TRAUMA SYSTEM

Injury Prevention Programs

POLICY #8100

I. Authority — Health and Safety code, Division 2.5, Sections 1797.107 and 1798.161

II. Purpose — To establish guidelines for the coordination of Injury Prevention Programs between trauma centers and public and private agencies

III. Policy

A. Trauma Centers as a part of their contractual agreement as a designated trauma center will participate in injury prevention programs with public and private agencies. These could include such established programs as, DARE, ENCARE, or Safe Kids.

B. Trauma Centers may produce their own Injury Prevention Programs based upon data analysis of the trauma system review at their facility. These might address community issues such as bicycle helmet safety, playground safety, or issue-specific programs defined by the higher volume injuries in the database.

C. Trauma Centers may utilize information developed by the EMS Agency as a result of system review to produce injury prevention programs for the public and private sector in their communities.

D. The EMS Agency is involved in injury prevention through a collaborative effort with the trauma centers. The EMS Agency will provide data reflective of the types of injuries throughout the entire county. Annual reporting from the trauma registry will provide the basis for the development of injury prevention programs.

APPROVAL

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EMS Medical Director

Ryan Kelley
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TRAUMA SYSTEM

Trauma Provider Marketing and Advertising POLICY #8200

Authority Health and Safety code, Division 2.5, Sections 1798.163 and 1798.165

II. Purpose To provide a guideline for utilization of the trauma terminology in marketing and advertising by a trauma care provider within the Imperial County EMS and Trauma System

III. Policy

A. In accordance with Section 1798.165 of the Health and Safety Code, " No health care provider shall use the terms, trauma facility, trauma hospital, trauma center, trauma care provider, trauma vehicle or similar terminology in its signs or advertisements, or in printed materials and information it furnishes to the general public, unless the use is authorized by the local EMS Agency.

B. Prior to implementation any marketing or advertising material will be reviewed by the EMS Agency based upon the following guidelines:

1) Shall provide accurate information
2) Shall not include false claims
3) Shall not be critical of other providers
4) Shall not include financial inducements to any providers or third parties.

C. Any local consumer protection ordinances related to advertising and marketing must be adhered to.

APPROVAL

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John Pritting
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TRAUMA SYSTEM

Repatriation of Stable Trauma Patient — POLICY #8300

I Authority — Health and Safety code, Division 2.5, Sections 1798.163 and 172

II. Purpose — To establish guidelines for repatriation of stable trauma patients to their health plan's facility.

III. Policy

A. All stable trauma patients shall be transferred to their health provider's facility when requested, as long as such transfer is medically prudent and in the best interest of the patient. All requests/discussions concerning transfer status of the patients will be made physician to physician. Transfer agreement will be based on patient condition and appropriateness of receiving facility resources.

B. Unless otherwise decided by the trauma surgeon or ED physician of record, no trauma patient requiring acute care admission will be transferred to a hospital that is not a designated trauma center until the condition is stable enough to be adequately cared for at that facility.

C. Hospitals which have repatriated trauma patients from designated trauma centers shall:

i. Provide the information required to complete the trauma registry on that patient to the transferring trauma center, and,

ii. Participate when indicated in system and trauma center quality improvement activities for those patients who have been transferred.

D. Trauma patients seen at Imperial County trauma centers may require diagnostic evaluation or immediate treatment prior to transfer. Trauma center evaluation does not necessitate preapproval by the patient's insurer.

APPROVAL

Bruce E. Haynes, M.D.
EMS Medical Director

John Pritting
EMS Manager

DATE: 1-1-04

TRAUMA SYSTEM

Trauma Catchment Service Areas

POLICY #8400

I. Authority: Health and Safety Code, Division 2.5, Section 1798.165

II. Purpose: To designate catchment service areas for each designated trauma center.

III Definition:

Trauma Catchment Area – Geographic Area with defined boundaries assigned to a designated trauma center for purposes of care for patients identified as critical trauma patients.

IV Policy:

A. The patient who is identified as a critical trauma patient will be transported to the closest most appropriate trauma center, that is within a thirty-minute transport from the scene.

B. Ground transport units have defined catchment areas of transport that will support the thirty-minute zone. The catchment areas are defined by narrative description (page 22) and map (Appendix A) for each of the designated trauma centers.

C. When transport to the closest most appropriate trauma center is beyond the thirty-minute zone for that trauma center's catchment area, then air transportation should be considered. It is necessary to provide the Imperial County Sheriff's dispatch center with this information to activate the dispatch of an air ambulance.

D. Utilization of air transportation will extend the boundaries of the catchment areas and facilitate transport.

APPROVAL

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TRAUMA SYSTEM

Trauma System Quality Improvement

POLICY #8500

I. Authority:
   a. Health and Safety Code, Division 2.5
   b. California Code of Regulation, Title 22, Division 9

II. Purpose
To monitor and evaluate the medical care of patients with traumatic injuries

III Policy

Structure
The Trauma System quality improvement process will be provided by two major components: the internal program within each trauma center, and the system process which includes; the scheduled Trauma Audit Committee (TAC) meetings, ongoing periodic review of each trauma center by the Emergency Medical Services Agency and the periodic evaluation of trauma care and the trauma system by an outside review team.

Process
TAC is an advisory committee to Imperial County Emergency Medical Services on issues related to trauma care. TAC will function as a sub-committee of the Emergency Medical Care Committee.

Trauma System Monitoring Role
1. The Committee will assist the EMS Agency in the review and evaluation of the medical aspects of the trauma system.
2. The Committee shall meet to monitor and assess the effectiveness of the trauma system and make known its findings and recommendations to the EMS Agency.

Scope of Audit Review
The scope of the review to be conducted by the committee will include, but not be limited to a review of the following:
a) Trauma Deaths
b) Appropriateness of triage criteria
c) Prehospital trauma care
d) Appropriateness of the level of trauma team activation
e) Timely availability of trauma team members
f) Hospital trauma care
g) Appropriateness of by-pass and transfers
h) Patient outcomes

Membership
The membership shall be broad based and shall represent the participants in the Trauma Care System and the local medical community. All positions are for a two-year term and may be renewed at the pleasure of the EMS Agency Medical Director.

Members:
a) ED Physician representative from each trauma center
b) Trauma Nurse representative from each trauma center
c) Surgeon representative as needed
d) Surgical sub-specialist as needed
e) Prehospital provider representatives, one private Ambulance, one fire department and representatives from air ambulance providers
f) EMS Dispatch representative, as needed
g) EMS Agency representative(s)
h) Medical Examiner/Coroner representative as needed
i) Other members as deemed appropriate

Attendance
1. Members are expected to participate in at least 50% of scheduled meetings

2. At a minimum the committee will meet quarterly

3. The EMS Agency Medical Director makes appointment to the committee.

4. Resignation from the committee should be in writing to the EMS Agency

5. Invitees may participate in the medical review of specific cases when their expertise is requested.

Minutes
Due to the confidential nature of the committee business, minutes shall be distributed at the beginning of each meeting and collected at the close of each meeting by EMS staff. No copies may be made or possessed by members of the Committee outside of the meeting.

Confidentiality
1. All proceedings, documents and discussions of the Trauma Audit Committee are confidential and are covered under Section 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of

testimony is provided to the Committee, which is established by a local government agency to monitor, evaluate, and report on the necessity, quality and level of specialty health services, including but not limited to, trauma care services.

2. Issues requiring system input may be sent in total to the EMS agency for input. Guests may be invited to discuss specific cases and issues in order to assist the Committee in making final case or issue determination. Guests may only be present for the portions of the meeting they have been requested to review or testify about.

3. All members must sign a confidentiality agreement not to divulge or discuss information that has been obtained solely through medical audit committee membership. Prior to any guest participation in the meeting, the Chairperson is responsible for explaining and obtaining a signed confidentiality agreement from the invited guest.

Trauma Audit Process

The committee, to guide them in case review, will establish audit screens. In every case review, the committee will make a finding of the appropriateness of the care rendered and will make recommendations regarding changes in the system to ensure appropriate care.

APPROVAL

Bruce E. Haynes, M.D.
EMS Medical Director

Ryan Kelley
EMS Manager

INTERFACILITY TRANSFER GUIDELINES

Policy: Patients with a level of acuity or need for diagnostics/treatment or consultation not available at any Imperial County hospital, will be transferred appropriately, expediently, and in compliance with EMTALA regulations. Relationships between receiving and transferring hospitals will allow for collegial education and feedback about transferred patients and the transfer process.

Procedure:

I. Identify Patients:

Any patient who may require resources, exceeding the trauma services available at the closest facility.

A. When patients present to the Emergency Department, begin initial evaluation and stabilization. The Emergency Department physician makes the determination of need for transfer. There should be simultaneous effort made to arrange for transfer while stabilizing care is delivered.

II. Provide Necessary Interventions:

This may include securing an airway, establishing venous access, performing procedures (such as chest tube insertion) administering medications, etc. There is no requirement for the transferring facility to stabilize the emergency medical condition necessitating transfer. Some conditions may not be able to be stabilized prior to transfer. Delays in transfer to obtain diagnostics or await test results should be avoided in high acuity patients. However, every attempt should be made to minimize the potential risks of transfer. If stabilizing operative procedures must be done prior to transfer, arrangements for transfer and acceptance at the higher-level trauma center should be initiated simultaneously. The patient remains an ED patient of record during the operative procedure and is transferred as soon as possible after the operative phase of care.

III. Contact the Receiving Trauma Center.

Secure a receiving facility and select the appropriate mode of transportation and level of care required in route. If pediatric patients meet the pediatric trauma triage criteria, transfer to Children's Hospital- San Diego is the appropriate destination for children ages 14 and under. Contact the appropriate receiving

service, (Attachment A) at the desired receiving facility. Higher-level trauma centers are expected to accept patients from facilities that lack the resource to provide the required care, if they have the necessary resources. They may require physician acceptance at their facility prior to transfer. Follow the requirements of the receiving facility regarding physician-to-physician contact and acceptance.

IV. Obtain Consent

Obtain informed patient consent for transfer. If the patient is unable to provide consent, obtain consent from family if possible. If the patient is unable to provide consent, and family is not available, the patient may be transferred under implied consent.

V. Have Transfer Documents Ready

Send the available information to the receiving facility. Information may be sent directly with the patient, or be sent by fax after the patient has departed. Include information such as demographics, procedures done; plan ahead and have appropriate copies ready for the transport unit when they arrive. Do not delay transfer due to preparation of transfer documents

APPROVAL

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EMS Medical Director

Ryan Kelley
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ATTACHMENT A
RECEIVING FACILITIES

Note: To serve as a template only – each facility should individualize as needed. An adequate number of options in each category must be provided to accommodate transfers when staffed beds are not available at earlier choices. All listed facilities can accept ground or air transports, method selected will be driven by patient need.

Major Trauma Patients

UCSD – SAN DIEGO

HOSPITAL CONTACT: Call the In-house Trauma Attending
PHONE: **619-543-6737** Page operator and ask for
The Trauma Attending on-call
or Call The Trauma Unit direct line and ask the Resuscitation
Nurse to page the trauma attending on call.
PHONE: **619-543-6745**
or Call The trauma service office during business hours
There is an answering service during off hours
PHONE: **619-543-7200**

SCRIPPS MEMORIAL HOSPITAL – SAN DIEGO

HOSPITAL CONTACT: **Transfer Center**
PHONE: **858- 626-6140** (0630 –1900 Mon-Fri)
Nighttime: **858-626-6157** Saturday/Sunday after 2100
Call the ED for all other times 858-626-6151

DESERT HOSPITAL– PALM SPRINGS

HOSPITAL CONTACT: For Field Transfers – Call their ED
PHONE: **760-323-6251**

HOSPITAL CONTACT: For ED transfers – Call the Trauma Service
PHONE : **1-800-24 SHOCK** (800-247-4625)

CHILDREN'S HOSPITAL & HEALTH CENTER– SAN DIEGO

HOSPITAL CONTACT: **CHET TEAM** for All Transports.
They will decide if ground or air transport is needed, and
make arrangements for transport.
PHONE: **858-277-3404**

Trauma Transport Destination Guideline

POLICY #8700

Subject: Trauma Transport Destination Guideline/Policy

Authority: Title 22, Division 9, Chapter 7

Purpose: To ensure that trauma patient destination is based upon the patient needs and the utilization of the highest level of resource available to provide timely appropriate trauma care.

Trauma Triage Criteria:

The primary goals of trauma triage in Imperial County is to rapidly and accurately identify victims who are at risk for life-threatening injuries. The specific criteria are identified in the guideline for, " Trauma Triage Criteria." Once a patient is identified as meeting the criteria to be classified as a trauma patient, the following guidelines are to be utilized in determining the appropriate patient destination.

Patient Destination Decision:

Patients who meet critical trauma triage criteria should be transported directly to the highest- level trauma center

1) Patients will be taken to the closest Level IV trauma center in Imperial County, unless they are critically injured and air transport is available.

2) When air transport is on scene then consideration of transport to a higher- level trauma center outside of the county is appropriate

3) If ground ambulance is on scene and air transport is in route to the scene, it may be in the patient's best interest to wait for air transport. Factors to consider include the severity of injury, air arrival time, and ground transport time to the Level IV trauma center. The Base Hospital should be consulted in making the determination to wait on scene for air transport.

4) Patients transported by ground ambulance that rendezvous with air transport at an alternate site, will have medical control provided by the air medical unit's base of operation, once the patient is turned over to the air transport team

5) Patients transported by ground ambulance that rendezvous with air transport at the Level IV trauma center helipad, are not required to have a medical clearance provided by the ED physician prior to air transport to a

higher- level trauma center. Medical control is maintained by the ground ambulance base hospital until the patient is turned over to the ALS air transport team. The use of the hospital helipad, (ground or roof), is looked upon as a 9-1-1 response location and does not obligate the hospital to provide a medical screening exam. If the ambulance provider (air or ground) request any medical intervention by hospital staff, the patients then becomes an ED patient and falls under the requirements for a medical screening exam.

Patient Destination Exceptions:

1. A trauma patient may at the option of the Base Hospital Physician, or air transport team, be brought to the closest appropriate medical facility, when the patient has life threatening condition, which overrides the need for expedient surgery. This would include conditions such as obstructed airway, tension pneumothorax, etc., which cannot be relieved or stabilized in the field.

2. Diversion – When a trauma center is on diversion and not able to respond to trauma activation (i.e. lack of CT, or lack of surgical coverage), notifications will be made according to the Hospital Diversion policy.

APPROVAL

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EMS Manager

TRAUMA SYSTEM

Prehospital Trauma Triage Criteria — POLICY #8800

Critical Trauma Patient Criteria

If any of the following apply, take to the highest level trauma center available, as per Trauma Patient Destination

Physiologic:

- Glasgow Coma Scale – Adults ≤11, Children ≤ 10
- Systolic Blood Pressure < 90 mm Hg, 80 age 7-14, 70 age < 7
- Respiratory Rate < 10 or > 29

Anatomic:

- Penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Amputation proximal to wrist or ankle
- Spinal Injury with limb paralysis
- Flail chest
- Two or more obvious proximal fractures of femur or humerus

Non Critical Trauma Patient

Paramedic judgment should always be considered in identifying the traumatically injured patient. Utilize Base Medical direction whenever necessary.

If any of the following mechanisms or co-morbid factors exist consider transport to the nearest available trauma center or hospital if no trauma center within 30 minutes.

Mechanism of Injury

- Fall > 20 feet
- Pedestrian hit at 20 mph or thrown 15 ft.
- Death of same car occupant
- Unrestrained roll over
- Heavy extrication time > 20 minutes
- MC, ATV, Bicycle Crash
- Passenger compartment intrusion
- Patient ejected from enclosed vehicle

Co-morbid Factors

- Age < 5 or > 60
- Medical Illness: Cardiac or Respiratory Disease, Morbid obesity Diabetic, cirrhosis, immunosuppressed, anticoagulants
- Hostile environment (heat or cold)
- Pregnancy
- Presence of intoxicants

DATE: 1-1-04

TRAUMA SYSTEM

Prehospital Trauma Triage Criteria

POLICY #8800

APPROVAL

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Collection and Management of Data — POLICY #8900

I. Authority: Health and Safety Code, Division 2, Sections 1798.161 and 1798.163 and California Evidence code 1157.7

II. Purpose: to establish a mechanism by which trauma registry information is obtained, stored, and utilized as part of the system assessment and quality assurance process.

III. Policy: Each designated trauma center shall submit a trauma registry record for each patient who meets the definition of the Critical Trauma Patient as described in the trauma triage criteria which considers physiologic and anatomical findings. Patients who are triaged as Non-Critical Trauma Patients but are admitted or transferred to a higher-level trauma center shall be entered into the trauma registry. All trauma deaths that occur at the trauma center must be included in the trauma registry.

A. Submission:

1. All trauma centers will submit their data electronically or by disc on a quarterly basis to the EMS Agency, on a schedule established by the TAC Committee.
2. If a trauma registry record is updated at the trauma center, the revised record will be submitted to the EMS Agency.

B. Storage/Access:

1. The Imperial County Trauma Registry will be stored in a secure manner with access restricted to personnel operating within the trauma quality assurance program.
2. The Imperial County Trauma Registry will be utilized for quality assurance purposes and therefore will be protected from disclosure per the California Evidence code, Section 1157.7.
3. The Imperial County Trauma Registry used strictly as a trauma database for the purpose of quality assurance is not subject to the mandated patient authorization procedures of HIPPA.
4. Each Employee with access to the Imperial County Trauma Registry will sign an Imperial County Oath of Confidentiality and Trauma Audit Committee Confidentiality Agreement.

C. Utilization:

1. The information within the trauma registry will be utilized primarily for quality assurance purposes related to the trauma system to monitor, evaluate and report on the necessity, quality and level of care provided by each hospital.

2. Aggregate data (does not include any patient or facility identifiers), may be utilized for reports, public health surveillance and injury prevention efforts in accordance with the TAC Committee expectations.
3. Specific information (without patient and facility identifiers) shall be integrated into the State EMS Authority data management system as required.

APPROVAL

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