** Utah Department of Health**

 **Bureau of Emergency Medical Services and Preparedness**

 **RESOURCE HOSPITAL and TRAUMA CAPABILITIES**

 **DESIGNATION APPLICATION**

**Application Date:**

|  |  |
| --- | --- |
| **Facility Name:**  | **Address** |
| **Facility Administrator:** | **Phone Number:** |
| **Email Address:** |
| **Emergency Department Medical Director:** | **Phone Number:** |
| **Email Address:**  |
| **Emergency Department Nurse Manager:** | **Phone Number:** |
| **Email Address:** |
| **Person Completing Application:** | **Phone Number:** |
| **Email Address:** |
| **Pediatric Emergency Care Coordinator:** | **Phone Number:**  |
| **Email Address:** |
| **EMS Agencies in Catchment Area** |
| **Agency** | **City** | **Service Level** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Dispatch Center Name: Phone Number:** |
| **Communication Capabilities: Radio:☐ Other:☐ (EXPLAIN)**  |
| **Facility Helipad GPS Location:**  |

|  |
| --- |
| THE RESPONSES TO THESE QUESTIONS ARE REQUIRED IN ACCORDANCE WITH STATE RULES: **R426-9-500**  **and R426-9-1000** PLEASE RESPOND AS ACCURATELY AS POSSIBLE - USE AS MUCH SPACE AS YOU NEEDIf you need clarification or assistance, please e-mail Carl Avery at carlavery@utah.gov or call (385) 522-1685 |

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**RESOURCE HOSPITAL AND TRAUMA CAPABILITIES**

**Please provide as much information as possible to adequately answer these questions.**

|  |  |  |
| --- | --- | --- |
| **RESOURCE HOSPITAL CAPABILITIES** | **Yes** | **No** |
| 1. Provide online medical control for all pre-hospital EMS providers who request assistance for patient care, 24 hours per day, 7 days per week.
 |  |  |
| 1. Have written pre-hospital emergency patient care protocols for use in providing online medical direction to pre-hospital EMS providers.
 |  |  |
| 1. Train new staff on the protocols before they are permitted to provide online medical direction control.
 |  |  |
| 1. Annually review pre-hospital EMS protocols with physician and nursing staff.
 |  |  |
| 1. Ensure pre-hospital protocols are readily available to ED staff.
 |  |  |
| 1. Have an established committee that reviews, on a **quarterly** basis, EMS care, provides continuing education and resolves EMS system and administrative issues, performance improvement findings, and are minutes of the proceeding kept.
 |  |  |
| 1. Cooperates with the pre-hospital EMS providers’ offline medical directors in the quality review process, including granting access to hospital medical records of patients served by the particular pre-hospital EMS provider.
 |  |  |
| 1. Have the capability to communicate with EMS providers for which the hospital acts as a resource hospital
 |  |  |
| 1. A registered nurse is on staff who serves as a resource and advocate for pediatric patients ( Between Hospital and EMSC)
 |  |  |
| 1. Hospital assists UDOH in evaluating EMS system effectiveness by submitting to UDOH, quarterly, electronic data as specified by UDOH.
 |  |  |
| 1. What barriers exist to the facility accessing training and continuing education for Trauma and EMS?

Location/TravelTimeBudget constraintsAvailability of appropriate classes |
| 1. What public awareness, injury prevention and education programs for the community are sponsored by the hospital?
 |
| 1. Describe on-line medical control process for your facility and EMS.
 |
| **Please indicate areas of concern related to emergency medical services/trauma care or emergency medical care for pediatric patients that you would like to see addressed by the Bureau of EMS.** |

If you have any questions concerning this survey, please contact Carl Avery, RN, CFRN at carlavery@utah.gov , or (385)522-1685

| **TRAUMA CAPABILITIES** | **Yes** | **No** |
| --- | --- | --- |
| 1. Facility has written trauma resuscitation protocols in the Emergency Department. **(Please make available during survey)** |  |  |
| 2. There separate protocols that address pediatric patients. **(Please make available during survey)** |  |  |
| 3. Facility has an organized trauma program. (i.e., a formally recognized Trauma Service that complies with Utah Trauma Center Criteria) |  |  |
| 4. Facility has a designated Trauma Team. **(Provide a list of who responds for this team)** |  |  |
| 5. Facility has instituted activation criteria for the Trauma Team. **(Please have criteria available during survey)** |  |  |
| 6. Nursing staff in the Emergency Department have yearly continuing education in the care of the Trauma Patient. **(Please provide examples and education roster)** |  |  |
| 7. Nursing staff in the Emergency Department participates in yearly continuing education in the care of the pediatric Trauma Patient. **(Please provide examples and education roster)** |  |  |
| 8. **Emergency Room nurses** have certifications in: **(Please provide list during survey)** | **Yes** | **No** |
| * + Emergency Nursing Pediatric Course (ENPC)
 |  |  |
| * + Neonatal Resuscitation Program (NRP)
 |  |  |
| * + Pediatric Advanced Life Support (PALS)
 |  |  |
| * + Trauma Nurse Core Course (TNCC) or
 |  |  |
| * + Advanced Trauma Core Course (ATCN)
 |  |  |
|  9. Does the nursing staff in your facility (non-ED) have yearly continuing education in the care of trauma patients? **(Please provide examples and education roster)** | **Yes** | **No** |
|  |  |
| 1. Do **non-Emergency Room Nurses** have certifications in
 | Please Check |
| * Pediatric Advanced Life Support (PALS)
 |  |  |
| * Emergency Nursing Pediatric Course (ENPC)
 |  |  |
| * Trauma Nurse Core Course (TNCC) or
 |  |  |
| * Advanced Trauma Core Course (ATCN)
 |  |  |
| * Neonatal Resuscitation Program (NRP)
 |  |  |
| 1. Is your Emergency Department staffed by physicians: **(Please provide a copy of ED Provider schedule)**
 | **Yes** | **No** |
| * In house 24/7
 |  |  |
| * On call outside the ED with 20 minute response time
 |  |  |
| * Advanced Practice Nurses or Physician Assistants with physician back up readily available
 |  |  |
| * Advanced Practice Nurses or Physician Assistants with no physician back up not readily available
 |  |  |
| 1. Is your Emergency Department staffed by physicians: **(Please provide a copy of ED Provider schedule)**
 | **Yes** | **No** |
| * In house 24/7
 |  |  |
| * On call outside the ED with 20 minute response time
 |  |  |
| * Advanced Practice Nurses or Physician Assistants with physician back up readily available
 |  |  |
| * Advanced Practice Nurses or Physician Assistants with no physician back up not readily available
 |  |  |
| 1. Does the facility use the State provided Critical Incident Stress Management (CISM) program?
 | **Yes** | **No** |
|  |  |
| 1. The following radiological services are available 24/7 either in house or on call**: (Please provide a copy of Radiology schedule)**
 | Please Check |
| * + Standard radiology
 |  |  |
| * + CT
 |  |  |
| * + Ultrasound Services
 |  |  |
| * + Angiography
 |  |  |
| * + MRI
 |  |  |
| 15. Are Clinical Laboratory Services available on site? **(Please describe hours of coverage- in-house and on-call):** |  |  |
| 16. Are pediatric patients (< 14 years of age) admitted to your facility? |  |  |
| 17. Does the hospital have basic pediatric equipment/supplies? **(Please provide equipment list or examples at time of survey)** |  |  |
| 18. Does the facility have a Pediatric Department recognized by medical staff bylaws with an administrative director? |  |  |
| 19. Does the facility admit ventilator dependent pediatric patients? |  |
| 20. What % pf pediatric Trauma Patients are transferred from you facility? |  |
| 21. Does the facility receive pediatric inter-facility transfers from other communities? |  |  |
| 22. Does the facility admit major trauma patients? 1 |  |  |
| 23. The following services are staffed and available in the facility: **(Please provide a copy of Schedules where appropriate)** | **Yes** | **No** |
| * + Intensive Care Unit with MD Intensivist or Hospitalist
 |  |  |
| * + Intensive Care Unit with RN staffing only
 |  |  |
| * + Respiratory Therapy Department
 |  |  |
| * + Operating Suites
 |  |  |
| * + Pediatric Unit
 |  |  |
| * + Pediatric ICU/CCU
 |  |  |
| * + Pediatric Surgery (designated)
 |  |  |
| * + Clinical Laboratory
 |  |  |
| * + Radiology Services
 |  |  |
| * + Anesthesia
 |  |  |
| * + Blood Bank
 |  |  |
| * + Pharmacy
 |  |  |
| * + Physical Therapy
 |  |  |
| * + Social Work (or designee)
 |  |  |
| 24. Does the facility have access to telemedicine services? |  |  |
| 25. Does the facility have written inter-facility clinical transfer protocols in place? |  |  |
| 26. Does the facility have written inter-facility transfer agreements in place? |  |  |
| 27. Does the facility use air ambulance services for inter-facility transfer? |  |  |
| 1. Approximately how many **AIR Medical Transfers** were made during the previous year (**from this application date**)?
 |  |

If you have any questions concerning this survey, please contact Carl Avery, RN, CFRN at carlavery@utah.gov , or (385)522-1685