

Nashville General Hospital
Nashville, Tennessee
Trauma Center Re-Designation Site Visit Report
April 16, 2026

Introduction

Nashville General Hospital was visited on April 16, 2026, for Level III Trauma Center re-designation. The site visit was conducted as required by the Health Facilities Commission as a performance-based review using the Trauma Center rules 0720-22. Generation of this report was accomplished by interviews with key personnel (hospital administrators, the Trauma Medical Director, the Trauma Program Manager and other involved personnel), direct evaluation of the system via review of provided documentation, analysis of trauma registry data and reports, review of the quality assurance program and other supporting documents. Trauma care provided at Nashville General Hospital is solely for adult patients 18 years of age or older.

Accomplishments

Numerous accomplishments have been noted in creation of this Level III Trauma program including:

1. Strong and burgeoning support from the hospital administration and the hospital system as a whole with a new CEO. This has provided Nashville General Hospital with funding from their administrative entity in the City of Nashville resulted in remodeling of the ED to include a well-stocked trauma bay, hiring of trauma service-specific personnel and purchase of needed trauma equipment.
2. Maturation of the Trauma Medical Director who is clearly invested in the trauma program; an engaged trauma program manager and addition of a performance improvement nurse, who is respected by peers in the system.
3. A strong outreach program that is geared towards the needs of the community.
4. A plan to grow surgical specialists and volume in the care of injured patients.
5. Meeting opportunities for improvement from previous designation visit.

Trauma Injury and Payor Data

At the time of the site visit, review of patient ISS revealed:

| Year | Total Admits | ISS 0-15 | ISS 16-25 | ISS 26-40 | ISS 41+ | Ave ISS |
|------|--------------|----------|-----------|-----------|---------|---------|
| 2025 | 135 | 132 | 3 | 0 | 0 | 4.52 |

Financial summary of patients includes

| Year | Self-Pay | Comm. Insur. | Medicare | Medicaid | TennCare | Work. Comp. | Other |
|------|----------|--------------|----------|----------|----------|-------------|-------|
| 2025 | 43% | 31% | 9.5% | 0.7% | 15.3% | 0.4% | --- |

Hospital Organization

| Position | Name | %Time Commitment |
|--|---|----------------------|
| Trauma Medical Director | Dr. Muiyiwa Adedokun | 100% |
| Trauma Program Manager | Bill Campbell | 100% |
| Trauma Registrar | Bill Campbell/Jonathan Jackson | 100%/50% |
| PI/Educator | Jonathan Jackson | 50% |
| Hospital Admin. Responsible for Trauma | Dr. Veronica Elders | |
| Trauma Surgeons | Dr. Muiyiwa Adedokun Dr. Bolanle Asiyanbola Dr. Nathan Cain | 100% 100% 100% |

Trauma Service/Activation Criteria/Response Times

There are currently 4 surgeons primarily responsible for trauma call. At the time of the visit, the institution was addressing internally a credentialing issue for one of the surgeons, resulting in three surgeons taking call at the time of the visit, and another surgeon being hired to start in a month to return to four surgeons. Dr. Adedokun, the TMD, is also the designated co-director of the ICU at Nashville General Hospital. All of the core surgeons are up to date in ATLS certification. At present, the majority of injured patients are admitted by a hospitalist and trauma surgery may consult on such admissions. The trauma service reviews all trauma admissions to a non-trauma service and track PI issues in relation to this. Dr. Adedokun leads the trauma multidisciplinary meetings. Attendance by the core members of the multidisciplinary committee meets the minimum of 50% and reaches 100% as meetings are now virtual. Peer review is performed at the trauma/multidisciplinary level, as well as at the hospital level.

Written, graded activation criteria were devised after the last visit and divided into Level I and II activations, as well as trauma consults. These were presented to the site survey team. Activation criteria for Level I and II admissions are appropriate and are consistent with national standards. Trauma activations are reviewed by the trauma program and appropriate patients are entered into the registry. The PI process revealed an issue with under triage, which has been addressed with the personnel initiating trauma activations and has shown improvement in reducing failures to activate.

The organization chart for the institution was reviewed and interviews with the administration, as well as other documentation, demonstrate support for the Trauma Program. A budget was presented.

Trauma response times were reviewed. The response times for the general surgeons were appropriate. Documentation for trauma patients currently occurs in the EMR.

Surgical Specialty Availability

Surgical specialty call schedules were reviewed, and 24/7 coverage of all required specialties was documented. Review of Trauma Performance documents did not demonstrate any problems with coverage or availability. Attendance by required specialists at multidisciplinary meetings met the threshold of 50%, and again approached 100% virtually.

Non-Surgical Specialty Availability

Non-surgical specialty call schedules were reviewed. There was immediate 24/7 coverage for internal medicine. Dialysis and medical consultation services were available. Review of Trauma Performance documents did not reveal any problems with Non-Surgical Specialty coverage or availability.

Facility Resources and Capabilities

Emergency Department: Personnel/Qualifications/Equipment

The Emergency Department has designated as Physician Director, Deann Bullock, MD, and is almost entirely staffed by physicians Board Certified in Emergency Medicine. One provider in the ED is not a board-certified Emergency Medicine physician but is current in ATLS. Adequate nursing staff are available 24/7. Tour of the Emergency Department verifies that all essential equipment is available. The trauma room is new and well-stocked.

Intensive Care Unit for Trauma Patients: Personnel/Qualifications/Equipment

Dr. Fremont is the Medical Director of the Intensive Care Unit. Dr. Adedokun is designated as the surgical co-director of the ICU for trauma purposes. In-house critical care physicians provide coverage to ensure 24/7 patient coverage. Nurse ratios are appropriate and there is immediate access to laboratory services and imaging. All essential equipment is available on the unit. ICU staff have access to ventilators, dialysis and massive transfusion protocols when needed.

Post-anesthetic Recovery Room

No deficiencies are documented. Recovery room capabilities are available after hours as an on-call option.

Acute Hemodialysis

Intermittent hemodialysis is available when needed.

Organized Burn Care

Nashville General Hospital does not have burn capability. Transfer agreements are in place with Vanderbilt University for the care of burned patients.

Radiologic Capabilities

The site reviewers toured the Radiologic Department. All required capabilities were noted present. Radiology technicians respond to trauma activations and CT scan capability is available 24/7. Radiologic reads are either provided by an in-house radiologist or contracted radiologic interpretation services.

Organ Donation Protocols

Organ donor protocols exist and are appropriate. Nashville General Hospital screens all patients appropriately for donation.

Operating Suite Special Requirements/Availability

There is an available operating room for trauma and emergencies at all times. At night, call teams are available within 30 minutes for emergency surgeries. Nashville General Hospital has adequate staff to cover emergent needs at all times. All the equipment required is available.

Clinical Laboratory Services

All essential Clinical Laboratory Services are available. Blood Bank has a protocol for massive transfusion and has devised simulations due to infrequent use. The protocol is activated and terminated by physicians and is monitored by the blood bank. The blood bank has O- PRBC's available, frozen plasma, platelets and cryoprecipitate. The Emergency Department or Nursing Supervisor provides runners to convey blood samples from the trauma room and to provide blood products when the massive transfusion protocol is activated.

Trauma Medical Director

Dr. Adedokun is the trauma medical director and has served in that role since November 2020. Dr. Adedokun participates in trauma call and is board certified and

is up to date in ATLS. Dr. Adedokun coordinates performance improvement and the peer review process, in conjunction with hospital-wide peer review processes. Dr. Adedokun has the stated support of hospital administration to provide oversight of mandatory trauma processes.

Attending General Surgeons on the Trauma Service

Dr. Asiyabola and Dr. Cain are the other core general surgeons taking trauma call. Both are board certified and current in ATLS. They attend at least 50% of the multidisciplinary trauma meetings, and 100% virtually.

Trauma Nurse Coordinator/Trauma Program Manager (TPM)

Bill Campbell, MBA, BSN, RN, is the Trauma Program Manager (100%). He is completely focused on administration of the trauma program. He shows dedication to the position and has taken the necessary training courses for TPM. A defined job description was presented to the site surveyors and was appropriate. Administrative and budget support for the trauma program was evident.

Trauma Registry

The hospital had outsourced the registry but recently is returning it to in house due to financial reasons. The TPM and TMD demonstrate understanding of the role of the registry. The TPM and PI Coordinator are presently in the process of completing coursework for the registry and are approaching concurrent entry. All patients with injury ICD-10 codes are placed in the registry with exclusions for late effects of injury, superficial injuries and foreign bodies. Data is obtained from retrospective chart review for registry entry. Nashville General is current in state registry submission.

Programs for Quality Assurance: Medical Care Education/Trauma Process Improvement/Operational Process Improvement (System Issues)

1. Morbidity and Mortality is conducted in conjunction with the trauma multidisciplinary meeting. Trauma related complications and deaths are reviewed for quality assurance. When necessary, cases may be forwarded to hospital quality review.

2. Multi-disciplinary Trauma Committee meets monthly and is comprised of trauma/general surgery, orthopedic surgery, emergency medicine, internal medicine, anesthesia, hospital administration and other pertinent parties. Quality of care issues, as well as systems issues, are discussed at this meeting. Most issues reviewed at this committee are resolved through discussion at the committee meeting and documented on the log sheet. An issue of special focus has included under-triage of patients.

Chart Reviews of Medical Care

Chart review was performed by members of the team during this redesignation visit. Review of the Peer Review of the minutes and Multidisciplinary Committee minutes was accomplished. Mortality reviews were deemed to have met standard of care. Issues identified for follow-up include admission of multisystem trauma patients to internal medicine, under-triage of injured patients and development and implementation of new practice guidelines, specifically one for rib fractures.

Trauma Bypass Log

The diversion log was reviewed. Though the hospital has not gone on bypass to trauma to date.

Outreach/Training/Public Education/Research

The hospital provided information on outreach and educational activities within the local community. These include activities in regional health fairs and outreach to EMS communities. The hospital supports TNCC designation for nurses who provide trauma care. Adequate ATLS certification is supported in the general surgeons and ED physicians but not required for the advanced practice providers. There is no requirement for research in Level III trauma facilities

Trauma System Development

Dr. Adedokun has attended at least one Trauma Care Advisory Council. Mr. Campbell has been active with the state TPM community.

Conclusions

Nashville General Hospital has demonstrated a commitment to maintaining Level III Trauma Center designation. The hospital administration has shown solid support for this endeavor, and the institution and trauma program have shown significant strides in addressing previous opportunities for improvement to keep Level III status. The Trauma Program Manager is a full FTE and is motivated to master additional skills such as the Trauma Registry. The hospital has hired a PI coordinator who is a strong addition to the trauma service. The hospital also has a solid start in regard to outreach and public education.

Areas of Improvement

1. The majority of trauma admissions go to the hospitalist. A new rib fracture guideline recommends admission to the trauma surgeon and pain management by anesthesia. This needs to be tracked to monitor compliance

- and outcomes. Other multisystem trauma or medically complex patients should primarily be admitted to and managed by the trauma surgeon. This will be an area to work on for both the surgical service and the ED, which may preferentially refer these patients to the internist/family medicine physician at this time.
2. There was evidence of significant under-triage especially at the Level II activation. The Trauma Service and Emergency Department are addressing this, but the data for success is unclear. Please track and monitor. Level II criteria response teams have been reduced to better allocate personnel resources, which then should allow Level II criteria extensions to injuries such as open fractures, complex wounds, etc.
 3. The Trauma Registry is the foundation of Performance Improvement and the process around this must be clarified. A single registrar should be hired (part time) to handle the volume and maintain consistency and internal validity. A robust registry allows PI to not only identify these issues but offers insight into how to correct them and track outcomes.
 4. We recommend the advanced practice providers in the Emergency Department who deal with injured patients (i.e. not necessarily trauma activations) be current in ATLS.
 5. With relatively low volumes, simulations/drills for various trauma issues need to occur – massive transfusion, emergent patient to the operating room, use of the rapid infuser, etc. be performed on a frequent schedule for both day and night shifts.
 6. Attendance at trauma meetings has been markedly improved by using the virtual mediums. This, however, does not ensure engagement of the participants in the design of performance improvement. To promote active participation and collaborative analysis, a more structured and interactive case review format is recommended. This may include facilitated discussion, designated peer reviewers, or assigned discussants who critically examine the case, raise alternative perspectives, and explore opportunities for improvement. Such an approach encourages deeper engagement in the PI process while remaining aligned with Quality oversight standards.

Exit Interview

Following the site visit, the team held a meeting to evaluate the findings and make conclusions. An exit interview was then held and the conclusions and recommendations as stated in this report were presented to the hospital administration, medical and nursing staff present. The site team found that Nashville General Hospital has met all requirements and standards to continue designation at Level III Trauma Center status.