



# Regional Trauma Triage Plan

**Rappahannock EMS Council**

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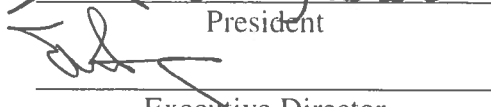
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REMS Executive Committee Approved March 14, 2019

This Regional Trauma Triage Plan has been reviewed and approved by the Rappahannock EMS Council Board of Directors.

Approved:  \_\_\_\_\_ Date: 04-04-2019

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President

Executive Director

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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:**

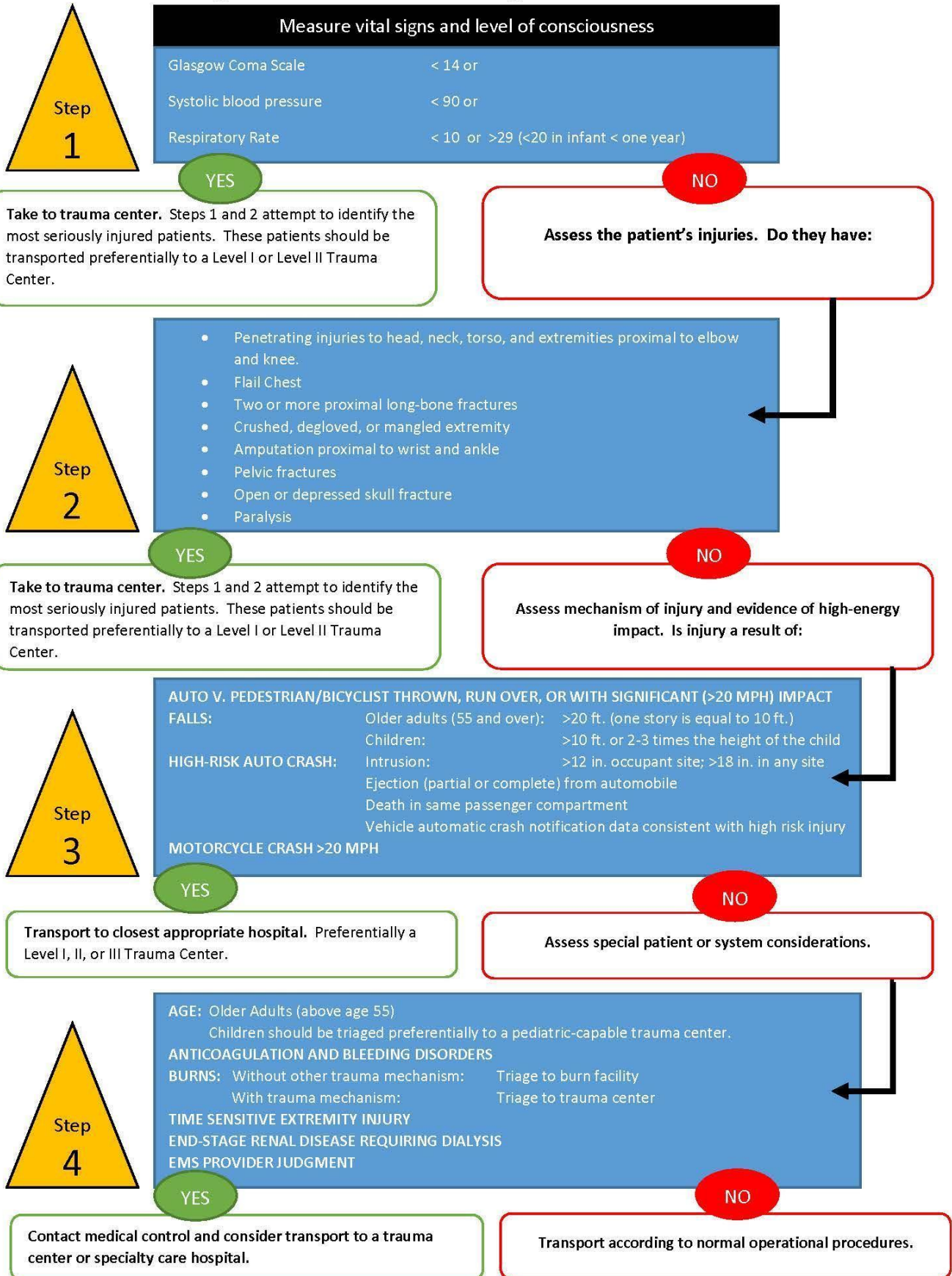
A person who has acquired potentially severe physical injury caused by an external source (fall, auto crash, farm or industrial accident, knife or gunshot wound, etc.) that requires emergency medical intervention to attempt to prevent loss of life or limb or substantial, permanent physical impairment. 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) 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.

# Rappahannock EMS Council Regional Field Trauma Triage Decision Scheme



**NOTE:** Pre-hospital providers should transport trauma patients with uncontrolled airway, uncontrolled hemorrhage, or if CPR is in progress to the closest emergency department for stabilization and transfer to a Trauma Center.

## Procedure:

### Agencies operating *within a 30-minute ground transport time* of a Trauma Center:

1. Provide appropriate care and initiate immediate transport towards (scene time less than 10 minutes) trauma center.
2. Establish early radio contact to alert trauma center staff.
3. Immediate transport; otherwise, document the reason for the delay.

### Agencies operating *outside a 30-minute ground transport time* to a Trauma Center:

1. Field transports by helicopter 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 the aero medical helicopter can be on scene in a time shorter than the ground unit can transport to the closest hospital.
  - c. If technicians can request air ambulance transport without authorization by medical control.
2. 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.
3. Establish early contact with the destination hospital. A facility may divert patient to a Trauma Center en-route or expedite transfer after arrival.
4. Patients that meet Mechanism of Injury, but **do not** meet Anatomic and Physiologic criteria, the provider should **contact medical control** to determine hospital destination.

## Note:

1. Consider transport to a Level 1 Trauma Center for patients with major amputations requiring re-implantation; 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.

## ***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>
	<i>Patients with Pediatric Trauma Scores less than &lt;6, see Pediatric Trauma Score on the next page:</i>
<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, hemothorax, 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) in patients under 10 or over 50 years of age
- Partial thickness burns and full thickness burns greater than 20% BSA in other age groups
- 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***

### **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.

<b>Mary Washington Hospital</b>	<b>Fredericksburg, VA</b>	<b>Level II</b>
INOVA Fairfax Hospital	Fairfax, VA	Level I
Washington Hospital Center	Washington, D.C.	Level I
Reston Hospital Center	Reston, VA	Level II
UVA Medical Hospital	Charlottesville, VA	Level I
VCU Medical Center	Richmond, VA	Level I
Henrico Doctor's Hospital	Richmond, VA	Level II

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

These facilities should be considered as needed for severe burn patients:

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:

These facilities should be considered as needed for pediatric trauma patients:

Children's National Medical Center - Washington, D.C.  
VCU Medical Center - Richmond, VA

## 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 23 bed Emergency Department.

### **Fauquier Hospital** - Warrenton, Virginia

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

### **Stafford Hospital Center** – Stafford, Virginia

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

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

This is an acute care hospital facility with a 20 bed Emergency Department.

Other full-service hospitals outside our region that our ambulances transport to include:

University of Maryland Charles Regional Medical Center	La Plata, MD
Riverside Tappahannock Hospital	Tappahannock, VA
Henrico Hospital	Richmond, VA
Memorial Regional Medical Center	Mechanicsville, VA
VCU Medical Center	Richmond, VA
St. Mary's Hospital	Richmond, VA

## ***Trauma Triage Related Resources***

1. Virginia Office of EMS Trauma Web Page: <http://www.vdh.virginia.gov/OEMS/Trauma/index.htm>
2. Virginia Office of EMS, Center Designation Manual: <https://goo.gl/QF3A03>
3. Centers for Disease Control and Injury Prevention
  - a) National Trauma Triage Protocol podcast: <http://www2c.cdc.gov/podcasts/player.asp?f=10649>
  - b) CDC Field Triage Powerpoint (download): <http://goo.gl/gIAs41>
4. American College of Surgeons, Committee on Trauma: <http://www.facs.org/trauma/index.html>
5. American Burn Association: <http://www.ameriburn.org/>

**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.

## ***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:

- a) The Incident Commander at the scene of a MCI according to the existing local protocol, usually via the local ECC.
- b) The local Emergency Management Coordinator, or that person's representative, of a political subdivision that has authority for the management of the incident.
- c) The Hospital Incident Commander, or appropriate representative of a health care facility that is required to evacuate or move patients.
- d) 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 utilizes two major committees who work together to ensure the quality improvement process. This includes the Rappahannock EMS Council Regional Trauma Systems Committee and the Rappahannock EMS Council Regional Trauma 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 Operational Medical Director (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 Operational Medical Directors. 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 preformed 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.