



## Regional Trauma Triage Plan

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## *Executive Summary*

The Rappahannock EMS Council Inc. recognizing the complexity of the region's variability in demographics and geography has adopted the Virginia Trauma Triage Plan as template for the REMS Regional Trauma Triage Plan. REMS has developed, monitored, and revised a regionalized trauma triage plan. Through regionalized Performance Improvement Committees, all issues of trauma triage, trauma care on scene, in transit and within hospitals can be addressed. Under the *Code of Virginia § 32.1-111.3*, The Office of Emergency Medical Services acting on behalf of the Virginia Department of Health has been charged with the responsibility of maintaining a Statewide Trauma Triage Plan. Emergency Medical Services (EMS) Agencies are required by EMS Regulation 12 VAC 5-31-390 to follow triage plans. This plan is to include pre-hospital and inter-hospital patient transfers.

The *Code* states the State Trauma Triage Plan shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The *Code* further directs the collection of data through The EMS Registry, whether paper or electronic, and Statewide Trauma Registry and protects its ability to be used by Trauma Committees that report to the Governors EMS Advisory Board. In accordance with § 32.1-116.2, any such data or information in the possession of or transmitted to the Commissioner (OEMS as the designee), the EMS Advisory Board, or any committee acting on behalf of the EMS Advisory Board, any hospital or pre-hospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

The Virginia Trauma System is an inclusive system, but all hospitals participate in the Trauma Triage Plan. Establishing a comprehensive statewide emergency medical care system, incorporating healthcare facilities, transportation, human resources, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality.

These goals can be achieved by reducing the time acutely injured patients are identified and assisted in reaching definitive high quality trauma care. A coordinated effort between ground and air pre-hospital resources, as well as hospitals, whether trauma designated or not, can lead to getting the right patient to the right hospital, in the shortest amount of time possible, while maximizing resources.

The REMS Regional Trauma Triage Plan provides a uniform set of proposed criteria for pre-hospital and Inter-hospital triage and transport of trauma patients. The development and monitoring of these criteria is performed by the REMS Regional Performance Improvement (PI) Committee.

These improvements can be accomplished by conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge, skills, and abilities of healthcare providers involved in trauma care. These criteria do not supersede applicable laws such as the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA).

## ***Trauma Patient Transport and Transfer Criteria***

### **Trauma Victim Defined:**

A person who has acquired potentially severe physical injury caused by an external source (fall, auto crash, farm or industrial accident, assault, knife or gunshot wound, etc.) that requires emergency medical intervention to attempt to prevent loss of life or limb or substantial, permanent physical impairment. It does not include moderate or minor injuries; heart attacks, strokes, or other internal conditions; chronic, contagious, or infectious diseases; or mental illness not caused by a severe physical injury

### **Two-tiered System for the recognition of a trauma patient:**

- Initial Field Triage in the pre-hospital environment (pre-hospital criteria) to include physiologic guidelines (blood pressure, respiration status and level of consciousness), because unlike the anatomy of the traumatic injury, physiologic status cannot be directly observed and is important for trauma recognition and obtaining a Revised Trauma Score and;
- Secondary triage or trauma patient recognition and appropriate timely triage by all Virginia hospitals

The purpose of a Regional Triage Plan is to establish pre-hospital and hospital criteria for identifying the trauma patient. The Regional Trauma Triage Plans identify the best point of entry plan for these patients. An identified trauma patient destination decision is guided by many factors including geography, hospital capabilities, and air medical services, among others.

# Field Triage of Injured Patients

1

**Measure vital signs and level of consciousness**

Glasgow Coma Scale	≤13
Systolic Blood Pressure (mmHg)	<90 mmHg
Respiratory Rate	<10 or >29 breaths per minute, or need for ventilatory support (<20 in infant aged <1 year)

NO

**Assess anatomy of injury**

2

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

NO

**Assess mechanism of injury and evidence of high-energy impact**

3

- **Falls**
  - Adults: >20 feet (one story is equal to 10 feet)
  - Children: >10 feet or two or three times the height of the child
- **High-risk auto crash**
  - Intrusion, including roof: >12 inches occupant site; >18 inches any site
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with a high risk of injury
- **Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact**
- **Motorcycle crash >20 mph**

NO

**Assess special patient or system considerations**

4

- **Older Adults**
  - Risk of injury/death increases after age 55 years
  - SBP <110 may represent shock after age 65
  - Low impact mechanisms (e.g. ground level falls) may result in severe injury
- **Children**
  - Should be triaged preferentially to pediatric capable trauma centers
- **Anticoagulants and bleeding disorders**
  - Patients with head injury are at high risk for rapid deterioration
- **Burns**
  - Without other trauma mechanism: triage to burn facility
  - With trauma mechanism: triage to trauma center
- **Pregnancy >20 weeks**
- **EMS provider judgment**

NO

**Transport according to protocol**

**YES**

**Transport to a trauma center.** Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.

**YES**

**Transport to a trauma center,** which, depending upon the defined trauma system, need not be the highest level trauma center.

**YES**

**Transport to a trauma center** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

**When in doubt, transport to a trauma center.**

Find the plan to save lives, at [www.cdc.gov/Fieldtriage](http://www.cdc.gov/Fieldtriage)

**Procedure:**

The goal of prehospital trauma management includes patient stabilization and immediate entry into the Trauma System. In addition to following the Trauma Triage Decision Scheme, the following procedures are intended to assist the field provider with making sound clinical judgement in the best interest of patient care. Time is a factor in most trauma incidents and must be part of the overall decision scheme.

1. Provide appropriate care and initiate immediate transport towards (scene time less than 10 minutes) the appropriate trauma center.
2. Establish early radio contact to alert trauma center staff.
3. Immediate transport; otherwise, document the reason for the delay.
4. Field transports by HEMS of trauma patients should be considered:
  - a. If patient meets the clinical triage criteria for transport and should be transported to the closest Trauma Center.
  - b. If patient requires a level of care greater than can be expected by the local ground provider **AND** if HEMS can be on scene in a time shorter than the ground unit can transport to the closest hospital.
  - c. If technicians can request HEMS without authorization by medical control.
5. If air transport is delayed or unavailable, transport patients meeting trauma center criteria to the closest hospital; keeping in mind the on-scene time should be 10 minutes or less.
6. Establish early contact with the destination hospital. A facility may divert patient to a Trauma Center en-route or expedite transfer after arrival.

**Note:**

1. Patient stabilization is the primary concern, which may necessitate transfer to the closest trauma center first over specialty care. However, consider transport to the closest Pediatric Trauma Center for the complex pediatric trauma patients; consider transport to the nearest Burn Center for burns that meet ABA Burn Center criteria.

## Documentation Guidance

The Virginia Pre-Hospital Information Bridge (VPHIB) system provides core validation rules for electronic patient care reports supporting required documentation fields of the trauma patient. While the validation rules ensure that data is entered, the following additional guidelines should be followed to help with the quality of patient care documentation and to support the overall assessment of the trauma system.

1. Ensure the appropriate Trauma Triage decision points are captured (Step 1, 2, 3, or 4). If “Provider Judgement” is only option selected, ensure that rationale is properly documented in the narrative.
2. **Ensure that a complete set of patient vitals are documented on scene prior to initiating transport.** Exceptions shall be documented in the narrative. This information is required for Trauma Registry Reporting.
3. Document the Medical Record Number (MRN) assigned after patient transfer.
4. EMS should document Trauma Center for hospital destination and document why patient was transported to a Trauma Center.

## ***Inter-hospital Transfer Criteria***

Hospitals not designated by the Virginia Department of Health as a Trauma Center should enter injured patients that meet the below physiological and/or anatomic criteria into the trauma system and initiate rapid transfer to an appropriate designated Trauma Center.

<b>Adult Patient</b>	<b>Pediatric Patient (Age &lt;15)</b>
	Patients with Pediatric Trauma Scores less than <6, see Pediatric Trauma Score below:
<b>Respiratory</b> <ul style="list-style-type: none"> <li>• Bilateral thoracic injuries</li> <li>• Significant unilateral injuries in pt's &gt; 55 years (e.g. pneumothorax, hemopneumothorax, pulmonary contusion, &gt;5 rib fractures)</li> <li>• Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease</li> <li>• Respiratory compromise requiring intubation</li> <li>• Flail chest</li> </ul>	<b>Respiratory</b> <ul style="list-style-type: none"> <li>• Bilateral thoracic injuries</li> <li>• Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease</li> <li>• Flail chest</li> </ul>
<b>CNS</b> <ul style="list-style-type: none"> <li>• Open skull fracture</li> <li>• Extra-axial hemorrhage on CT, or any intracranial blood</li> <li>• Paralysis</li> <li>• Focal neurological deficits</li> <li>• GCS less than 13; Unable to follow commands (in the absence of suspected ETOH/Substance use)</li> </ul>	<b>CNS</b> <ul style="list-style-type: none"> <li>• Open skull fracture</li> <li>• Extra-axial hemorrhage on CT Scan</li> <li>• Focal neurological deficits</li> </ul>
<b>Cardiovascular</b> <ul style="list-style-type: none"> <li>• Hemodynamic instability as determined by the treating physician</li> <li>• Persistent hypotension</li> </ul>	
<b>Injuries</b> <ul style="list-style-type: none"> <li>• Any penetrating injury to the head, neck, torso, or extremities proximal to the elbow or knee without a surgical team immediately available where the physician in charge feels treatment of injuries would exceed capabilities of the medical center</li> <li>• Serious burns/burns with trauma (see below)</li> <li>• Significant abdominal to thoracic injuries in patients where the physician in charge feels treatment of injuries would exceed capabilities of the medical center</li> </ul>	<b>Injuries</b> <ul style="list-style-type: none"> <li>• Any penetrating injury to the head, neck, chest abdomen or extremities proximal to the knee or elbows without a surgical team immediately available where the physician in charge feels treatment of injuries would exceed capabilities of the medical center.</li> <li>• Any injury or combination of injuries where the physician in charge feels treatment of the injuries would exceed the capabilities of the medical center</li> </ul>
<b>Special Considerations</b> <ul style="list-style-type: none"> <li>• Trauma in pregnancy (greater than 20 weeks gestation)</li> <li>• Geriatric</li> <li>• Bariatric</li> <li>• Special needs individuals</li> </ul>	



### Pediatric Trauma Score

COMPONENT	+2	+1	-1
<b>Size</b>	Child/adolescent, >20 Kg	Toddler, 11-20 Kg Infant, <10 Kg	Infant, <10 Kg
<b>Airway</b>	Normal	Assisted O <sub>2</sub> , mask, cannula	Intubated: ETT, King, LMA, Cricothyrotomy
<b>Consciousness</b>	Awake	Obtunded; loss of consciousness	Coma; unresponsiveness
<b>Systolic B/P</b>	>90 mm/Hg; good peripheral pulses, perfusion	51-90 mm/Hg; peripheral pulses, pulses palpable	<50 mm/Hg; weak peripheral or no pulses
<b>Fracture</b>	None seen or suspected	Single closed fracture anywhere	Open, multiple fractures
<b>Cutaneous</b>	No visible injury	Contusion, abrasion; laceration <7 cm not through fascia	Tissue loss; any GSW or Stabbing through fascia

### Burn Related Injuries

The American Burn Association has identified the following injuries that usually require referral to a burn center

- Partial thickness and full thickness burns greater than 10% of the total body surface area (BSA)
- Partial thickness and full-thickness burns involving the face, eyes, ears, hands, feet, genitalia or perineum of those that involve skin overlying major joints
- Full-thickness burns greater than 5% BSA in any age group
- Electrical burns, including lightning injuries; (significant volumes of tissue beneath the surface may be injured and result in acute renal failure and other complications)
- Significant chemical burns
- Inhalation injuries
- Burn injury in patients with pre-existing illness that could complicate management, prolongs recovery, or affects mortality
- Any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center
- Children with burns seen in hospitals without qualified personnel or equipment for their care should be transferred to a burn center with these capabilities
- Burn injury in patients who will require special social and emotional or long term rehabilitative support, including cases involving child abuse and neglect

## **Inter-Hospital Transports by Helicopter**

Appropriate air medical transport may include the following:

1. Trauma patients transported by air should meet the clinical trauma triage criteria for transport to the most appropriate trauma or burn center.
2. Patient requires a level of care greater than can be provided by the local hospital.
3. Patient requires time critical intervention, out of hospital time needs to be minimal, or distance to definitive care is long.
4. Utilization of local ground ambulance leaves local community without ground ambulance coverage.

All trauma patients meeting the inter-hospital triage criteria as identified in Table 2 being transported by helicopter must be transferred to the closest appropriate Level I or Level II trauma center or burn center.

## ***Hospitals, Trauma Centers, Burn Centers, and Pediatric Trauma Centers***

### **Hospitals:**

Within the Rappahannock EMS Council region there are 5 full service hospital facilities and one freestanding emergency department which operate 24-hour emergency departments. They are listed as follows:

**Mary Washington Hospital - Fredericksburg, Virginia**

This is an acute care hospital facility with a 50 bed Emergency Department.

**Designated as a Level II Trauma Center.**

**Mary Washington Hospital Emergency Department at Lee's Hill – Spotsylvania, Virginia**

This is an 11 bed freestanding Emergency Department.

**UVA Culpeper Hospital - Culpeper, Virginia**

This is an acute care hospital with a 15 Emergency Department.

**Fauquier Hospital - Warrenton, Virginia**

This is an acute care hospital with a 32 bed Emergency Department.

**Stafford Hospital Center – Stafford, Virginia**

This is an acute care hospital with a 14 bed Emergency Department.

**Spotsylvania Regional Medical Center – Spotsylvania, Virginia**

This is an acute care hospital facility with a 14 bed Emergency Department.

### **State Designated Trauma Centers:**

A trauma center's designation is defined by the following criteria:

- Level I:** Level I trauma centers have an organized trauma response and are required to provide total care for every aspect of injury, from prevention through rehabilitation. These facilities must have adequate depth of resources and personnel with the capability of providing leadership, education, research, and system planning.
- Level II:** Level II trauma centers have an organized trauma response and are also expected to provide initial definitive care, regardless of the severity of injury. The specialty requirements may be fulfilled by on-call staff that are promptly available to the patient. Due to limited resources, Level II centers may have to transfer more complex injuries to a Level I center. Level II centers should also take on responsibility for education and system leadership within their region.
- Level III:** Level III trauma centers, through an organized trauma response, can provide prompt assessment, resuscitation, stabilization, emergency operations and also arrange for the transfer of the patient to a facility that can provide definitive trauma care. Level III centers should also take on responsibility for education and system leadership within their region.

The Rappahannock EMS Council region currently includes one state-designated level trauma center. There are several Level I Trauma Centers that patients from our region are transported to either by ground or by air. They are as listed.

#### **Level I**

HCA Chippenham Hospital	Richmond, VA
INOVA Fairfax Hospital	Fairfax, VA
Norfolk General Hospital	Norfolk, VA
Carillion Roanoke Memorial Hospital	Roanoke, VA
UVA Medical Center	Charlottesville, VA

VCU Medical Center	Richmond, VA
Medstar Washington Hospital Center	Washington, DC

### **Level II**

HCA Henrico Doctors' Hospital	Richmond, VA
Lynchburg General Hospital	Lynchburg, VA
Mary Washington Hospital	Fredericksburg, VA
HCA Reston Hospital Center	Fairfax County, VA
Riverside Medical Center	Richmond, VA
Virginia Hospital Center in Arlington	Arlington, VA
Winchester Medical Center	Winchester, VA

### **Level III**

New River Valley Medical Center	Christiansburg, VA
Lewis Gale-Montgomery	Blacksburg, VA
Loudoun Hospital	Loudoun, VA
Southside Regional Medical Center	Petersburg, VA
Virginia Beach General Hospital	Virginia Beach, VA
Sentara Northern Virginia Medical Center	Woodbridge, VA

### **Virginia American Burn Association Verified Burn Centers\*:**

HCA Chippenham Hospital	Richmond, VA
Norfolk, General Hospital	Norfolk, VA
VCU Medical Center	Richmond, VA

### **\* Other burn treatment centers include:**

John Hopkins Regional Burn Center	Baltimore, MD
MedStar Washington Hospital Center	Washington, DC

### **American College of Surgeons Verified Pediatric Trauma Centers:**

Children's National Medical Center	Washington, D.C.
VCU Medical Center	Richmond, VA
Children's Hospital of the Kings Daughters	Norfolk, VA
Roanoke Memorial Hospital	Roanoke, VA

**NOTE:** For additional information regarding regional resources, such as data regarding the number of agencies, vehicles, or providers in the REMS region, please consult the Regional Surge Plan.

### **Trauma Triage Related Resources**

1. Virginia Office of EMS Trauma Web page:  
<http://www.vdh.virginia.gov/OEMS/Trauma/index.htm>
2. Centers for Disease Control and Injury Prevention
  - CDC Field Triage Main page: <http://www.cdc.gov/fieldtriage/>
  - CDC National Trauma Triage Protocol Podcast:  
<http://www2a.cdc.gov/podcasts/player.asp?f=10649>
  - CDC Field Triage PowerPoint:  
[http://www.cdc.gov/fieldtriage/pdf/field\\_triage\\_powerpoint\\_speakers\\_notes-a.pdf](http://www.cdc.gov/fieldtriage/pdf/field_triage_powerpoint_speakers_notes-a.pdf)

3. American College of Surgeons – Committee on Trauma  
<http://www.facs.org/trauma/index.html>
4. Virginia Office of EMS: Guide to Trauma Center designations:  
[http://www.vdh.virginia.gov/OEMS/Files\\_page/trauma/TraumaDesignationLevelInfo.pdf](http://www.vdh.virginia.gov/OEMS/Files_page/trauma/TraumaDesignationLevelInfo.pdf)

### ***Implementation of Rappahannock Regional MCI Plan***

The goal of the Rappahannock Emergency Medical Services (REMS) Council's Mass Casualty Incident Plan is to prepare on a regional basis for a unified, coordinated, and immediate emergency medical services (EMS) mutual aid response by pre-hospital and hospital agencies to, and the effective emergency medical management of, the victims of any type of Mass Casualty Incident (MCI). It includes patients who are involved in any emergency evacuation of any health care facility in the REMS Council region and/or any such facility outside the region. The Rappahannock EMS Regional Mass Casualty Incident Plan document should be the primary reference and Standard Operating Guidance for training and response to Regional MCI's.

Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district and related jurisdictions which comprise the REMS Council region as provided in the Code of Virginia, Section 32.1-113.

The following individuals can implement or activate the Regional MCI Plan for EMS mutual aid:

1. The Incident Commander at the scene of a MCI according to the existing local protocol, usually via the local ECC.
2. The local Emergency Management Coordinator, or that person's representative, of a political subdivision that has authority for the management of the incident.
3. The Hospital Incident Commander, or appropriate representative of a health care facility that is required to evacuate or move patients.
4. Any health care facility in the REMS Council region when additional resources are necessary to provide appropriate patient care.

It is strongly recommended that the Regional MCI Plan be activated through the local Emergency Communications Center, which will communicate directly with MCI Medical Control and with localities whose pre-hospital resources may be used within the REMS Council region.

To activate the MCI Medical Control component of the Regional MCI Plan, call land telephone line or cellular phone of hospital.

1. The person authorized to request activation should identify herself/himself and request activation of this plan (Rappahannock EMS Council Mass Casualty Plan).
2. The person should give a brief summary of the incident. The information should include time of the incident, type of incident, location, initial number of patients involved, and a callback phone number.
3. Depending on local protocol and the scope of the incident, the local Emergency Communications Center will activate the Pre-hospital Component of the MCI Plan through established mutual aid agreements among pre-hospital volunteer and career EMS agencies.
4. The Emergency Communications Center dispatcher should emphasize that the mutual aid request for ambulances and/or equipment is under the activated REMS Council MCI Plan.

***For more details, please consult the Mass Casualty Incident Plan.***

## Performance Improvement Process

### **Purpose:**

To review trauma care delivered in the region by examining data and patient outcomes. Trending of the data and outcomes will be done to identify strong and weak points in our region's trauma care system with the goal of no preventable trauma deaths as identified by a multi-disciplinary performance improvement (PI) committee.

### **Committees:**

The system for evaluating trauma in our region the Rappahannock EMS Council Regional Performance Improvement Committee which consists of members representing a balance of regional ALS and BLS providers, a member from each designated trauma center in region, an air medical representative, and an EMS Physician (OMD). The data collection and information disseminated by these committees is reported to the Regional Medical Direction committee, and/or, the Regional Medical Director. The EMS system is also represented by the Rappahannock EMS Council on the Mary Washington Healthcare Trauma Operational Performance Committee.

### **Frequency of Meetings:**

A minimum of quarterly.

### **Flow of Quality Improvement Process:**

The following is a brief explanation of the flow of the quality improvement process will be mentioned at this point as it relates to trauma and the internal review of trauma.

The cornerstone of the review process consists of data collection done by the hospitals for the Trauma Registry and by the Rappahannock EMS Council Performance Improvement committee through selected indicators.

As it pertains to the indicators, the trends are recorded and presented to the Regional and EMS Physicians. The data are compared with thresholds and if it is sufficiently improved over time will be dropped and a new indicator can be created. The Regional Medical Director reviews the indicators quarterly as they pertain to the trauma systems within the pre-hospital setting.

Information gathered through complaints or questions on individual calls pertaining to trauma in the pre-hospital system are presented to the Performance Improvement committee and/or referred to the appropriate EMS Agency to be reviewed through their own Quality Management Program. In all cases the Agency OMD should be notified and involved. QI Statistical Data obtained through the process will be shared with the region's OMDs.

***For regional Performance Improvement forms and additional information regarding this process, please consult the Performance Improvement Plan or the Trauma Performance Improvement Plan.***

## *References*

### **Code of Virginia**

#### **§ 32.1-111.3** Statewide Emergency Medical Care System

- A. The Board of Health shall develop a comprehensive, coordinated, emergency medical care system in the Commonwealth and prepare a Statewide Emergency Medical Services Plan which shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The Board shall review, update, and publish the Plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth's emergency medical care system. Publishing through electronic means and posting on the Department website shall satisfy the publication requirement. The objectives of such Plan and the system shall include, but not be limited to, the following:
1. Establishing a comprehensive emergency medical services patient care data collection and evaluation system pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter; [...]
  12. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.);
- B. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Trauma Triage Plan designed to promote rapid access for pediatric and adult trauma patients to appropriate, organized trauma care through the publication and regular updating of information on resources for trauma care and generally accepted criteria for trauma triage and appropriate transfer. The Trauma Triage Plan shall include:
1. A strategy for implementing the statewide Trauma Triage Plan through formal regional trauma triage plans developed by the Regional Emergency Medical Services Councils which can incorporate each region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A of this section. The regional trauma triage plans shall be implemented by July 1, 1999, upon the approval of the Commissioner.
  2. A uniform set of proposed criteria for pre-hospital and inter hospital triage and transport of trauma patients, consistent with the trauma protocols of the American College of Surgeons' Committee on Trauma, developed by the Emergency Medical Services Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and pre-hospital care providers. The Emergency Medical Services Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.

**§ 32.1-116.2.** Confidential nature of information supplied; publication; liability protections

- A. *The Commissioner and all other persons to whom data is submitted shall keep patient information confidential. Mechanisms for protecting patient data shall be developed and continually evaluated to ascertain their effectiveness. No publication of information, research, or medical data shall be made which identifies the patients by names or addresses. However, the Commissioner or his designees may utilize institutional data in order to improve the quality of and appropriate access to emergency medical services.*
- B. *No individual, licensed emergency medical services agency, hospital, Regional Emergency Medical Services Council or organization advising the Commissioner shall be liable for any civil damages resulting from any act or omission performed as required by this article unless such act or omission was the result of gross negligence or willful misconduct.*

**§ 8.01-581.19.** Civil immunity for physicians, psychologists, podiatrists, optometrists, veterinarians, nursing home administrators, and certified emergency services personnel while members of certain committees.

- A. *Any physician, chiropractor, psychologist, podiatrist, veterinarian or optometrist licensed to practice in this Commonwealth shall be immune from civil liability for any communication, finding, opinion or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission or other entity that is responsible for resolving questions concerning the admission of any physician, psychologist, podiatrist, veterinarian or optometrist to, or the taking of disciplinary action against any member of, any medical society, academy or association affiliated with the American Medical Association, the Virginia Academy of Clinical Psychologists, the American Psychological Association, the Virginia Applied Psychology Academy, the Virginia Academy of School Psychologists, the American Podiatric Medical Association, the American Veterinary Medical Association, the International Chiropractic Association, the American Chiropractic Association, the Virginia Chiropractic Association, or the American Optometric Association; provided that such communication, finding, opinion or conclusion is not made in bad faith or with malicious intent.*
- B. *Any nursing home administrator licensed under the laws of this Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission or other entity that is responsible for resolving questions concerning the admission of any health care facility to, or the taking of disciplinary action against any member of, the Virginia Health Care Association, provided that such communication, finding, opinion, decision or conclusion is not made in bad faith or with malicious intent.*
- C. *Any emergency medical services personnel certified under the laws of the Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision, or conclusion made in performance of his duties while serving as a member of any regional council, committee, board, group, commission or other entity that is responsible for resolving questions concerning the quality of care, including triage, interfacility transfer, and other components of emergency medical services care, unless such communication, finding, opinion, decision or conclusion is made in bad faith or with malicious intent.*

## **EMS Regulation**

### **12 VAC 5-31-390. Destination / Trauma Triage**

An EMS agency shall participate in the Regional Trauma Triage Plan established in accordance with §32.1-111.3 of the Code of Virginia.