

Designation Application Level III Trauma Service

2007 – 2009 Designation Cycle

Example



Office of Emergency Medical Services and Trauma System

P.O. Box 47853

Olympia, Washington 98504-7853

www.doh.wa.gov/hsqa/emstrauma/traumadesig.htm

800-458-5281 (*option #3, in-state only*)

360-236-2871

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LEVEL III TRAUMA SERVICE DESIGNATION APPLICATION

Certifications and Assurances

Trauma Service Profile

Trauma Service Components of Care

1. Trauma Service Administration
2. Trauma Quality Improvement Program
3. Trauma Registry
4. Diversion & Interfacility Transfer
5. Trauma Team Activation
6. Emergency Department
7. Surgery, Anesthesiology, OR, PACU
8. Critical Care
9. Diagnostic Imaging
10. Lab & Blood Services
11. Other Trauma Patient Care Services
12. Public & Prehospital Provider Education

EXHIBITS

- A. Referenced Designation WAC's
- B. Trauma Service Designation Definitions
- C. Frequently Asked Questions
- D. Resource List: Trauma Program Managers Experienced with the Application Process
- E. Washington State Trauma Registry Inclusion Criteria
- F. Using & Analyzing Data for the Designation Application

1. DESIGNATION INFORMATION

1.1 **Trauma System History and Designation Authority**

In March 1990, the Washington State Legislature passed RCW 70.168, the “Statewide Emergency Medical Services and Trauma Care System Act.” This act mandated that the Department of Health (DOH) develop a comprehensive emergency medical services and trauma care system. DOH was then given the authority to designate health care facilities wanting to provide trauma care services for adult and pediatric trauma patients through to the rehabilitation phase. DOH designates all facilities, every three years, based on the evaluation of a written application, in accordance with Washington Administrative Code (WAC) 246-976 trauma care standards. Any health care facility that wants to provide trauma care services must complete a designation application.

1.2 **Trauma Care Standards**

Washington Administrative Codes 246-976-430 thru 910 and 990 (revised January 2004) are Washington State’s standards for trauma care. Do not use any other version of WAC to complete this application. All designated facilities must meet the applicable trauma care standards to participate in the Washington State trauma system. This application for trauma service designation is based on these standards for trauma care, which are listed in the application and broken out by each component of care such as Trauma Service Administration, Trauma Quality Improvement Program, Trauma Registry, etc. All other applicable WAC’s are provided in the “Exhibits” section of this application. The trauma care WAC’s are online at doh.wa.gov/hsqa/emstrauma/wacindex.htm.

1.3 **Minimum/Maximum Numbers and Trauma Service Levels**

The numbers and levels of trauma services designated within each EMS and Trauma Care Region (a state map showing all regions can be found at doh.wa.gov/hsqa/emstrauma/download/designmap.pdf) are based on the minimum and maximum (min/max) numbers established by each Regional Council and approved by DOH. Current min/max numbers can be found online at doh.wa.gov/hsqa/emstrauma/download/tsdmin-max.pdf. Any hospital, whether previously designated or not, may apply for trauma service designation at the level deemed appropriate by its administration, and in accordance with the min/max numbers for its region. Competition for designation exists within a region when the number of hospitals applying for a specific level of designation exceeds the maximum number of trauma services allowed.

2. COMPLETING THE DESIGNATION APPLICATION

2.1 **Application Schedule**

Applications are released for all levels of designation, by region, in accordance with the application schedule. You will be notified immediately if a schedule change affects your hospital. The schedule was provided with the designation announcement letter. To obtain a copy, go to doh.wa.gov/hsqa/emstrauma/download/designappsched.pdf.

2.2 Application Contact

All communication concerning the interpretation of content, clarification of the process, or requests for additional materials, must be directed to the DOH Designation Administrator identified below. Oral communication not confirmed in writing by the Designation Administrator will be considered unofficial and will not bind the Department of Health. The DOH Designation Administrator is:

Sandi Shaw, Trauma Service Designation Administrator

Phone: 360-236-2871 or toll free 1-800-458-5281 (*in-state only, option 3*)

Email: sandi.shaw@doh.wa.gov

Address: WSDOH
Office of EMS & TS
PO Box 47853
Olympia WA 98504-7853

Street address: 310 Israel Road SE
Tumwater WA 98501

2.3 Application Requirements

This document is the official trauma service designation application for the 2007-2009 designation cycle. Any other versions will not be accepted. DOH reserves the right to make corrections or amendments to this application. Corrections will be provided to all applicants immediately.

Per WAC 246-976-485, you have 90 days to complete this application. **Your completed application, in its entirety, must be postmarked by the due date for your region, per the application schedule.** Please check with the Designation Administrator if there is a perceived problem meeting this deadline. Send your written application to the Designation Administrator at the above address. Materials submitted in response to this application become the property of DOH. Selection or rejection of an application does not affect this right.

2.4 Application Format and Copy Instructions

DOH copy: Your application must be submitted on standard 8½" x 11" white paper, double-sided where possible (do not copy to the front or back of a tab page or to the back of any component of care page), no staples, plastic covers, or binders please. 3-hole punch your whole application at the same time so that all of the pages line up and will fit in your application binder on file at DOH. Each section and component of care within the application must be separated by a labeled tab divider page (not numbers); for example, Certifications and Assurances, Trauma Service Profile, and Trauma Service Administration, Trauma Quality Improvement Program, Trauma Registry, etc. (each component of care). After each tab, insert the corresponding component of care application page, and then your responses to all questions and any requested documentation. Special packaging is not required for the DOH copy; just use a rubber band, binder clip, or such.

Surgeon and nurse reviewer copies: Provide two bound, tabbed copies, using the same instructions as for the DOH copy. A spiral binding is best.

2.5 Application Instructions

There are three sections of the application to complete. The application must be completed and submitted to the Designation Administrator listed in 2.2, by the application due date. The application must be prepared in the format described in 2.4. Portions of the application can be completed electronically, just click on a form field (shaded rectangle, text box) and type your responses. The text box will expand and wrap to allow space for your answers. You can tab through the application to move from one text box to the next. To activate/mark a checkbox, just point your cursor and click in the checkbox you want to mark. To unmark it, just re-click the checkbox. If you need to adjust tables (e.g., add rows), call Designation Administrator at 360-236-2871 for instructions before inputting data or you may lose your data. The three sections of the application include:

1. **Certifications and Assurances** – Obtain all the appropriate signatures.
2. **Trauma Service Profile** – Provide the information and data requested, using the correct registry data, as indicated.
3. **Trauma Service Components of Care** – This section is organized by key trauma service components of care such as Trauma Service Administration, Trauma Quality Improvement Program, Trauma Registry, etc. The trauma care standards (WAC 246-976) are listed for each component of care. Indicate whether your service meets the trauma care standards by checking all the appropriate boxes, answering all questions, and providing requested supporting documentation. Respond to the following requests for information for the trauma service components of care:
 - **Documentation** – All requested documentation must demonstrate your hospital's compliance with the trauma care standards. Documents must be labeled and numbered to correspond with each request for information. Documentation must be in order, and inserted after the appropriate component of care application page. You are not being asked to submit all important documentation in your application; however, should the review team make a request at the site review, it must be readily available. For example, this would include any trauma related policies, procedures, protocols; education verification; transfer agreements; call schedules; etc.
 - **Staff Education & Training** – All staff must meet the education and training requirements outlined in WAC 246-976-535. The intent of the 90% rule, WAC 246-976-885, is to allow for the influx of new staff; otherwise, the expectation is that **all** staff meet the education and training requirements. DOH does not require currency in ATLS, ACLS, TNCC, and PALS; unless using ATLS to meet PER. Appropriate staff must have had those courses once during their career to meet DOH standards. Use current information to complete the staff education and training tables. Before submitting your application, verify that your general surgeons are those listed on your call schedule and that they are not on trauma and/or emergency call simultaneously at more than one hospital.

2.6 **Proprietary Information and Public Disclosure**

Your application is confidential until any contract resulting from this process is signed by your hospital's signing authority and the DOH Contracts Officer. Thereafter, the application will be deemed public record as defined in RCW 42.17.250 to .340. In the event you choose to claim portions of the application as exempt from disclosure, under the provisions of RCW 42.17.250 to .340, it is incumbent upon you to clearly identify those portions of the application by page number and particular exception(s) from disclosure, upon which you are making that claim. Each page claimed to be exempt from disclosure must be clearly identified by the word "confidential" printed on the upper right-hand corner of the page. DOH will consider your request for exemption from disclosure; however, DOH will make a decision predicated upon the applicable laws.

An assertion that an entire application be exempt from disclosure will not be honored. Responses to a request to view or copy an application shall be according to agency public disclosure procedures. If any information is marked as proprietary in the application, such information will not be made available without giving you an opportunity to seek a court order preventing disclosure.

2.7 **To Withdraw an Application**

You may withdraw your application at any time, up to the application due date. A written request, signed by an authorized representative of your hospital, must be submitted to the Designation Administrator. After withdrawing your application, you may submit another application at any time, up to the application due date.

3. DESIGNATION APPLICATION EVALUATION PROCESS

3.1 **DOH Evaluation**

DOH staff evaluate your application for completeness and compliance with Washington State trauma care standards (WAC 246-976) and the administrative and format requirements, as specified in the information and instruction sections of this application.

3.2 **Clinical Evaluation**

Clinical providers, who are experts in trauma care, examine your application and conduct an on-site review to evaluate the appropriateness and quality of your trauma care, in compliance with the applicable Washington State trauma care standards (WAC 246-976) for your level of designation. Site reviewers are hired based on their expertise and in accordance with WAC 246-976-485(3) (Exhibit A) so that they can provide quality feedback to your trauma service.

3.3 **Site Review**

A hospital applying for Level I, II, or III Trauma Service designation (adult and/or pediatric) must have a site review—the site review team will verify equipment and staff training/education, conduct a facility tour, interview staff, and review medical records and quality improvement documentation. The team's initial findings are presented to you at the end of the site review at the closing conference.

3.4 **Site Review Fee**

A fee is assessed to defray the cost of the site review, in accordance with WAC 246-976-990. The fee is due no later than 30 days prior to your site review. You will be notified in writing of the site review date and team members, along with your fee and due date, no later than six weeks prior to your site review.

3.5 **Final Report**

No later than 90 days after your site review, you will receive a written final report summarizing the department's administrative review and the site review team's clinical peer review. Any additional requirements to complete your application for trauma service designation will be listed within the report. If your application is competitive, your final report is sent within 90 days of announcing designation decisions.

4. DESIGNATION DECISIONS, CONTRACT, and OTHER INFORMATION

4.1 **Designation Decisions**

DOH makes the final determination of designation. DOH will designate the hospital it considers most qualified to provide trauma services based on:

- The evaluation of all applications submitted;
- Recommendations from the site review team;
- Trauma patient outcomes during the previous designation period;
- The impact of designation on the effectiveness of the trauma system;
- Expected patient volume of the area;
- The number, levels, and distribution of designated trauma services established in the regional EMS/TC plans;
- Each applicant's ability to comply with regional EMS/TC plan goals; and
- Each applicant's compliance with its designation contract during the previous designation period.

In regions where competition for designation exists, and the evaluation of applications produces results that are substantially equivalent, DOH reserves the right to award designation to the hospital whose application is considered in the best interest of the department and Washington's trauma system. Criteria and the procedures used to make such a determination will be communicated to the unsuccessful hospital in such an event.

To ensure adequate trauma care in a specific area of the State, DOH may provisionally designate a hospital that is not able to meet all applicable trauma care standards (WAC 246-976). A provisional designation is only for two years. Designation decisions are announced in writing, after all applications have been evaluated and site reviews are completed within a region. Decisions are announced for each region no later than the date indicated by the application schedule.

4.2 Designation Contract

If successful, you must enter into a contractual agreement with the DOH to provide trauma services. The minimum contract period for designation is three years. Once awarded trauma service designation, you must adhere to the contract requirements. As required by your contract, any pertinent changes to your trauma service, including turnover in the Trauma Medical Director, Trauma Program Manager, and Trauma Registrar positions, and the general and specialty surgeon availability, must be communicated to DOH in a timely manner.

4.3 Protest Procedure

You may appeal a denial of designation decision in accordance with the provisions of RCW 34.05 and WAC 246-10, the Administrative Procedure Act. If you receive a denial letter, you have 28 days from receipt of the letter to apply for an adjudicative proceeding. Adjudication instructions will be included.

4.4 Non-endorsement

As a result of selection, DOH is neither endorsing nor suggesting that your service is the best or only trauma service. You agree to make no reference to DOH or the State in any literature, promotional material, brochures, sales presentation, or the like, without the express written consent of DOH or the State.

Example

LEVEL III TRAUMA SERVICE DESIGNATION APPLICATION

Example

Certifications and Assurances - Level III

We, the undersigned, understand that the truthfulness of the facts affirmed here, and the compliance with these requirements, are conditions precedent to the award of the related contract for trauma service designation with the Washington State Department of Health (DOH). We make the following certifications and assurances:

1. We endorse and fully support our application for, and maintenance of, a Level III Trauma Service.
2. We further support our hospital's participation in the statewide trauma system.
3. We understand that the release of this application does not compel the DOH to designate or contract with our hospital.
4. Our application for trauma service designation is true and accurate. If for any reason a part of this application changes, we will contact the DOH in writing with the change.
5. In preparing this application, we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this application, and who was assisting in other than his/her official, public capacity.
6. We understand that the DOH is not liable for any errors, misrepresentations, or omissions contained in our application for trauma service designation.
7. We understand that the DOH will not reimburse us for any costs incurred in the preparation of our application, and that it becomes the property of the DOH. We therefore claim no proprietary rights to the ideas, writings, items, or samples within our application.
8. If designated, we will comply with all regulations promulgated under Chapter 246-976 Washington Administrative Code; any requirements contained in our designation final report; and our DOH contract and amendments as outlined in the general terms, conditions, and statement of work.
9. We assure the commitment of our hospital's financial, human, and physical resources to treat all trauma patients at the level of designation approved by DOH.
10. We are committed to providing injury prevention education to our community.

Chairman/President of governing body Date

Hospital Administrator/CEO Date

Trauma Medical Director (general surgeon) Date

Trauma Program Manager (RN) Date

Trauma Service Profile – Level III

Hospital: <small>(Trauma Service name to appear on certificate)</small>	Phone:	Fax:
County:	EMS/TC Region:	
Physical Address:	City:	Zip:
Mailing Address:	City:	Zip:
<input type="checkbox"/> Publicly or <input type="checkbox"/> Privately Owned <input type="checkbox"/> For profit or <input type="checkbox"/> Non-profit <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Suburban		

Personnel Information

Hospital Administrator: Phone: Email (required):	ED Medical Director: Phone: Email:
Trauma Medical Director: Medical specialty: Phone: Email (required): TMD address:	Director of Nursing Services: Phone: Email:
	Critical Care Medical Director: Phone: Email:
Trauma Program Manager: Phone: Email: Fax:	Trauma Registrar: Phone: Email: Fax:

Community, Hospital, and Trauma Service Statistics (use year 2006 data)

Community population:	Licensed hospital beds:
Patient catchment area (square miles):	Staffed hospital beds:
Annual emergency department census:	Staffed beds in the ED: # for trauma:
Trauma patient average ED length of stay:	Staffed beds in the Critical Care Unit (avg):
Number of phys. on active & courtesy med. staff:	Number of operating rooms for trauma:
Number of general surgeons on trauma call:	Paid <input type="checkbox"/> on-call or <input type="checkbox"/> activation stipend? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of orthopedic surgeons on trauma call:	Paid <input type="checkbox"/> on-call or <input type="checkbox"/> activation stipend? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of EMS agencies that transport trauma patients to your hospital:	
Number of patients that meet trauma registry inclusion criteria:	/Average ISS:
Number of trauma patients transferred-in:	transfer-out: /Avg ISS: /Avg ED LOS:
Number of trauma team activations: Full:	/Average ISS: Modified: /Average ISS:
Number of trauma patients admitted for definitive care:	/Average ISS: Average ED LOS:
Number and percent of trauma patients admitted from the ED to: OR CCU Ward	
Number of trauma patients that died in your hospital:	
Average hours per month dedicated to Trauma Medical Director responsibilities:	
FTE for Trauma Program Manager duties:	FTE for Trauma Registrar duties:

Trauma Service Components of Care – Level III

1. Trauma Service Administration
2. Trauma Quality Improvement Program
3. Trauma Registry
4. Diversion & Interfacility Transfer
5. Trauma Team Activation
6. Emergency Department
7. Surgery, Anesthesiology, OR, PACU
8. Critical Care
9. Diagnostic Imaging
10. Lab & Blood Services
11. Other Trauma Patient Care Services
12. Public & Prehospital Provider Education

Example

1. Trauma Service Administration - Trauma Care Standards

- A written scope of trauma service for both adult and pediatric trauma patients consistent with chapter 246-976 WAC, community needs and the approved regional plan. The written scope of trauma service must delineate the resources and capabilities available for trauma patient care 24 hours, every day;
- A trauma service director responsible for organization and direction of the trauma service. The director must be a general surgeon with special competence in care of the injured. The director may delegate duties to another surgeon or physician with special competence in care of the injured, but the director must maintain responsibility for the trauma service;
- A trauma service coordinator responsible for ongoing coordination of the trauma service. The coordinator must be a registered nurse w/special competence in the care of the injured;
- A multidisciplinary trauma committee chaired by the trauma service director with membership that reflects your written scope of trauma service. The multidisciplinary committee must have responsibility and authority for establishing and changing trauma care policy and procedure and for conducting the trauma service quality improvement program in accordance with WAC 246-976-881 (Exhibit A).

Trauma Service Administration - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. *(An update will be required at the site review.)*
2. Highlight any significant accomplishments or changes to your trauma service that have occurred over the last designation cycle (2004-2006).
3. Provide the amount of your Trauma Participation Grants received during the last designation cycle (2004-2006). Explain how the funds were used to support your **trauma service**.
4. Provide the hospital organizational chart/diagram and explain the reporting structure. The chart should clearly identify the governing entity of the hospital and show how the trauma service reports to that entity, including the Multidisciplinary Trauma Quality Improvement Committee. The trauma service's relationship to the departments of Surgery, Emergency Medicine, Critical Care, and other major services should also be evident.
5. Explain how your Trauma Medical Director is compensated for providing leadership services.
6. Provide Trauma Medical Director, Trauma Program Manager, and Registrar job descriptions.
7. Complete the scope of trauma service template provided on the following page. Your scope of trauma service must clearly define all of the current, applicable services you provide for trauma patients. The purpose of the scope of trauma service is to identify the minimum level of resources available for trauma patient care at your hospital on a 24 hour, 7 day per week (24/7) basis. The State standard that must be met 24/7 is included for each area of care. However, some questions address resources above the minimum standard for a Level III, and are not required; yet it is important for DOH and the site review team to be aware of all services provided to trauma patients. The form can be completed electronically. Just tab through the document to answer each question, or click on a form field (gray rectangle, text box) to type your response. The text box will wrap to allow you space for your answer. Click a checkbox to "activate" or "deactivate" it. If this template is not large enough, adapt it to accommodate the additional information. Call the DOH Designation Administrator for help.

Scope of Trauma Service – Level III

Emergency Department

Standard: A physician with special competence in resuscitation, care, and treatment of trauma patients, available within 5 minutes of patient arrival.

1. Are ED physicians in-house 24/7? Yes No, provide the ED physician coverage: _____.
2. Indicate the medical specialty of your ED physicians: # on staff # board-certified
 Emergency Medicine: _____
 Internal Medicine: _____
 Family Practice: _____
 Other (list): _____: _____

Radiology

Standard: A radiologist on-call & available w/in 30 minutes of team leader's request; a technician able to perform routine radiological capabilities on-call & available w/in 20 min. of notification of team activation; a technician able to perform computerized tomography on-call & available w/in 20 min. of team leader's request.

1. Is a radiologist in-house 24/7? Yes No, provide the radiologist coverage: _____.
2. Is teleradiology used? No Yes, what is the service used, & include coverage? _____.
3. Indicate which of the following services are in-house and available 24/7.
 Angiography FAST in the ED Sonography
 CT MRI Plain film
 CT-Angiography
If a service is not in-house 24/7, indicate which and include coverage: _____.

Anesthesiology

Standard: An anesthesiologist or certified registered nurse anesthetist on-call & available w/in 30 minutes of team leader's request.

1. Are anesthesiology services available for trauma patients 24/7? Yes No, explain: _____
2. How many anesthesiologists are available for trauma patient care? _____
3. How many certified registered nurse anesthetists are available for trauma patient care? _____

General Surgery

Standard: An attending general surgeon on-call & available within 30 minutes of notification of team activation.

1. How many board-certified general surgeons take trauma call? _____
2. Are any non board-certified gen. surgeons taking trauma call? No Yes, explain: _____.
3. Are all of those general surgeons on-call & available w/in 30 minutes? Yes No, explain the availability: _____.
4. Do your general surgeons take emergency or trauma call at other hospitals? Yes No
5. Do you ensure that they are not on-call simultaneously at another hospital? Yes No
6. List the general surgery procedures typically transferred to a higher level trauma service: _____.

Scope of Trauma Service – Level III (continued)

Orthopedic Surgery

Standard: Orthopedic surgery services on-call for patient consultation or management.

1. Are orthopedic surgery services available for trauma patient care 24/7? Yes No
2. How many orthopedic surgeons take trauma call? _____
3. Are those orthopedic surgeons on-call and available within 30 minutes? Yes No
4. List the typical orthopedic procedures performed for trauma patients: _____.
5. List the typical orthopedic injuries transferred to a higher level trauma service: _____.

Neurosurgery

*Standard: The ability to resuscitate and stabilize acute head and/or spinal cord injuries. A neurosurgeon on-call & available w/in 30 minutes of team leader's request **or** written transfer guidelines & agreements for head & spinal cord injuries.*

1. Are neurosurgery services available for trauma patient care 24/7? Yes No
2. How many neurosurgeons take trauma call? _____
3. Are your neurosurgeons paid an on-call or activation stipend? Yes No
4. List the typical neurosurgery procedures performed for trauma patients: _____.
5. List the typical neurosurgery injuries transferred to a higher level trauma service: _____.

Other Surgery Services

*Standard: Obstetric surgery services, on-call & available w/in 30 minutes, as requested by the trauma team leader **or** a plan to manage the pregnant trauma patient. (The other services are not required for Level III Trauma Service designation.)*

1. Are these surgical services on-call and available within 30 minutes, 24/7 for trauma patients?
 Obstetric surgery No, explain coverage: _____.
 Thoracic surgery No, explain coverage: _____.
 Urologic surgery No, explain coverage: _____.
 Vascular surgery No, explain coverage: _____.

Standard: The following surgical services are not required for Level III Trauma Service designation.

1. Are these surgical services on-call for trauma patient consultation or management 24/7?
 Gynecologic surgery No, explain coverage: _____.
 Ophthalmic surgery No, explain coverage: _____.
 Oral/maxillofacial **or** ENT surgery No, explain coverage: _____.
 Plastic surgery No, explain coverage: _____.

Critical Care Unit

Standard: A critical care service.

1. Describe the critical care services available for trauma patients (address acute hemodialysis, intracranial pressure monitoring, cardiac output monitoring, mechanical ventilation.): _____.

Scope of Trauma Service – Level III (continued)

Operating Room

Standard: Essential personnel on-call & available w/in 30 minutes of notification of team activation.

1. Is an OR crew available 24/7? Yes No
2. Is a second OR crew available 24/7? Yes No

Medical Services

Standard: Designation as a pediatric trauma service or written transfer guidelines and agreements for pediatric trauma patients requiring critical care services. (The other services are not required for Level III Trauma Service designation.)

The following medical services are available for trauma patient care:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal medicine | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Hematology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pulmonology |
| <input type="checkbox"/> Infectious disease phys. | <input type="checkbox"/> Pathology | |

Example

2. Trauma Quality Improvement Program - Trauma Care Standards

- A quality improvement (QI) program conducted by the multidisciplinary trauma committee that reflects and demonstrates a process for continuous quality improvement consistent with the written scope of trauma service, with:
 - An organizational structure that facilitates the process of quality assurance and improvement and identifies the authority to change policies, procedures, and protocols that address the care of the trauma patient;
 - Developments of standards of quality care;
 - A process for monitoring compliance with or adherence to the standards;
 - A process of peer review to evaluate specific cases or problems identified by the monitoring process;
 - A process for correcting problems or deficiencies;
 - A process to analyze and evaluate the effect of corrective action; and
 - A process to insure that confidentiality of patient and provider information is maintained according to the standards of RCW 70.41.200 and 70.168.090.
- Participation in the regional quality assurance program:
 - Establish, coordinate and participate in the regional EMS/TC systems quality assurance and improvement program;
 - Ensure participation in the regional quality assurance and improvement program by your trauma service director and the RN who coordinates the trauma service; and
 - Ensure maintenance and continuation of the regional quality assurance and improvement program.

Trauma Quality Improvement Program - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. *(An update will be required at the site review.)*
2. Multidisciplinary Trauma Quality Improvement Committee (MTQIC) attendance records for 5/2006 through 4/2007. If peer review is conducted separately, also provide attendance for the same time period. If poor attendance was an issue, explain how it was addressed.
3. Provide examples of all trauma QI tracking documents used by your trauma service.
4. Explain whether these issues were addressed by your MTQIC over the last designation period (2004-2006), and if a policy or guideline was revised/developed, provide a copy:
 - Access to Diagnostic Imaging services.
 - Blood product availability.
 - ED length of stays.
 - Trauma team activation compliance.
 - Patient work-ups prior to transfer.
 - Timeliness of transfers out.
5. Provide a list of your quality indicators/audit filters used over the previous designation cycle (2004-2006) to screen trauma patient care, and include your **analysis** of the results. DOH is interested in the filters you developed to specifically address issues concerning your trauma service, not ACS or JCAHO filters. Some examples of filters might include: full TTA for a SBP <90, air transport utilization, time to CT for a GCS <14, time to OR, and geriatric care management w/a long ED LOS. List any filters that were retired. Mark as confidential.

Trauma Quality Improvement Program - Documentation to Submit (continued)

6. Provide your trauma quality improvement plan for 2007. It must include and/or explain at a minimum:
 - The time period it addresses;
 - A defined population of patients to be monitored;
 - A description of your Multidisciplinary Trauma Quality Improvement Committee (MTQIC), include its authority, responsibility, & function (the process used to oversee trauma quality improvement activities) and how the trauma QI program is integrated into the hospital QI program. List the multidisciplinary trauma committee members—include each member's name, credential, medical specialty, title, & department/svc represented;
 - A description of how trauma patient care issues of concern—whether physician, nursing, prehospital, or system focused—are identified and reviewed through your QI program; clearly outlining your trauma QI process from problem identification through to loop closure or when an issue is resolved. If peer review is conducted separately from the MTQIC, explain that process as well;
 - The role of the Trauma Medical Director in the MTQIC and peer review. Explain how the Trauma Medical Director assures that patient care and QI processes for trauma patients admitted to specialty services are consistent with trauma service standards;
 - The role of the Trauma Program Manager in the MTQIC and physician & nursing review;
 - The trauma care standards that have been established by your trauma service;
 - The trauma quality indicators and/or audit filters that will be used to evaluate your trauma patient care;
 - A description of how your hospital participates in the regional trauma QI process; and
 - The date the MTQIC reviewed & approved the trauma QI plan.
7. Provide a **summary of your quality review** of a significant trauma care issue that was addressed through your trauma QI program in 2006 or 2007, for each category listed. The cases must be real, not hypothetical. Include the issue, conclusions, recommendations, action plans from all committees, and the evaluation/measurement of the desired outcome (loop closure). Remove ALL patient and practitioner identifiers. Mark as confidential.
 - A system issue, involving more than one entity in either a hospital or out-of-hospital setting. (Do not use trauma team activation as your system issue.);
 - A physician **or** a nursing practice issue; and
 - A death case review from your service. Include results of any regional QI review.
8. Describe your process to provide feedback to prehospital providers and the EMS Medical Program Director regarding trauma patients transported to your service.
9. List the regional QI meetings for 5/2006-4/2007, indicate those the TMD and TPM attended. What do you find of value in attending Regional QI? What would you like to change about Regional QI to make it more beneficial to you?
10. As a higher-level trauma service in your region, explain how you provide leadership to your regional quality improvement committee (besides chairing the committee or attendance) and to the smaller trauma services within your region.

3. Trauma Registry - Trauma Care Standards

- Participate in the state trauma registry as required in WAC 246-976-430 (Exhibit A).
- Have a person identified as responsible for coordination of trauma registry activities.
- Collect patient data for patients who meet inclusion criteria identified in WAC 246-976-430.
- Submit required data via electronic transfer. Data must be submitted no later than 90 days after the end of each quarter.

Trauma Registry - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. *(An update will be required at the site review.)*
2. For calendar year 2006, report the percentage of ambulance reports missing from the medical record for patients transported by prehospital personnel to your facility: _____. Describe what you are doing to improve prehospital completion and timely submission of run sheets to your service. Include the barriers you have had to overcome and any recognized as a current problem.
3. Over the previous designation period (2004-2006), list how many times your trauma registry data submissions were late to DOH: _____. Also, explain how trauma registry problems/issues are identified and addressed, especially late or insufficient data submissions (data not submitted by DOH's deadline, duplicate records, missing or incorrect data, data not being captured and therefore entered as "unknown" or "inappropriate," etc.). If submissions have been late, what is your administration doing to help you ensure that data is submitted on time?
4. Describe the process used to evaluate coding accuracy and how you resolve injury-coding questions in your trauma service; include contact with hospital coders, physicians, etc.
5. Indicate attendance by the Trauma Registrar or Trauma Program Manager at any of the following courses and include the year attended:
 - Any AIS or Washington State Trauma Coding Course: _____;
 - Any Washington State Trauma Registry course: _____; and
 - Any other trauma registry course: _____.
6. Describe how your trauma service communicates which trauma patients are likely to be eligible for enhanced Medicaid trauma funds to:
 - Hospital financial services: _____; and
 - Physician billing services: _____.

4. Diversion & Interfacility Transfer - Trauma Care Standards

- A written policy and procedures to divert patients to other designated trauma care services when the facility's resources are temporarily unavailable for trauma patient care; to include:
 - The facility and/or patient criteria used to decide when to divert a trauma patient;
 - A process to coordinate trauma patient diversions with other area trauma services and prehospital agencies; and
 - A method for documenting trauma patient diversions, including: Date, time, duration, reason, and decision maker.
- Interfacility transfer guidelines and agreements consistent with your written scope of trauma service and consistent with WAC 246-976-890 (Exhibit A).
- A heli-stop, landing zone or airport located close enough to permit the facility to receive or transfer patients by fixed-wing or rotary-wing aircraft.

Diversion & Interfacility Transfer - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. (*An update will be required at the site review.*)
2. Provide your policy for trauma patient diversion, which should include this information:
 - Why you go on trauma divert;
 - Your plan for POV patients while on divert;
 - Who makes the decision to divert; and
 - How you track trauma diversions and what you track.
3. Submit the list of trauma patients diverted by your trauma service from 5/2006-4/2007; include the date, time, duration, reason, and decision maker for each patient diverted.
4. Describe how decisions regarding mode of transportation to your service are made with sending facilities, and list the number of trauma patients received in 2006 via:
Ground EMS services: _____ Air EMS services: _____ Privately owned vehicle: _____
5. Explain when the decision to transfer-out a trauma patient is initiated in your trauma service. Do you track/time the decision-making process in the patient record? Yes No
6. Provide your adult and pediatric transfer criteria and guidelines that clearly define patients with special trauma care needs exceeding the capabilities of your service. (Transfer criteria must be consistent with your scope of trauma service.) Include your transport guidelines.
7. Describe the formal process you use to inform sending facilities of their trauma patients' outcomes (for admitted patients and those discharged from the ED). For what percentage of patients received in-transfer did you provide the following to the sending facility's Trauma Program Manager and attending physician:
Discharge summary: _____ Final diagnoses: _____ Final Injury Severity Score: _____
8. Using your trauma registry, provide a list of all trauma patients (use hospital index numbers not names) transferred-out from your ED for 5/2006-4/2007. For each patient, include the receiving hospital, indicate whether you received a discharge summary, and include the patient's final major diagnosis and ISS. Also, indicate whether you have a formal transfer agreement with each of those hospitals for trauma transfers. Mark as confidential.

5. Trauma Team Activation - Trauma Care Standards

- A method for activating a full trauma team, consistent w/WAC 246-976-870. The method must:
 - Be based on patient information obtained from prehospital providers and other sources appropriate to the circumstances;
 - Include mandatory presence of the general surgeon;
 - Specify patient criteria for determining mandatory activation of the full trauma team;
 - Be applied regardless of time post injury or previous care, whether delivered by EMS or other means, and whether transferred from the scene or from another hospital;
 - The method for activation of the full trauma team may include response by a neurosurgeon instead of a general surgeon when, based on prehospital information, the mechanism of injury clearly indicates isolated penetrating trauma to the brain; and
 - The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with the full trauma team activation criteria.
- A full trauma team to provide initial evaluation, resuscitation, & treatment. The team must include:
 - A general surgeon with special competence in care of the injured, who organizes and directs the team & assumes responsibility for coordination of overall trauma patient care;
 - An emergency physician who is responsible for providing team leadership and care for the trauma patient until the arrival of the general surgeon in the resuscitation area; and
 - The trauma service must identify all other members of the team to reflect your written scope of trauma service.
- A method for activating a modified trauma team (optional). The method must:
 - Specify patient criteria for determining activation of the modified trauma team;
 - Include a mechanism to upgrade the level of trauma team response to full based on newly acquired information; and
 - The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with your modified trauma team activation criteria.

Trauma Team Activation - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. (*An update will be required at the site review.*)
2. Explain the results of your trauma team activation quality improvement (QI) review (over and under triage) for calendar year 2006, include the following information:
 - The QI indicators/audit filters (including documentation) used;
 - The specific QI steps used to evaluate activations and non-activations;
 - The number and percentage of over- and under-triaged trauma patients (over-triage is when the patient received a TTA, but did not meet TTA criteria; and under-triage is when the patient did not receive a TTA, but met TTA criteria. (May occur w/full & mod. TTA);
 - Actions taken to improve trauma team activation compliance and/or the process of trauma team activation;
 - The evaluation/measurement of the desired outcomes;
 - The conclusions of your QI review;
 - Any corrective/follow-up actions taken or still needed; and
 - The re-evaluation/re-measurement of your trauma care to determine whether the desired outcome has been achieved.

Trauma Team Activation - Documentation to Submit (continued)

3. Submit your methodology for full and/or modified trauma team activation (TTA). A full TTA is when resources, including the general surgeon, are mobilized (from the time the EMS call is received to the arrival of the surgeon) for an automatic response to the patient bedside. (For the trauma registry, check the data dictionary definitions for full and modified TTA's, and consults.) Include the following in your TTA policy/guideline:
- The individuals (nurse and physician) authorized to take the EMS call and activate the trauma team;
 - The method used to notify all team members;
 - Adult and pediatric trauma patient physiologic and/or anatomical injury criteria for full and modified (if used) TTA;
 - A list of team members required to respond automatically to a full and/or modified TTA;
 - An activation tool/form used to identify trauma patients needing TTA;
 - How patients who arrive by POV are triaged & evaluated to determine the need for TTA;
 - How patients who are transfers-in from another facility are evaluated for TTA need; and
 - Also, the procedure used to upgrade a patient to a full activation, when warranted.
4. Does your hospital charge for Trauma Team Activations?
- Full Yes No
 - Modified Yes No
 - If yes, does your hospital bill for TTA charges using the UB-92 billing code 068X?
 Yes No

Example

6. Emergency Department - Trauma Care Standards

An emergency department, including:

- Emergency department equipment for resuscitation and life support of pediatric and adult trauma patients, including equipment described in WAC 246-976-620 (Exhibit A).
- An area designated for adult and pediatric resuscitation.
- The ability to resuscitate and stabilize burn patients, with:
 - A physician directed burn unit staffed by nursing personnel trained in burn care and equipped to care for extensively burned patients **or** Written transfer guidelines and agreements in accordance with the guidelines of the American Burn Association.
- Written standards of care to ensure immediate and appropriate care for adult and pediatric trauma patients.
- A physician director, who:
 - Is board-certified in emergency medicine, surgery, or other relevant specialty;
 - Is ATLS and ACLS trained, except this requirement does not apply to a physician board-certified in emergency medicine or surgery; and
 - Has completed the pediatric education requirement (PER), defined in WAC 246-976-886 (Exhibit A), except this requirement does not apply to a physician board-certified in pediatric emergency medicine.
- Physicians, who:
 - Have special competence in resuscitation, care, and treatment of trauma patients;
 - Are available within 5 minutes of patient's arrival in the emergency department;
 - Are ATLS and ACLS trained, except this requirement does not apply to a physician board-certified in emergency medicine; and
 - Have completed the PER as defined in WAC 246-976-886, except this requirement does not apply to a physician board-certified in pediatric emergency medicine.
- Registered nurses, who:
 - Are in the emergency department and available within 5 minutes of patient's arrival;
 - Are ACLS trained;
 - Have completed the PER as defined in WAC 246-976-886; and
 - Have successfully completed a trauma life support course, defined in WAC 246-976-885.

Emergency Department - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. *(An update will be required at the site review.)*
2. Explain how you ensure that trauma patients do not by-pass the ED.
3. Provide your guideline for adult and pediatric trauma resuscitation.
4. Provide your policy/procedure/guideline and chart form for resuscitation, assessment, and care of adult and pediatric burn patients.
5. List the types of mid-level providers, by specialty (PA or ARNP), that provide trauma care in the ED, and include the required education and training (ATLS, ACLS, PALS, TNCC, etc.).

Emergency Department - Documentation to Submit (continued)

6. Provide a policy or explain who accompanies the trauma patient (a patient activated by your trauma service) to the radiology department.
7. Provide your trauma patient admission policy and/or guideline. Include the service that admits trauma patients, and if general surgery services are provided, whether trauma patients receive a general surgery evaluation/consultation.
8. Describe how your trauma service used the DOH trauma clinical document, "Resource Assessment for Care of the Morbidly Obese Trauma Patient," which can be found at www.doh.wa.gov/hsqa/emstrauma/traumaguidelines.htm.
9. Provide your policy and guideline for cervical spine clearance. The policy should include:
 - The criteria used to identify a patient at risk for cervical spine injury;
 - How these patients are protected from further injury;
 - The methods used to assess cervical spine injury in alert patients, and in patients with an altered level of consciousness;
 - Who decides that cervical spine injury is ruled out;
 - Who removes the patient's cervical spine precautions;
 - How cervical spine injury clearance is documented; and
 - The care provided for patients with diagnosed cervical spine injuries.Did your trauma service use the DOH clinical guideline, "Identifying Cervical Spine Injuries Algorithm," when developing hospital cervical spine clearance guidelines? Yes No
(It can be found at www.doh.wa.gov/hsqa/emstrauma/traumaguidelines.htm.)
10. Provide your hospital's emergency department trauma flowsheet.

EXHIBIT

Emergency Department - Staff Education & Training

ED Medical Director:	Board-certified in Emergency Medicine, Surgery, or relevant specialty?		ACLS* training achieved?	ATLS* training achieved?	PER# complete?
	<input type="checkbox"/> Yes, specialty: _____ <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
List all ED physicians:	Board-certified? <i>(Not required for a Level III)</i>	Special competence in care of trauma patients?	ACLS* training achieved?	ATLS* training achieved?	PER# complete?
	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes, spec: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
The percentage of ED registered nurses who meet the ACLS training requirement:					
The percentage of ED registered nurses who meet Pediatric Education Requirements:					
The percentage of ED registered nurses who meet trauma training requirements (WAC 246-976-885):					

* ACLS & ATLS training not required if board-certified in emergency medicine or surgery.
 # Pediatric Education Requirements (PER) not required if board-certified in pediatric emergency medicine, WAC 246-976-886 (Exhibit A).

7. Surgery, Anesthesiology, OR, & PACU - Trauma Care Standards

General surgery services, with:

- An attending general surgeon on-call and available within 30 minutes of notification of team activation.
- All general surgeons who are responsible for care and treatment of trauma patients must:
 - Be trained in ATLS and ACLS, except this requirement does not apply to a physician board-certified in surgery;
 - Have completed the PER as defined in WAC 246-976-886, (Exhibit A); and
 - Have specific delineation of trauma surgery privileges by the medical staff.
- The ability to resuscitate and stabilize acute head and/or spinal cord injuries.
- A neurosurgeon on-call and available within 30 minutes of team leader's request **or**
- Written transfer guidelines and agreements for head and spinal cord injuries.
- Obstetric surgery services, on-call and available within 30 minutes, as requested by the trauma team leader **or**
- A plan to manage the pregnant trauma patient.
- Orthopedic surgery services on-call for patient consultation or management.

Anesthesiology, with:

- An anesthesiologist **or** certified registered nurse anesthetist who:
 - Is on-call and available within 30 minutes of team leader's request;
 - Is ACLS trained, except this requirement does not apply to a physician board-certified in anesthesiology; and
 - Has completed the pediatric education requirement (PER) as defined in WAC 246-976-886.

An operating room, with:

- A registered nurse or designee, available within 5 minutes of notification of team activation, to open and prepare the operating room;
- Other essential personnel, as identified by the trauma service, on-call and available within 30 minutes of notification of team activation;
- A written policy providing for mobilization of additional surgical teams for trauma patients; and
- Instruments and equipment appropriate for pediatric and adult surgery, including equipment described in WAC 246-976-620 (Exhibit A).

A post anesthetic recovery service, with:

- At least one registered nurse on-call and available 24 hours a day.
- Nurses ACLS trained; and
- Nurses who have completed the PER as defined in WAC 246-976-886 (Exhibit A).

Surgery, Anesthesiology, OR, & PACU - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the applicable trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. *(An update will be required at the site review.)*
2. List the types of hospitalists, by specialty, that provide care to trauma patients throughout the hospital, and include your facility's required trauma education and training.
3. List the types of mid-level providers, by specialty (PA, ARNP, CRNA), that provide care to trauma patients on behalf of specialists (general surgeons, orthopedic surgeons, neurosurgeons, anesthesiologists, etc.) throughout the hospital, and include your facility's required education and training (ATLS, ACLS, PALS, TNCC, etc.).
4. Provide a policy that outlines the availability of an operating room for trauma 24/7; including anesthesiology, surgery staff, equipment, and room availability.

General Surgery - Staff Education & Training

List all attending physicians board-certified in General Surgery:	Specific delineation of trauma surgery privileges by the medical staff?			PER complete?
	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
List all non board-certified general surgeons:	Specific delineation of trauma surgery privileges by the medical staff?	ACLS* training achieved?	ATLS* training achieved?	PER complete?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

* ACLS & ATLS training not required if board-certified in surgery.

Neurosurgery - Staff Education & Training

List all neurosurgeons:	Ability to resuscitate and stabilize acute head and/or spinal cord injuries?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Anesthesiology - Staff Education & Training

List all anesthesiologists board-certified in Anesthesiology (board certification not required for Level III designation & ACLS training not required if board-certified in Anesthesiology.):		PER complete?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
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		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
List all non board-certified anesthesiologists:	ACLS training achieved?	PER complete?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
List all certified registered nurse anesthetists:	ACLS training achieved?	PER complete?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Post Anesthetic Recovery Unit - Staff Education & Training

The percentage of PARU registered nurses who meet the ACLS requirement:
The percentage of PARU registered nurses who meet the Pediatric Education Requirements:

8. Critical Care - Trauma Care Standards

A critical care service, with:

- A medical director, who:
 - Is board-certified in surgery, internal medicine, or anesthesiology, with special competence in critical care; and
 - Responsible for coordinating with the attending staff for the care of trauma patients.
- A physician directed code team.
- Critical care registered nurses, with special competence in trauma care, who:
 - Are ACLS trained; and
 - Have successfully completed a trauma life support course, WAC 246-976-885 (Exhibit A).
- Designation as a pediatric trauma service **or** Written transfer guidelines and agreements for pediatric trauma patients requiring critical care services.
- Critical care equipment as described in WAC 246-976-620 (Exhibit A).

Critical Care - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. *(An update will be required at the site review.)*
2. List the types of physicians, by specialty, that provide care to trauma patients in the Critical Care Unit, and include your facility's required trauma education and training.
3. Provide a policy or protocol of how a room is made available in the Critical Care Unit for trauma patients when the unit is full.
4. Describe the nurse:patient staffing ratio for trauma patients in the Critical Care Unit. How do you ensure that nurses assigned to trauma patients meet trauma education requirements?
5. Provide a policy or guideline that outlines the care a trauma patient receives in the CCU; include when a trauma patient is admitted to the general surgeon versus a surgical sub specialist or non-surgeon (indicate the team leader), when a trauma patient is transferred from a general surgeon's care, what physician provides the continuous care/monitoring, etc.
6. The number of pediatric patients (age 14 years or less) who were admitted to the Critical Care Unit during calendar year 2006, and indicate how many were QI reviewed: _____.

Critical Care - Staff Education & Training

Critical Care Medical Director:	Board-certified in Surgery, Internal Medicine, or Anesthesiology?	Special competence in Critical Care?
	<input type="checkbox"/> Yes, board-certification: <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

The percentage of Critical Care registered nurses, with special competence in trauma care, who meet the ACLS training requirement:

The percentage of Critical Care registered nurses, with special competence in trauma care, who meet trauma training requirements (WAC 246-976-885, Exhibit A):

9. Diagnostic Imaging - Trauma Care Standards

Radiological services, with:

- A radiologist:
 - On-call and available within 30 minutes of team leader's request;
- A technician able to perform routine radiological capabilities:
 - On-call and available within 20 minutes of notification of team activation; and
- A technician able to perform computerized tomography:
 - On-call and available within 20 minutes of team leader's request.

Diagnostic Imaging - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. (*An update will be required at the site review.*)
2. Describe how Diagnostic Imaging prioritizes services for trauma patients, and include:
 - Any evaluation of trauma patient access to the diagnostic image services provided;
 - Who is responsible for initial image readings, final interpretation, and how discrepant readings are identified, monitored, resolved, and followed-up—with timelines and any remaining barriers.
3. Do you use a diagnostic imaging panel for trauma patient care?
 No Yes, provide a copy of the orders.
4. Explain what has been done to ensure that all of the appropriate adult and pediatric trauma patient monitoring and resuscitation equipment can be easily located in the radiology suite when an emergency arises.
5. What methods do you use for receiving diagnostic images from sending hospitals? What is the percentage of films that need to be re-taken for trauma patients?
6. What methods do you use for sending diagnostic images to receiving hospitals for trauma patients you transfer-out?

10. Lab & Blood Services - Trauma Care Standards

Clinical laboratory services, including:

- A clinical laboratory technologist, available within 5 minutes of notification of team activation;
- Standard analysis of blood, urine, and other body fluids;
- Coagulation studies;
- Blood gases and pH determination;
- Microbiology;
- Serum alcohol determination; and
- Drug or toxicology screening.

Blood and blood-component services, including:

- Blood and blood components available from in-house or through community services, to meet patient needs;
- Non crossmatched blood, available on patient arrival in the emergency department;
- Ability to obtain blood typing and crossmatching;
- Policies and procedures for massive transfusion;
- Autotransfusion; and
- Blood storage capability.

Lab & Blood Services - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. (*An update will be required at the site review.*)
2. Do you use a lab panel for trauma patient care? No Yes, provide a copy of the orders.
3. Describe how your Clinical Laboratory prioritizes services for trauma patient care.
4. Describe how the Lab prioritizes services for trauma patients, and include:
 - Any evaluation of trauma patient access to the lab services provided (obtaining blood specimens, testing, and providing blood products);
 - The turn-around time for each blood product; and
 - Indicate how accessibility problems are monitored, identified, and resolved—with timelines and any remaining barriers.

11. Other Trauma Patient Care Services - Trauma Care Standards

Respiratory therapy on-call & available within 30 minutes of notification of team activation.

Acute dialysis capability **or** Written transfer agreements for dialysis services.

These services on-call & available for patient consultation/management during the in-patient stay:

Internal medicine No, explain: _____.

Pathology No, explain: _____.

Written policies and procedures for access to ancillary services for in-patient care, including:

Chemical dependency services No, explain: _____.

Child & adult protection services No, explain: _____.

Clergy or pastoral care No, explain: _____.

Nutritionist services No, explain: _____.

Pharmacy services No, explain: _____.

Occupational therapy services No, explain: _____.

Physical therapy services No, explain: _____.

Speech therapy services No, explain: _____.

Social services No, explain: _____.

Psychological services No, explain: _____.

Staff to facilitate the trauma patient's access to rehabilitation services.

A designated trauma rehabilitation service **or** Written agreements to transfer patients to a designated trauma rehabilitation service when medically feasible.

Other Trauma Patient Care Services - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. (*An update will be required at the site review.*)

2. Indicate whether trauma patients are consistently tested for blood alcohol level and urine toxicology:

- Provide a policy that indicates any testing requirement (age specific?);
- Do you intervene for trauma patients who test positive? Yes No; and
- Describe your interventions and include any documentation tool used.

3. Describe the process to screen and refer major trauma patients to inpatient and/or outpatient (physical) rehabilitation services. Also, include the rehab services available to trauma patients at your facility and how and when those services are initiated.

4. Describe how you screen and track non-accidental trauma NAT in children; including screening for repetitive NAT.

12. Public & Prehospital Provider Education - Trauma Care Standards

- A public education program addressing injury prevention or Documentation of participation in regional injury prevention activities.
- Make the facility available for initial and maintenance training of invasive manipulative skills for prehospital personnel.

Public & Prehospital Provider Education - Documentation to Submit

1. To ensure DOH that your hospital **currently** meets all of the above trauma care standards, only check those standards that you currently meet. If there are standards not currently being met, explain in detail how your service will be brought into compliance, and include a completion date. (*An update will be required at the site review.*)
2. List your top three mechanisms of injury (MOI) for trauma patients from the last designation cycle (2004-2006): 1) _____, 2) _____, 3) _____.
Describe in general, the public injury prevention education you conducted/sponsored/partnered over the last designation cycle. Describe how data was used to select and monitor your injury prevention education activities, and to evaluate the effectiveness of your activities.
3. List your current top three mechanisms of injury for trauma patients: 1) _____, 2) _____, 3) _____. Was there any change?
Describe in general, the public injury prevention education you plan to conduct/sponsor/partner over the next designation cycle. Describe how data was used to plan your future injury prevention education activities for each MOI, include:
 - Your target audience;
 - Who will be conducting the education/activities;
 - Funding resources; and
 - List any local, regional, or state partnerships (present or future) developed to accomplish your prevention education goals for the next designation period.
4. Provide the number of prehospital personnel that have utilized your hospital for initial and maintenance training of invasive manipulative skills in the last designation period. Explain any barriers that you have had to overcome since the last designation cycle, or any future barriers you foresee, in being able to provide access for this training.
5. Describe your process for monitoring, identifying, communicating, and intervening on care or system issues with an individual sending service and/or provider (other than routine discharge summaries). Also, describe your process for communicating exemplary care to sending services and providers.
6. Describe how you have fostered cooperative relationships with facilities in your region that refer trauma patients to you, and the facilities that receive your trauma patients in transfer.

EXHIBITS

Example

Exhibit A

Referenced Designation WACs

WAC 246-976-430

Trauma registry - Provider responsibilities

1. Trauma care providers, prehospital and hospital, must place a trauma ID band on trauma patients, if not already in place from another agency.
2. All trauma care providers must protect the confidentiality of data in their possession and as it is transferred to the department.
3. All trauma care providers must correct and resubmit records which fail the department's validity tests described in WAC 246-976-420(6). You must send corrected records to the department within three months of notification.
4. Licensed prehospital services that transport trauma patients must:
 - a. Assure personnel use the trauma ID band.
 - b. Report data as shown in Table E for trauma patients defined in WAC 246-976-420. Data is to be reported to the receiving facility in an approved format within ten days.
5. Designated trauma services must:
 - a. Assure personnel use the trauma ID band.
 - b. Report data elements shown in Table F for all patients defined in WAC 246-976-420.
 - c. Report patients discharged in a calendar quarter in an approved format by the end of the following quarter. The department encourages more frequent data reporting.

WAC 246-976-485 (3)

Designation of facilities to provide trauma care services.

3. The department must conduct an on-site review of your facility before you can be designated as level I, II or III trauma care service, or level I, II or III pediatric trauma care service. The department will use a multidisciplinary team to conduct this review.
 - a. For level I and II services, the department will only choose members for the review team who live or work outside your state.
 - b. For level III services, the department will only choose members for the review team who live or work outside your region.
 - c. The department will provide you with the names of members of the review team. You should send any objections to the department within ten days of notification.
 - d. The team will give an oral report of preliminary findings before leaving your facility.
 - e. The department and the team will maintain confidentiality of information, records, and reports developed pursuant to on-site reviews in accordance with the provisions of RCW 70.41.200 and 70.168.070.
 - f. The department will conduct an on-site review within eighteen months of designating a joint service, to confirm that you meet the requirements of this chapter. This requirement shall not be construed to limit the department's right to conduct an on-site review at any earlier or later time, or to limit its authority under WAC 246-976-490 to suspend or revoke designation for cause at any time prior to the on-site review of the jointly designated trauma care service.

WAC 246-976-620

Equipment Standards for Trauma Service Designation

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
1. Have the following equipment, both adult and pediatric sizes in the emergency department (or resuscitation area for level V):	X	X	X	X	X	X	X	X
a. Airway control and ventilation equipment, including:	X	X	X	X	X	X	X	X
i. Airways;	X	X	X	X	X	X	X	X
ii. Laryngoscopes, including curved and straight blades;	X	X	X	X	X	X	X	X
iii. Endotracheal tubes, with stylets available;	X	X	X	X	X	X	X	X
iv. Bag-valve-mask resuscitator;	X	X	X	X	X	X	X	X
v. Pulse oximeter;	X	X	X	X	X	X	X	X
vi. CO ₂ measurement;	X	X	X	X	X	X	X	X
vii. Sources of oxygen;	X	X	X	X	X	X	X	X
viii. Ability to provide mechanical ventilation;	X	X	X	X	X	X		
b. Suction devices, including:	X	X	X	X	X	X		
i. Back-up suction source;	X	X	X	X	X	X	X	X
ii. Suction catheters;	X	X	X	X	X	X	X	X
iii. Tonsil tip suction (except level V clinics);	X	X	X	X	X	X	X	X
c. Cardiac devices, including:	X	X	X	X	X	X	X	X
i. Cardiac monitor;	X	X	X	X	X	X	X	X
ii. Defibrillator;	X	X	X	X	X	X	X	X
iii. Electrocardiograph;	X	X	X	X	X	X	X	X
iv. Portable cardiac monitor;	X	X	X	X	X	X	X	X
v. Blood pressure cuffs;	X	X	X	X	X	X	X	X
vi. Doppler device;	X	X	X	X	X	X	X	
d. Intravenous supplies, including:	X	X	X	X	X	X	X	X
i. Standard intravenous fluids and administering devices, including:	X	X	X	X	X	X	X	X
A. IV access devices;	X	X	X	X	X	X	X	X
B. Intraosseous needles;	X	X	X	X	X	X	X	X
C. Infusion control device;	X	X	X	X	X	X	X	X
ii. Drugs & supplies necessary for adult & pediatric emergency care;	X	X	X	X	X	X	X	X
e. Sterile surgical sets for standard emergency department procedures, including:	X	X	X	X	X	X	X	X
i. Thoracotomy set;	X	X	X	X	X	X	X	
ii. Chest tubes with closed drainage devices (except level V clinics);	X	X	X	X	X	X	X	X
iii. Emergency transcutaneous airway set (except level V clinics);	X	X	X	X	X	X	X	X
iv. Peritoneal lavage set;	X	X	X	X	X	X		
f. Nasogastric tubes (except level V clinics);	X	X	X	X	X	X	X	X

WAC 246-976-620

Equipment Standards for Trauma Service Designation (continued)

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
g. Ability to provide thermal control equipment, including:	X	X	X	X	X	X	X	X
i. Patient warming capability (except level V clinics);	X	X	X	X	X	X	X	X
ii. Blood and fluid warming capability (except level V clinics);	X	X	X	X	X	X	X	X
iii. Expanded scale thermometer capable of detecting hypothermia (except level V clinics);	X	X	X	X	X	X	X	X
h. Immobilization devices, including:	X	X	X	X	X	X	X	X
i. Cervical injury immobilization devices;	X	X	X	X	X	X	X	X
ii. Long-bone immobilization devices, including traction splints; and	X	X	X	X	X	X	X	X
iii. Backboard;	X	X	X	X	X	X	X	X
i. Other equipment:	X	X	X	X	X	X	X	X
i. Urinary bladder catheters (except level V clinics);	X	X	X	X	X	X	X	X
ii. Infant scale for accurate weight measurement under twenty-five pounds;	X	X	X	X	X	X	X	X
iii. Medication chart, tape, or other system to assure ready access to information on proper doses-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients;	X	X	X	X	X	X	X	X
iv. Two-way radio linked with EMS/TC vehicles;	X	X	X	X	X	X	X	X
2. Have the following equipment, both adult and pediatric sizes, in the surgery department:	X	X	X	X	X	X	X	
a. Cardiopulmonary bypass;	X	X						
b. Ability to provide thermal control equipment for:	X	X	X	X	X	X	X	
i. Patient warming and cooling;	X	X	X	X	X	X	X	
ii. Blood and fluid warming;	X	X	X	X	X	X	X	
c. Rapid infusion capability;	X	X	X	X	X	X	X	
d. Autologous blood recovery and transfusion;	X	X	X	X	X	X		
e. Ability to provide bronchoscopic capability in the operating room;	X	X	X	X	X	X		
f. Ability to provide endoscopes;	X	X	X	X	X	X	X	
g. Craniotomy set;	X	X	X	X				
3. Have the following equipment, both adult and pediatric sizes, in the critical care unit:								
4. NOTE for level III pediatric: If your written scope of trauma service includes critical care services, then your service must meet the level II pediatric critical care equipment standards.						X		
5. NOTE for level IV: If your written scope of trauma service includes critical care services, then your service must meet the level III critical care equipment standards.							X	

WAC 246-976-620

Equipment Standards for Trauma Service Designation (continued)

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
a. Airway control and ventilation devices, including:	X	X	X	X	X			
i. Oral and nasopharyngeal airways;	X	X	X	X	X			
ii. Laryngoscopes with curved and straight blades;	X	X	X	X	X			
iii. Endotracheal tubes with stylets available;	X	X	X	X	X			
iv. Bag-valve-mask resuscitators;	X	X	X	X	X			
v. Ability to provide mechanical ventilator;	X	X	X	X	X			
vi. Noninvasive oximetry and capnometry;	X	X	X	X	X			
vii. Oxygen source with concentration controls;	X	X	X	X	X			
b. Suction devices, including:	X	X	X	X	X			
i. Suction machine;	X	X	X	X	X			
ii. Suction catheters;	X	X	X	X	X			
iii. Tonsil tip suction;	X	X	X	X	X			
c. Cardiac devices, including:	X	X	X	X	X			
i. Cardiac pacing capabilities;	X	X	X	X	X			
ii. Electrocardiograph;	X	X	X	X	X			
iii. Cardiac monitor with at least two pressure monitoring modules including cardiac output and hard copy recording; with capability to continuously monitor heart rate, respiratory rate, temperature;	X	X	X	X	X			
iv. Defibrillator;	X	X	X	X	X			
v. Portable transport monitor with ECG and pressure monitoring capability;	X	X	X	X	X			
vi. Blood pressure cuffs;	X	X	X	X	X			
vii. Doppler device;	X	X	X	X	X			
viii. Noninvasive blood pressure machine;	X	X	X	X	X			
d. Intravenous supplies, including:	X	X	X	X	X			
i. Standard IV fluids and administration devices appropriate for pediatric patients including:	X	X	X	X	X			
A. IV catheters;	X	X	X	X	X			
B. Intraosseous needles;	X	X	X	X	X			
C. Infusion sets and pumps with micro-infusion capabilities;	X	X	X	X	X			
D. Infusion controllers;	X	X	X	X	X			
ii. Adult and pediatric dosages/dilutions of medications;	X	X	X	X	X			
e. Sterile surgical sets, including:	X	X	X	X	X			
i. Thoracotomy set;	X	X	X	X	X			
ii. Chest tubes;	X	X	X	X	X			
iii. Emergency surgical airway sets;	X	X	X	X	X			
iv. Peritoneal lavage set;	X	X	X	X	X			

WAC 246-976-620

Equipment Standards for Trauma Service Designation (continued)

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
f. Intracranial pressure monitoring devices;	X	X	X	X				
g. Gastric supplies, including NG tubes;	X	X	X	X	X			
h. Ability to provide thermal control equipment, including:	X	X	X	X	X			
i. Patient warming and cooling devices;	X	X	X	X	X			
ii. Blood and fluid warming device;	X	X	X	X	X			
iii. Expanded scale thermometer capable of detecting hypothermia;	X	X	X	X	X			
iv. Device for assuring warmth during transport;	X	X	X	X	X			
i. Other equipment, including:	X	X	X	X	X			
i. Ability to provide patient weighing devices;	X	X	X	X	X			
ii. Cardiac emergency cart.	X	X	X	X	X			

Example

WAC 246-976-870

Trauma team activation

1. The purpose of trauma team activation is to assure all personnel and resources necessary for optimal care of the trauma patient are available when the patient arrives in the emergency department. To assure optimal patient care:
 - a. Patient status must be reported from the field by prehospital providers to the emergency department in the receiving trauma service;
 - i. It is the responsibility of the prehospital providers to record all relevant information and report it to the receiving trauma service; and
 - ii. It is the responsibility of the receiving trauma service to request any relevant information that is not volunteered by the prehospital providers.
 - b. The trauma service must use the prehospital information to determine activation of a trauma team and/or resources appropriate for the care of the patient; and
 - c. The presence of the general surgeon, when included in your written scope of trauma service, is necessary to direct resuscitation, to exercise professional judgment that immediate surgery is not indicated, as well as to perform surgery when it is indicated, and to direct patient transfer if necessary.
2. A facility designated to provide trauma services must adopt and use a method for activating its full trauma team. The method must:
 - a. Be based on patient information obtained from prehospital providers and other sources appropriate to the circumstances;
 - b. Include mandatory presence of the general surgeon for levels I - III and for level IV if general surgery services are included in your written scope of trauma service (the surgeon must be at least a postgraduate year four for level I and II);
 - c. Specify patient criteria for determining mandatory activation of the full trauma team;
 - d. Be applied regardless of time post injury or previous care, whether delivered by EMS or other means, and whether transferred from the scene or from another hospital;
 - e. The method for activation of the full trauma team may include response by a neurosurgeon instead of a general surgeon when, based on prehospital information, the mechanism of injury clearly indicates isolated penetrating trauma to the brain; and
 - f. The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with your full trauma team activation criteria.
3. A facility designated to provide trauma services may adopt and use a method for activating a modified trauma team. The method must:
 - a. Specify patient criteria for determining activation of the modified trauma team;
 - b. Include a mechanism to upgrade the level of trauma team response to full based on newly acquired information; and
 - c. The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with your modified trauma team activation criteria.

WAC 246-976-881

Trauma quality improvement programs for designated trauma care services

1. All designated levels I - V and pediatric levels I - III trauma services must have a quality assessment and improvement program conducted by the multidisciplinary trauma committee that reflects and demonstrates a process for continuous quality improvement consistent with your written scope of trauma service, with:
 - a. An organizational structure that facilitates the process of quality assurance and improvement and identifies the authority to change policies, procedures, and protocols that address the care of the trauma patient;
 - b. Developments of standards of quality care;
 - c. A process for monitoring compliance with or adherence to the standards;
 - d. A process of peer review to evaluate specific cases or problems identified by the monitoring process;
 - e. A process for correcting problems or deficiencies;
 - f. A process to analyze and evaluate the effect of corrective action; and
 - g. A process to insure that confidentiality of patient and provider information is maintained according to the standards of RCW 70.41.200 and 70.168.090.

WAC 246-976-885

Educational requirements - Designated trauma service personnel

1. To allow for timely and orderly establishment of the trauma system, the department must consider that education requirements established in this chapter for all personnel caring for trauma patients in a designated trauma care service, have been met if:
 - a. At the time of initial designation, twenty-five percent of all personnel meet the education and training requirements defined in this chapter;
 - b. At the end of the first year of designation, fifty percent of all personnel meet the education and training requirements defined in this chapter;
 - c. At the end of the second year of designation, seventy-five percent of all personnel meet the education and training requirements defined in this chapter; and
 - d. At the end of the third year of designation, and in all subsequent designation periods, ninety percent of all personnel meet the education and training requirements defined in this chapter.
2. To meet the requirements for a trauma life support course:
 - a. Emergency department registered nurses in levels I, II, III and IV trauma care services, and in levels I, II, and III pediatric trauma care services, must have successfully completed a trauma nurse core course (TNCC), or a department-approved equivalent that includes a minimum of sixteen contact hours of trauma-specific education on the following topics:
 - i. Mechanism of injury;
 - ii. Shock and fluid resuscitation;
 - iii. Initial assessment;
 - iv. Pediatric trauma; and
 - v. Stabilization and transport.
 - b. Registered nurses in critical care units in level I or II trauma services must have successfully completed a minimum of eight contact hours of trauma-specific education;
 - c. Registered nurses in critical care units in level III trauma care services must have successfully completed a minimum of four contact hours of trauma-specific education; and
 - d. For level IV services, if your written scope of trauma service includes critical care for trauma patients, registered nurses in critical care units must have successfully completed a minimum of four contact hours of trauma-specific education.

WAC 246-976-886

Pediatric education requirements (PER) for nonpediatric designated facilities

1. In designated levels I, II, III, and IV general trauma care services emergency physicians and emergency RNs who are involved in the resuscitation and stabilization of pediatric trauma patients shall have PER, as provided in subsection (3) of this section, appropriate to their scope of trauma care.
2. In designated levels I, II, and III general trauma care services general surgeons, anesthesiologists, CRNAs and PACU RNs who are involved in the resuscitation and stabilization of pediatric trauma patients shall have PER, as provided in subsection (3) of this section, appropriate to their scope of trauma care.
3. PER can be met by the following methods:
 - a. One-time completion of pediatric advanced life support (PALS) or a substantially equivalent training course; or
 - b. Current certification in ATLS; or
 - c. Completion of a least five contact hours of pediatric trauma education during each designation period. PER contact hours will:
 - i. Include the following topics:
 - A. Initial stabilization and transfer of pediatric trauma;
 - B. Assessment and management of pediatric airway and breathing;
 - C. Assessment and management of pediatric shock, including vascular access;
 - D. Assessment and management of pediatric head injuries;
 - E. Assessment and management of pediatric blunt abdominal trauma;
 - ii. Be accomplished through one or more of the following methods:
 - A. Review and discussion of individual pediatric trauma cases within the trauma QA/QI program;
 - B. Staff meetings;
 - C. Classes, formal or informal;
 - D. Web-based learning; or
 - E. Other methods of learning which appropriately communicate the required topics listed in this section.

WAC 246-976-887

Pediatric education requirements (PER) for pediatric designated facilities.

1. In designated levels I, II, III pediatric trauma care services emergency physicians, emergency RNs, general surgeons, pediatric intensivists, anesthesiologists, CRNAs, ICU RNs and PACU RNs who are involved in the resuscitation, stabilization and in-patient care of pediatric trauma patients shall have PER, as provided in subsection (2) of this section, appropriate to their scope of trauma care.
2. PER can be met by the following methods:
 - a. One-time completion of pediatric advance life support (PALS) or a substantially equivalent training course; or
 - b. Current certification in ATLS; or
 - c. Completion of at least seven contact hours of pediatric trauma education during each designation period. PER contact hours will:
 - i. Include the following topics:
 - A. Initial stabilization and transfer of pediatric trauma;
 - B. Assessment and management of pediatric airway and breathing;
 - C. Assessment and management of pediatric shock, including vascular access;
 - D. Assessment and management of pediatric head injuries;
 - E. Assessment and management of pediatric blunt abdominal trauma;
 - F. Pediatric sedation and analgesia;
 - G. Complications of pediatric multiple system trauma;
 - ii. Be accomplished through one or more of the following methods:
 - A. Review and discussion of individual pediatric trauma cases within the trauma QA/QI program;
 - B. Staff meetings;
 - C. Classes, formal or informal;
 - D. Web-based learning; or
 - E. Other methods of learning which appropriately communicate the required topics listed in this section.

WAC 246-976-890

Interhospital transfer guidelines and agreements

Designated trauma service must:

1. Have written guidelines consistent with the written scope of trauma service to identify and transfer patients with special care needs exceeding the capabilities of the trauma service.
2. Have written transfer agreements with other designated trauma services. The agreements must address the responsibility of the transferring hospital, the receiving hospital, and the prehospital transport agency, including a mechanism to assign medical control during interhospital transfer.
3. Have written guidelines consistent with the written scope of trauma service to identify trauma patients who are transferred in from other facilities, whether admitted through the emergency department or directly into other hospital services.
4. Use verified prehospital trauma services for interfacility transfer of trauma patients.

WAC 246-976-910

Regional quality assurance and improvement program

1. The department will:
 - a. Develop guidelines for a regional EMS/TC system quality assurance and improvement program including:
 - i. Purpose and principles of the program;
 - ii. Establishing and maintaining the program;
 - iii. Process;
 - iv. Membership of the quality assurance and improvement program committee;
 - v. Authority and responsibilities of the quality assurance and improvement program committee;
 - b. Review and approve written regional quality assurance and improvement plans;
 - c. Provide trauma registry data to regional quality assurance and improvement programs in the following formats:
 - i. Quarterly standard reports;
 - ii. Ad hoc reports as requested according to department guidelines.
2. Levels I, II, and III, and Level I, II and III pediatric trauma care services must:
 - a. Establish, coordinate and participate in regional EMS/TC systems quality assurance and improvement programs;
 - b. Ensure participation in the regional quality assurance and improvement program of:
 - i. Their trauma service director or codirector; and
 - ii. The RN who coordinates the trauma service;
 - c. Ensure maintenance and continuation of the regional quality assurance and improvement program.
3. The regional quality assurance and improvement program committee must include:
 - a. At least one member of each designated facility's medical staff;
 - b. The RN coordinator of each designated trauma service; and
 - c. An EMS provider.
4. The regional quality assurance program must invite the MPD and all other health care providers and facilities providing trauma care in the region, to participate in the regional trauma quality assurance program.
5. The regional quality assurance and improvement program may invite:
 - a. One or more regional EMS/TC council members; and
 - b. A trauma care provider who does not work or reside in the region.
6. The regional quality assurance and improvement program must include a written plan for implementation including:
 - a. Operational policies and procedures that detail committee actions and processes;
 - b. Audit filters for adult and pediatric patients;
 - c. Monitoring compliance with the requirements of chapter 70.168 RCW and this chapter;
 - d. Policies and procedures for notifying the department and the regional EMS/TC council of identified regional or state-wide trauma system issues, and any recommendations;
 - e. Policies regarding confidentiality of:
 - i. Information related to provider's and facility's clinical care, and patient outcomes, in accordance with chapter 70.168 RCW;
 - ii. Quality assurance and improvement committee minutes, records, and reports in accordance with RCW 70.168.090(4), including a requirement that each attendee of a regional quality assurance and improvement committee meeting is informed in writing of the confidentiality requirement. Information identifying individual patients may not be publicly disclosed without the patient's consent.

Exhibit B

Trauma Service Designation Definitions

Designated Trauma Service Levels in Washington State – I, II, III, IV, and V adult acute care; I, II, and III pediatric acute care; I, II, and III adult rehabilitation; and I pediatric rehabilitation.

Designation – a formal determination by the Department of Health that hospitals or health care facilities are capable of providing trauma services as outlined in RCW 70.168.070.

Diversion – EMS transport of a trauma patient past the usual receiving trauma service to another trauma service due to temporary unavailability of trauma care resources at the usual receiving trauma service.

Emergency Medical Services and Trauma Care Regions – the geographic areas within the state established by Department of Health.

Emergency Medical Services and Trauma Care System Plan – a statewide plan that identifies all emergency medical services and trauma care objectives, priorities, equipment, personnel, training, and other needs required to maintain a viable statewide trauma system. The plan also outlines the implementation of state, regional, and local activities that will maintain and enhance the system. The plan is formulated by compiling all regional emergency medical services and trauma care plans. It is updated every two years.

Interfacility Transfer – process in which the facility's medical staff assesses the patient and determines that a higher level of care is needed. The patient is then transferred to a higher-level trauma service.

Level I (Adult and Pediatric) Trauma Service – provides the highest level of definitive and comprehensive surgical and medical care for trauma patients with multiple and complex injuries requiring the most specialized care. Trauma-trained emergency physicians, registered nurses, and general surgeons are in-house and available to the trauma patient within 5 minutes to initiate resuscitation and stabilization, and to direct patient care. A Level I must conduct applicable trauma research and injury prevention activities, provide statewide professional and community education, and consultative community outreach services.

Level II (Adult and Pediatric) Trauma Service – provides definitive comprehensive surgical and medical care for multi-system trauma patients. Trauma-trained emergency physicians and registered nurses are in-house and available to the trauma patient within 5 minutes to initiate resuscitation and stabilization. A trauma trained general surgeon is available within 20 minutes to direct patient care. A broad range of specialists, comprehensive diagnostic capabilities, and support services are available. Injury prevention activities, professional and community education, and consultative community outreach services are provided.

Level III (Adult and Pediatric) Trauma Service – provides comprehensive surgical and medical care for trauma patients. Trauma-trained emergency physicians and registered nurses are in-house and available within 5 minutes to initiate resuscitation and stabilization. A trauma trained general surgeon is available within 30 minutes to direct patient care. The general surgeon may provide treatment including surgery, or initiate transfer to a higher-level trauma service. Select specialty, diagnostic, and support services are available. Injury prevention activities are provided.

Level IV Trauma Service – provides initial resuscitation and stabilization. Trauma-trained registered nurses are in-house and available within 5 minutes to initiate resuscitation and stabilization, and trauma-trained physicians are on-call and available within 20 minutes to provide resuscitation, stabilization, and treatment, and to initiate transfer. Trauma-trained general surgeons and trauma critical care services may be available, but are not required. Standard diagnostic and support services are provided.

Level V Trauma Service – provides initial resuscitation, stabilization, and transfer of trauma patients. Trauma-trained physicians, physician assistants, or advanced registered nurse practitioners are available within 20 minutes. Level V facilities are rural hospitals or clinics.

Level I (Adult and Pediatric) Trauma Rehabilitation Service – provides in-patient rehabilitative treatment to trauma patients with traumatic brain injuries, spinal cord injuries, complicated amputations, and other diagnoses resulting in moderate to severe functional impairment.

Level II Trauma Rehabilitation Service – provides in-patient rehabilitative treatment to trauma patients with musculoskeletal trauma, peripheral nerve injuries, lower extremity amputations, and other diagnoses resulting in moderate to severe functional impairment.

Level III Trauma Rehabilitation Service – provides out-patient rehabilitative treatment to trauma patients with limited musculoskeletal injuries, peripheral nerve injuries, uncomplicated lower extremity amputations, and other diagnoses resulting in minimal to moderate functional impairment.

Major Trauma – a patient with a single injury or multisystem injuries that requires immediate medical or surgical intervention to prevent death, and/or requires comprehensive in-patient care to prevent disability. These injuries usually result in a total Injury Severity Score of 16 or greater.

Pediatric Trauma Patient – a trauma patient known or estimated to be less than 15 years of age.

Physician with Specific Delineation of Surgical Privileges – a physician with surgical privileges delineated for emergency/life-saving surgical intervention and stabilization of a trauma patient prior to transfer to a higher level of care. Surgery privileges are awarded by the facility's credentialing process.

Prehospital Trauma Triage Procedures – the method used by prehospital providers to evaluate injured patients and determine whether to activate the trauma system from the field. It is described in WAC 246-976-930(2).

Quality Improvement (QI) – a process/program to monitor and evaluate care provided in trauma services and EMS/TC systems.

Scope of Trauma Service – the minimum range of capabilities routinely available at a trauma service. It is determined by the trauma service by using standards of care in compliance with its designated level of trauma service.

Special competence – an individual has been deemed competent and committed to a medical specialty area with documented training, board certification and/or experience, which has been reviewed and accepted as evidence of a practitioner's expertise:

- For physicians, by the facility's medical staff.
- For registered nurses, by the facility's department of nursing.
- For physician assistants and advanced registered nurse practitioners, as defined in the facility's bylaws.

Standards of Care – a written framework of the components of care including assessment, diagnosis, management, and evaluation procedures. Should also include key quality indicators, specific measurement criteria, skills, equipment, processes, personnel, and performance aspects.

Trauma Medical Director – the provider with oversight responsibility for the organization, direction, and quality improvement of the trauma service.

Trauma Program Manager – a registered nurse with special competence in the care of the injured adult and child, with the authority and responsibility to monitor, coordinate, and organize the trauma service. Also includes responsibilities for quality assessment and improvement, clinical and system oversight, education, and regulatory compliance.

Trauma Registry Coordinator – a person with special competence in medical terminology, auditing and abstraction, coding, and computer and software use, with the authority and responsibility to casefind, report, and track trauma patients meeting registry inclusion criteria, and to manage the trauma registry.

Trauma Rehabilitation Coordinator – a person designated to facilitate early rehabilitation interventions and the trauma patient's access to a designated rehabilitation center.

Trauma System – an organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with injuries requiring immediate medical or surgical intervention to prevent death or disability. The trauma system includes injury prevention activities, prehospital care, hospital care, and rehabilitation.

Trauma Team Activation – the automatic response of a predetermined group of clinical providers to rapidly provide initial evaluation, resuscitation, and treatment to the trauma patient. A full trauma team activation requires the general surgeon to automatically respond to the patient's bedside. The activation of the trauma team is based on prehospital data, or in-house data for patients that arrive by privately owned vehicle (POV).

Exhibit C

Frequently Asked Questions

1. **Q:** Why do we have to apply for re-designation, when we are already designated?
A: Trauma designation rules require that DOH conduct a competitive application process every three years. The re-designation process allows for new hospitals to apply and compete (if necessary) for trauma designation. Also, currently designated hospitals may gracefully back out of their commitment, or apply and compete (if necessary) for a higher-level trauma designation. Additionally, the re-designation process provides an opportunity for the hospital and physicians to reaffirm their commitment to trauma care. The Department of Health is able to reassess the system, make adjustments as needed, and reaffirm to the public that standards of care are being met and resources are available throughout the state as needed.
2. **Q:** If we apply for a higher level designation, but we cannot meet all of the standards, are we automatically designated at the lower level?
A: A slot must exist in your region, and then DOH must handle those decisions on a case-by-case basis.
3. **Q:** What does “provisional designation” mean?
A: When necessary to ensure adequate trauma care in specific areas of the state, DOH has authority to provisionally designate a trauma service that is not able to meet all of the designation requirements. Provisional designation is for no more than two years and usually requires a re-survey prior to awarding full designation status.
4. **Q:** Does the application have to have page numbers?
A: Application page numbers help the reviewers when reading your application, and assure that pages are not missing. Page numbers can be applied as simply as handwriting numbers on the lower corner of each page on the original when it is finalized, so that subsequent photocopies have the same page numbers.
5. **Q:** Can the completed application be submitted electronically?
A: No, you will have some documents that are not electronic, but need to be added to the completed application.
6. **Q:** How should the questions requiring a narrative be answered?
A: Answers can be in-depth or bulleted, but to the point is best. Choose as appropriate.
7. **Q:** In the “Trauma Care Standards” section for each component of care in the application, does each item listed need to be addressed?
A: Yes & No. Review the standards listed to ensure that your facility meets all of the standards, check the box to show those standards currently being met, and do not check the box if a standard is not being met. Then explain what is being done to bring your hospital into compliance with that standard(s).

8. **Q:** Can a policy be referred to throughout the application, without putting a copy of it in all the sections where it applies?
A: No, it puts the burden on the reviewer to find the policy each time he wants to review a point, and review time is very limited.
9. **Q:** What if I don't have control over participation grant money?
A: Trauma Program Managers should know where that money is spent. Having control over it, in an account separate from the ED or general fund, would be best. DOH may ask for a more specific accounting of that money in future applications. That money is to be spent in support of your trauma service.
10. **Q:** What is the purpose of the Scope of Service?
A: We frequently need to know what the state's resources are. Not all Level III's, for instance, have the same resources. The Scope of Service document will enable us to have a better inventory of services across the state.
11. **Q:** If we activate a full trauma team, but we know the patient is probably going to be transferred out, does the general surgeon have to see the patient anyway?
A: Yes, the purpose of trauma team activation is to use patient information from the field to identify trauma patients who would benefit from evaluation and treatment by a general surgeon upon their arrival in the ED, regardless of whether the patient would be admitted or transferred. Trauma services are required to develop and follow their patient criteria that trigger mandatory activation of the general surgeon. (Also, for registry purposes, it is important to be consistent to have accurate statewide data analysis. A full activation requires the general surgeon to respond to the patient bedside automatically.)
12. **Q:** Can a general surgeon be on call at more than one facility at a time?
A: WAC rules are clear about the required response times for general surgeons. If the on-call general surgeon is unavailable because he/she is performing elective surgery, or managing emergency or trauma patient care at another facility; then the facility calling the trauma team activation would need to go on divert and that facility would not be meeting trauma standards of care.
13. **Q:** Should a general surgeon be performing elective surgery while on trauma call?
A: If your general surgeon is performing elective surgery while on call, then your service is not meeting the trauma standards established in WAC. A surgeon back-up system is necessary if this is a recurring situation.
14. **Q:** If EMS reports an isolated head trauma, can the neurosurgeon substitute for the general surgeon when a full trauma team activation is called?
A: Only if the mechanism of injury is clearly penetrating. In blunt trauma, the first appropriate surgeon for response is the general surgeon, although the neurosurgeon is a welcome addition. "The method for activation of the full trauma team may include response by a neurosurgeon instead of a general surgeon, when based on prehospital information, the mechanism of injury clearly indicates isolated penetrating trauma to the brain;" WAC 246-976-870.

- 15. Q:** Tracking diversions – what is acceptable for trauma designated hospitals?
- A:** DOH will accept your statement that your facility doesn't ever divert trauma patients and there is no tracking done. However, if services are not available for trauma patient care such as equipment; beds; surgeons (e.g. neuro); etc., and you divert a patient from the field, then that would be a divert. If you feel a patient would be better served at a facility with a comparable designation and you divert the patient, while acceptable, this should be tracked.
- 16. Q:** Is it appropriate for a general surgeon's PA to respond to the ED for a full trauma team activation when the general surgeon is in the OR?
- A:** The general surgeon must see the patient within the required response time. The ED physician and surgical PA can begin care until the arrival of the general surgeon.
- 17. Q:** What is the standard of care for the OR?
- A:** (WAC 246-976-535) Level I-IV facilities must have an RN or designee who opens and prepares the OR within 5 minutes of TTA. This would include activities such as unlocking doors, turning on lights, turning on warmer, pulling out (not opening) trays, setting up OR chart forms. This person might also call the OR crew and get direction about what trays should be pulled for the type of injuries anticipated. This person could even be a central supply technician.
- 18. Q:** Not all staff meet the education requirements. Is there an allowance for new staff?
- A:** Ninety percent of all trauma personnel must meet the education and training requirements at any given time. The intent of the ninety percent rule is to allow time for new hires to receive the appropriate trauma training. If your facility is temporarily out of compliance with this rule, you must submit a written plan of compliance with an expected completion date in your application for re-designation.
- 19. Q:** Do staff have to be current in the required courses (ACLS, ATLS, TNCC, PALS, etc.)?
- A:** No, trauma designation rules simply require providers to have taken the course at least once during their career. Many hospitals require staff to maintain currency, which is commendable, but not required.
- 20. Q:** If our physicians refuse to take ATLS and other required courses, how can we get the physicians to comply?
- A:** If staff are not in compliance with education and training requirements, the hospital must take action. Non-compliance could result in a provisional trauma designation from DOH. DOH is advised on setting these standards and requirements by physicians and nurses from across the state. Most of the State's trauma services have been designated for 15 years. The WAC rule about a 90% compliance rate was written that way to allow for new hires, who should be in compliance within a year. Using participation grant money for physician and nurse training might be a way to obtain compliance.

- 21. Q:** What topics must be included in the trauma-specific education for critical care nurses?
A: Currently, there are no specific topic requirements. The education must address critical care trauma nursing. Although regular continuing trauma nursing education is desirable for every critical care nurse, this education is only required once in a nurse's career, WAC 246-976-885. The Trauma Program Manager has the responsibility of determining the appropriateness of program content.
- 22. Q:** What are some best practices for trauma QI in small facilities?
A: Some small facilities have invited surgeons from other areas to review their trauma cases, and attend a trauma QI committee meeting to provide input and education. These have been successful in bringing new information to the community physicians, enhancing the relationship between sending and receiving facilities and staff, and providing objective review of trauma care.
- 23. Q:** What is the purpose of Regional QI? What cases should be brought to Regional QI?
A: The purpose is for caregivers to evaluate and improve the performance of the Washington State trauma system. Broad cases such as those involving EMS and the regional system, patient destination decisions, transfers, collaboration of more than one agency/facility, or cases providing specific educational benefit are appropriate for Regional QI.
- 24. Q:** What is learned at Regional QI versus hospital QI?
A: The focus of Regional Trauma QI is determined by the members of the committee, and usually addresses broad trauma system issues that need actions or input by several entities, or is an opportunity for learning that benefits all facilities within the region. In hospital QI, the facility's trauma committee identifies in-house and provider-based processes or performances that need improvement, develops action plans, and evaluates the final outcome to close the loop. Hospital QI also provides educational opportunities.
- 25. Q:** Does a facility's program for EMS training of invasive procedures need to be formal?
A: This is not a new WAC requirement. A formal training program is preferred.
- 26. Q:** Where can the Hospital Trauma Registry Data Dictionary be found?
A: On the DOH web at www.doh.wa.gov/hsqa/emstrauma/download/hospitaldictionary.pdf
- 27. Q:** HIPPA has become a problem when trying to follow-up on patients at receiving hospitals.
A: Harborview Medical Center (HMC) has set up a U-Link system for physicians to access electronic info on referred patients. Call the Physicians Liaison Program at 206-731-8846 (HMC) to sign up; or www.uwmedicine.org/patientcare/informationforhealthcareprofessionals/makeareferral/ulink.htm. For other facilities, call the Trauma Program Manager directly for follow-up.

28. Q: Do we have to test all trauma patients for alcohol?

A: No, trauma designation rules do not require you to test for drugs or alcohol. However, there are required data elements in the Collector software for BAC Tox screen results. In the past, in the trauma service designation application, DOH asked trauma services to provide a policy for assessment and intervention for trauma patients admitted with a positive blood alcohol level or drugs of intoxication screen. Research demonstrates that assessing and addressing drug and alcohol abuse as part of the initial trauma assessment reduces the rate of trauma recidivism.

29. Q: How do we get a transfer agreement, & what facilities do we have to have an agreement with?

A: You are required to have a transfer agreement with all designated trauma services that receive your trauma patients. Contact the Trauma Program Manager at the receiving trauma service to initiate a standard trauma transfer agreement.

30. Q: Where can I find the American Burn Association's transfer guidelines?

A: To access the guidelines go to, <http://www.ameriburn.org/pub/guidelinesops.pdf>

Example

Exhibit D

Resource List

If you are a new Trauma Program Manager (TPM) or have never completed a trauma service designation application, there are TPM's that can help. Even if a TPM listed below is at a different level trauma service than yours, they have years of experience and can offer assistance with most aspects of the application.

Regions Contact by Level

Central	<u>Level I & Level I Pediatric</u> Chris Martin, RN Harborview Medical Center ▪ Seattle clmartin@u.washington.edu	206▪731▪3345
	<u>Level III</u> Debbi Mitchell, RN Auburn Regional Medical Center ▪ Auburn debbi.mitchel@uhsinc.com	253▪333▪2561
East	<u>Level II</u> Sally Staples, RN Deaconess Medical Center ▪ Spokane staplesj@empirehealth.org	509▪473▪7183
	<u>Level III & Level III Pediatric</u> Paula Hornbeck, RN St. Joseph Regional Medical Center ▪ Lewiston phornbeck@sjrmc.org	208▪799▪5458
	<u>Level III</u> Lisa Foster, RN Holy Family Hospital ▪ Spokane fosterl@holy-family.org	509▪252▪6315
North	<u>Level III</u> Patrick Michaelis, RN St. Joseph Hospital ▪ Bellingham pmichaelis@peacehealth.org	360▪738▪6300
South Central	<u>Level III & Level III Pediatric</u> Susan Leathers, RN St. Mary Medical Center ▪ Walla Walla leathers@smmc.com	509▪525▪3320

Regions	Contact by Level	
South Central	<u>Level III</u>	
	Roger Casey, RN Kadlec Medical Center ▪ Richland caseyr@kadlecmed.org	509▪942▪2751
Southwest	<u>Level II</u>	
	Denise Haun-Taylor, RN Southwest Washington Medical Center ▪ Vancouver dhauntay@swmedctr.com	360▪514▪1675
	<u>Level III</u>	
	Judy Rose, RN St. John Medical Center ▪ Longview jrose@peacehealth.org	360▪414▪7562
West	<u>Level II</u>	
	Barbara Carrier, RN St. Joseph Medical Center ▪ Tacoma barbcarrier@chiwest.com	253▪426▪6845
	Linda Casey, RN Madigan Army Medical Center ▪ Ft Lewis linda.casey@nw.amedd.army.mil	253▪968▪1241
	Karen Kiesz, RN Tacoma General Hospital ▪ Tacoma karen.kiesz@multicare.org	253▪403▪7758
	<u>Level III</u>	
	Linda Hubbard, RN Grays Harbor Community Hospital ▪ Aberdeen lhubbard@whnet.org	360▪537▪5406
Laurie Gaston, RN St. Peter Hospital ▪ Olympia laurie.gaston@providence.org	360▪493▪4587	

Exhibit E

Washington State Trauma Registry Inclusion Criteria

(Effective January 31, 2002)

Data must be reported to the Washington Trauma Registry (WTR) for all patients with a discharge ICD9-CM diagnosis code of 800-904, or 910-959, or 994.1 (drowning), 994.7 (asphyxiation), or 994.8 (electrocution) AND any one or more of the following:

- All patients (any diagnosis) for whom the Trauma Resuscitation Team was activated; or
- All trauma patients who were dead on arrival at your facility; or
- All trauma patients who died in your facility; or
- All trauma patients transferred out to another facility by EMS/ambulance; or
- All trauma patients transferred in from another facility by EMS/ambulance; or
- All pediatric (age 0-14) trauma patients admitted to your facility; or
- All adult (age 15+) trauma patients admitted to your facility with length-of-stay more than 2 days (48 hours)

Note: *The diagnosis codes above include all subcodes; e.g., 806 includes 806.00-806.99.*

While **isolated hip fractures/femoral neck fractures** (ICD9-CM 820 with no other significant injuries noted) in elderly patients are included in registry requirements, WAC 246-976-420, *DOH does not require you to report those injuries at this time. It is applicable to patients 65 and older.*

Patients with diagnoses of **foreign bodies** (ICD9-CM 930-939) are required to be included in the registry **only if** there is a resulting injury. In these cases, the resulting injury should be coded in addition to the foreign body.

Transfers: Patients sent from one hospital to another hospital via private vehicle (non-ambulance) are not considered transfers for the purpose of inclusion. It is expected that patients with serious injuries will be transferred via ambulance, and that private vehicles are used only for patients with minor injuries.

Admitted to your facility: Patients moved from the emergency department to any bed in the hospital are considered admitted to the facility.

Readmissions: The Trauma Registry does not require readmission records for the same injury. Only the initial episode of care (first admission) is required. Exception: If a patient is discharged home from the emergency department and is subsequently admitted for a missed diagnosis of the same injury, both records should be included.

Trauma services may include additional patients that do not meet the state inclusion criteria. However, hospital comparative reports, regional quality improvement reports, and other state-prepared reports will only reflect records that meet the state criteria. This helps assure comparability across facilities and regions.

A detailed list of the discharge diagnosis codes for registry inclusion are provided below. Refer to ICD9-CM documentation for all sub-object detail. **Required ICD9-CM Injury Diagnoses:**

800	Fx of vault of skull	846	Sprains and strains of sacroiliac region
801	Fx of base of skull	847	Sprains and strains of other and unspecified parts of back
802	Fx of face bones	848	Other and ill-defined sprains and strains
803	Other and unqualified skull fxs	849	Unspecified site of sprain and strain
804	Multiple fx involving skull or face with other bones	850	Concussion
805	Fx of vertebral column without mention of spinal cord injury	851	Cerebral laceration and contusion
806	Fx of vertebral column with spinal cord injury	852	Subarachnoid, subdural, and extradural hemorrhage following injury
807	Fx of rib(s), sternum, larynx, and trachea	853	Other and unspecified intracranial hemorrhage following injury
808	Fx of pelvis	854	Intracranial injury of other & unspecified nature
809	Ill-defined fx of bones of trunk	860	Traumatic pneumothorax and hemorrhage
810	Fx of clavicle	861	Injury to heart and lung
811	Fx of scapula	862	Injury to other & unspecified intrathoracic organs
812	Fx of humerus	863	Injury to gastrointestinal tract
813	Fx of radius and ulna	864	Injury to liver
814	Fx of carpal bone(s)	865	Injury to spleen
815	Fx of metacarpal bone(s)	866	Injury to kidney
816	Fx or one or more phalanges of hand	867	Injury to pelvic organs
817	Multiple fxs of hand bones	868	Injury to other intra-abdominal organs
818	Ill-defined fx of upper limb	869	Internal injury to unspecified or ill-defined organs
819	Multiple fxs involving both upper limbs, and upper limb with rib(s) and sternum	870	Open wound of ocular adnexa
820	Fx of neck of femur (or hip fx) (optional)	871	Open wound of eyeball
821	Fx of other and unspecified parts of femur	872	Open wound of ear
822	Fx of patella	873	Other open wound of head
823	Fx of tibia and fibula	874	Open wound of neck
824	Fx of one or more tarsal and metatarsal bones	875	Open wound of chest wall
825	Fx of calcaneus	876	Open wound of back
826	Fx of one or more phalanges of foot	877	Open wound of buttock
827	Other, multiple, and ill-defined fx of lower limb	878	Open wound of genital organs (external) including traumatic amputation
828	Multiple fxs involving both lower limbs, lower with upper limb, & lower limb(s) with rib(s) & sternum	879	Open wound of other and unspecified sites, except limbs
829	Fx of unspecified bones	880	Open wound of shoulder and upper arm
830	Dislocation of jaw	881	Open wound of elbow, forearm, and wrist
831	Dislocation of shoulder	882	Open wound of hand except finger(s) alone
832	Dislocation of elbow	883	Open wound of finger(s)
833	Dislocation of wrist	884	Multiple & unspecified open wound of upper limb
834	Dislocation of finger	885	Traumatic amputation of thumb (complete) (partial)
835	Dislocation of hip	886	Traumatic amputation of other finger(s) (complete) (partial)
836	Dislocation of knee	887	Traumatic amputation of arm & hand (complete) (partial)
837	Dislocation of ankle	890	Open wound of hip and thigh
838	Dislocation of foot	891	Open wound of knee, leg (except thigh), & ankle
839	Other, multiple, and ill-defined dislocations	892	Open wound of foot except toe(s) alone
840	Sprains and strains of shoulder and upper arm	893	Open wound of toe(s)
841	Sprains and strains of elbow and forearm	894	Multiple & unspecified open wound of lower limb
842	Sprains and strains of wrist and hand	895	Traumatic amputation of toe(s) (complete) (partial)
843	Sprains and strains of hip and thigh	896	Traumatic amputation of foot (complete) (partial)
844	Sprains and strains of knee and leg		
845	Sprains and strains of ankle and foot		

897	Traumatic amputation of leg(s) (complete) (partial)	935	Foreign body in mouth, esophagus, & stomach
900	Injury to blood vessels of head and neck	936	Foreign body in intestine and colon
901	Injury to blood vessels of thorax	937	Foreign body in anus and rectum
902	Injury to blood vessels of abdomen & pelvis	938	Foreign body in digestive system, unspecified
903	Injury to blood vessels of upper extremity	939	Foreign body in genitourinary tract
904	Injury to blood vessels of lower extremity and unspecified sites	940	Burn confined to eye and adnexa
910	Superficial injury of face, neck, & scalp except eye	941	Burn of face, head, and neck
911	Superficial injury of trunk	942	Burn of trunk
912	Superficial injury of shoulder and upper arm	943	Burn of upper limb, except wrist and hand
913	Superficial injury of elbow, forearm, and wrist	944	Burn of wrist(s) and hand(s)
914	Superficial injury of hand(s) except finger(s) alone	945	Burn of lower limb(s)
915	Superficial injury of fingers	946	Burns of multiple specified sites
916	Superficial injury of hip, thigh, leg, and ankle	947	Burn of internal organs
917	Superficial injury of foot and toes(s)	948	Burns classified according to extent of body surface involved
918	Superficial injury of eye and adnexa	948	Burn, unspecified
919	Superficial injury of other, multiple, and unspecified sites	950	Injury to optic nerve and pathways
920	Contusion of face, scalp, and neck except eye(s)	951	Injury to other cranial nerve(s)
921	Contusion of eye and adnexa	952	Spinal cord injury without evidence of spinal bone injury
922	Contusion of trunk	953	Injury to nerve roots and spinal plexus
923	Contusion of upper limb	954	Injury to other nerve(s) of trunk, excluding shoulder and pelvic girdles
924	Contusion of lower limb and of other and unspecified sites	955	Injury to peripheral nerve(s) of shoulder girdle and upper limb
925	Crushing injury of face, scalp, and neck	956	Injury to peripheral nerve(s) of pelvic girdle and lower limb
926	Crushing injury of trunk	957	Injury to other and unspecified nerves
927	Crushing injury of upper limb	958	Certain early complications of trauma
928	Crushing injury of lower limb	959	Injury, other early complications of trauma
929	Crushing injury of multiple and unspecified sites	994.1	Drowning and nonfatal submersion
		994.7	Asphyxiation and strangulation
		994.8	Electrocution & nonfatal effects of electric current

For ICD9-CM 930-939, foreign bodies are required only if an injury results. In these cases, the resulting injury diagnosis should also be coded along with the foreign body diagnosis.

930	Foreign body on external eye
931	Foreign body in ear
932	Foreign body in nose
933	Foreign body in pharynx and larynx
934	Foreign body in trachea, bronchus, and limb

Washington State Trauma Registry Inclusion Criteria

Revised July 2002

Does the patient have a discharge diagnosis (ICD9-CM) code of 800-904, 910-959, or 994.1 (drowning), 994.7 (asphyxiation), or 994.8 (electrocution)?

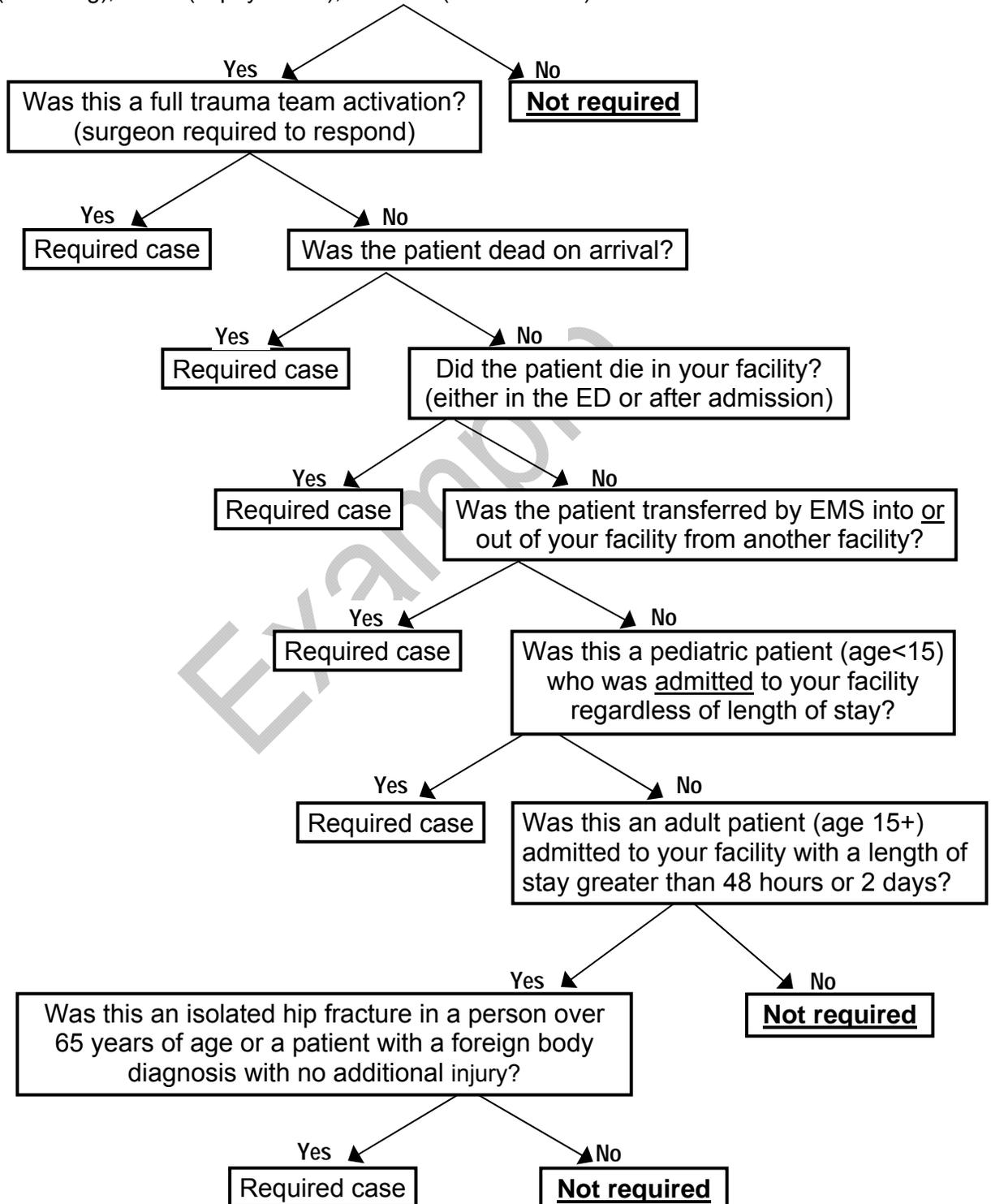


Exhibit F

Using & Analyzing Data for the Designation Application

Hospital, patient, and community data are required throughout the designation application. DOH also uses your trauma registry data to prepare for your site review. Below are some questions you might want to think about when compiling your data and preparing your application. Although you are not being asked to run registry reports for this application, DOH will be running specific queries to determine which medical records to evaluate at your site review, so you should be running your own reports to see how your registry presents your trauma patients. DOH and the review team also review your comparative reports, so be prepared to discuss those as well.

Trauma Registry Data Evaluation

1. After running your reports, review them for quality and completeness.
2. Is the query you have written actually finding the right patients, the patients you expected?
3. Do the number of patients located by the query match your expectation, or are there more or fewer charts than you expected?
4. Is the patient you know captured by the query and listed in the report? If not, why?
5. Is there a possibility that the query is not finding the patients you intend it to find? What would be the reasons for missing patients (query language, record not yet in registry, record does not have data in the fields you are querying)? What else is missing?
6. You may want to put a “dummy” patient in the registry to test the validity of the query.
7. Once you have identified your set of patients with the query, are the report fields giving you the information you need to evaluate the records, performance, quality, issues?
8. What is the report saying about your patients? Are there any red flags (a major trauma patient w/a SBP <90 and no TTA)? If you were a trauma reviewer, which patient would you ask to see?
9. Is the suspected problem or issue revealed by the data you see in the report? Are there other issues apparent?
10. Is there data that surprises you, that does not make sense, or do you need more data fields to confirm your understanding of the situation?
11. Are there now a couple of charts that you want to review more closely to see the full scope of the situation? Or do you need to review some charts to confirm the accuracy of the data entered into the registry record?
12. Do the outcome, ISS, SBP, procedures, disposition, etc. match the injuries?
13. What can the registry show you about the issues identified in your last final report? How would this year’s report compare to 3 years earlier?
14. What has changed about your facility:
 - Structure - new ED, beds closed, new ED or trauma position, new computer system.
 - Process - documentation changed, responsibility moved from one position to another, policy/procedure changed.
 - Outcomes - ED LOS, deaths, morbidity, complications, hospital LOS, disposition. And, how have those changes influenced your data?
15. What is the total volume of registry records for the time period? How many trauma deaths?

16. How many kids, adults, seniors are in your trauma registry? Use a standard report, "Demographics", in Collector to do a quick count.
17. How does the "Suitability for TRISS Analysis" look? The 80% range is desirable.
18. Are there "not givens" or blank elements that represent data which should really be in your registry; such as transfer, direct admit, patient sex, time to death, autopsy, or age?
19. Does the acuity shown in the report match your understanding of your patient population?
20. Take a look at the report as a whole. Are you disappointed by a report because it shows many more patients with _____ or not many records meeting _____.
21. Are there charts you didn't expect to be in the report?
22. How would the report be viewed by an objective nurse or physician reviewer?
23. Does the report confirm that the trauma service is performing well? It is always best to be up front about a report and your trauma service. Recognition of an issue or "area for improvement" is the first step to making it better and reflects the trauma service's maturity.

Reports Used by DOH to Query Your Trauma Registry

Trauma Team Activation: Patients with Scene or ED SBP <90 or HR Scene ED >120

- What are your trauma service's full and modified trauma team activation criteria (full requires a general surgeon at the patient bedside w/in the prescribed time period)? Do you think your trauma service complies with your established criteria? Does the ED staff agree? Does your trauma service activate on patients that have a SBP <90 in the field or in the ED? Why?
- How does ISS match up with blood pressures, GCS, HR, and trauma team activation, ED LOS, ED disposition? Is there anything you want to investigate further?
- Is patient age a factor in TTA compliance? Are there commonalities among the hypotensive or tachycardic patients that do not get a TTA?
- What does a SBP of 85 mean? What if it is a toddler?
- Which patient charts are likely to be requested by the site review team? Which ones do you want to look at first?

Pediatric Care: Patients with age <15 years & ISS >9 who were admitted

- Is the number of children (age ≤14 years) surprising compared to the number of adults?
- What are the most common ED dispositions for pediatric trauma patients? What are your age ranges for an ISS ≥9?
- Are the appropriate children being admitted or transferred? Are children staying longer in the ED than other patients? Why? Are they being seen in the ED by a surgeon?
- What service admits pediatric trauma patients?
- What are the common mechanisms of injury for your pediatric trauma patients? What are their common injuries (orthopedic, brain)?

Delayed Transfer: Patients w/ISS ≥ 9, admitted, then transferred to another acute care facility

- How many patients were admitted to your hospital setting, then transferred to another acute care facility for trauma care?
- Was this an expected transfer? Was the patient transferred to the right place?
- Do you find any commonalities among the late transfers?
- Has this number increased or decreased over the last few years?

Transfer of Minor Injuries: Patients w/ISS <9 & transferred from ED to acute care facility

- What percentage of trauma patients with an ISS 0 to 8 are transferred out by your trauma service? Is that a reasonable percentage, especially in relation to your overall trauma volume? Are these transfers appropriate? Are too many being transferred; are too few?
- What are the common reasons for these minor injury transfers? Are there commonalities such as ED provider, on-call surgeon, on-call sub specialist, day of week, or time of day?
- Are the patients being transferred to an appropriate, trauma-designated facility?
- Could those patients have been cared for at your facility? Are these types of injuries or types of procedures usually cared for at your facility? What is different?

Emergency Department Length of Stay >3 Hours: Patients w/ISS ≥16 & ED LOS >3 hours

- What is your “gut feel” for average your ED LOS, compared to the actual registry report?
- What is the range of LOS?
- What are the common reasons for a long ED LOS in your facility? What has already been done? What really needs to be done?
- How does injury, age, ISS, ED disposition, provider, staffing, etc. affect long ED stays?

Operating Room: Patients w/ISS ≥ 16 & ED disp. to OR & surgeon resp. time >20 min. or unknown

- Looks at ISS ≥16 and ED to OR disposition and surgeon response time ≥20 minutes or unknown. What is the WAC standard for your level? What is your facility’s standard for response times?
- What does injury, TTA, SBP, ED provider or surgeon, and hospital disposition have to do with surgeon response time?

Geriatric Care: Patients w/age ≥ 65 & an ISS ≥16, admitted to the OR, or other inpatient unit

- What percentage of your patient volume is represented by age ≥65, with an ISS ≥16 and admitted to the OR?
- Look at how often they receive a TTA, are admitted, have surgery, or go to the ICU.
- Where do these patients usually go after the ED? How stable are they in the ED?
- Where do they go after their hospital stay?

The DOH Comparative Report

This report is sent to you annually. It shows your trauma patient population over several years. It includes the number of trauma patients in your registry, the volume of patients with ISS >16, MOI, EMS run form data, TTA for patients with SBP ≤90, percentage of transfers from ED to another facility, etc. There is also a report provided that shows aggregate data for all other hospitals at your same designation level so you can compare your service to those hospitals.

- What are the reasons for the differences between your facility and the aggregate report?
- Are average data appropriate? Do you expect to meet or exceed those benchmarks?
- Does this represent the best care our system can provide? What were the advantages/disadvantages to the patient?
- What can we learn from this report? The patient chart?
- What would we do differently next time? What would we like to do differently next year? Will the changes be patient-focused?
- Who to include in the decision-making, planning, evaluation—family, physicians, staff?