entered into system late.

☐ Physician did not come to telephone/radio for patient report and orders.

☐ Patient not transported to appropriate trauma center

☐ Patient transport designation issues

☐ Patient transport issue Statement added to document
☐ Air ☐ Ground

☐ No PCR left at Hospital.

☐ Other: _____

Explain the occurrence fully below; do not just check box.

ATCC ID#_____

Comments on Benchmark Indicators for Review at the 3/18/2010 QA/QI Meeting

Benchmark Indicator 201.3 scoring has been revised to reflect changes in the Current Status Score. The current status is now graded a 2 of a possible 5. In summary, the original Trauma System Benchmark Indicator Planning Tool was revised to more closely address the true deficiencies. These are the lack of inclusion of the role of Rehabilitative Services in the State Trauma System rules and policies and the absence of rules and regulations addressing the role of the ATS in mass casualty incidents.

The Benchmark Indicator 202.3 Worksheet is now complete. Our current status score is 3 of a possible 5. This current status score will be upgraded to 5 when the one remaining trauma region that is not in the ATS begins its participation in the System. The goal for this region to begin participation is summer quarter, 2010.

Benchmark Indicator Planning Tool 201.3

200. Policy Development. *Promoting the use of scientific knowledge in decision making that includes building constituencies; identifying needs and setting priorities; legislative authority and funding to develop plans and policies to address needs; and ensuring the public's health and safety.*

Benchmark 201 Comprehensive state statutory authority and administrative rules support trauma system leaders and maintain trauma system infrastructure, planning, oversight, and future development.

Indicator:

201.3 Administrative rules and regulations direct the development of operational policies and procedures at the state and regional levels.

Scoring: MTSPE Scoring Descriptor best describing **current status =2**

There is legal authority but there are no administrative rules or regulations governing ATS development. Such components of the trauma system as designation of trauma facilities, triage guidelines, integration of pre-hospital providers, rehab communications protocols, and integration with mass casualty incident preparedness are not included in the rules and regulations.

MTSPE Scoring Descriptor best describing **goal status = 5**

The ADPH OEMS&T regularly reviews the rules and regulations governing ATS performance through established committees and stakeholders, e.g. the Alabama Hospital Association, EMS Services, local medical facilities. These reviews include policies and procedures for System operation at the state and regional levels and address integration with rehabilitation services as well as public health and mass casualty incident preparedness.

1. **Who:** State and local EMAs, state and local rehab agencies, Fire Departments, EMS agencies and personnel, state and regional Trauma System committees, ADPH Emergency Preparedness .
2. **What:** ATS administrative rules and regulations governing integration the ATS with rehabilitative services and mass casualty incident preparedness.
3. **When:** Upon completing the functional establishment of the ATS in all six EMS regions.
4. **Where:** Statewide
5. **How:** By including the role of the ATS in statewide mass casualty incidents in its administrative rules and regulations. Also to be included are the incorporation of requirements for rehabilitative services within these rules and regulations.

6. **Barriers:** Lack of written agreements, standards, and plans for the integration of for the integration of the ATS with rehab services or mass casualty incident preparedness. No rehab services representation in the ADPH.
7. **Potential strategies for overcoming barriers:** Partner with ADPH Emergency Preparedness in developing rules and regulations for maximizing the use of the ATS in mass casualty incidents. To integrate the ATS with rehab services use existing relationship with the Alabama Head Injury Task Force.
8. **Resources required:** Existing resources are adequate to accomplish the goal status.

Benchmark Indicator 202.3 Worksheet

200. Policy Development. Promoting the use of scientific knowledge in decision making that includes building constituencies; identifying needs and setting priorities; legislative authority and funding to develop plans and policies to address needs; and ensuring the public's health and safety

Benchmark 202. Alabama Trauma System leaders, i.e. lead agency, trauma center personnel, and other stakeholders, use a process to establish, maintain, and constantly evaluate and improve a comprehensive trauma system in cooperation with medical, professional, governmental, and citizen organizations.
Essential Service: *Inform, Educate, Empower*
Indicator 202.3 A clearly defined and easily understood structure is in place for the trauma system decision-making process.

MTSPE Indicator Scoring Descriptor best defining **current status = 3**
The decision-making process is articulated within the ATS Plan, although it has not been fully implemented.
MTSPE Indicator Scoring Descriptor best defining **goal status = 5**
There is a clearly defined process for making decisions affecting the trauma program. The process is articulated in the ATS Plan and is further identified within system policies. Stakeholders know and understand the process and use it to resolve issues and to improve the program.

Tasks to achieve **goal status**:

1) **Who**: State Trauma Advisory Committee members and ADPH State Trauma Office staff as well as others in the Office of EMS and Trauma.
2) **What**: A clearly defined structure for the trauma system decision-making process
3) **When**: Summer 2010. The decision making process itself, as it now exists, will be applied throughout the state in the foreseeable future. The QA/QI process for the ATS will be an on-going function. It will help to identify areas in which changes in the decision making process are needed to improve the existing system
4) **Where**: Statewide
5) **How**: Implementation of existing trauma system policies in all six trauma regions in the state. The system decision making process has been proven to be effective in the trauma regions in the state that are currently participating in the ATS.
6) **Barriers**: In order to achieve our goal status, we need only activate the ATS in one more of the trauma regions (of a total of six trauma regions)
7) **Potential Strategy for Overcoming Barriers**: Agreements with out-of-state hospitals to participate in the Alabama Trauma System will help coverage in the one remaining trauma region. However, there is still a potential for in-state hospitals in that region to agree to become trauma centers.
8) **Resources Required**: Incorporating the remaining trauma region into the ATS should not require additional financial support.