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Trauma Service Administration and Leadership

This section demonstrates compliance with WAC 246-976-700 requirements for trauma program organization, direction, leadership, and education of leaders.

Section Item 1:

☐ A trauma medical director responsible for the organization and direction of the [adult] trauma service, who:

Level: I, II

☐ Is a board-certified general surgeon, current in Advanced Trauma Life Support (ATLS)

Level III

☐ Is a general surgeon, ACLS trained and current in ATLS

Level: IV

☐ Is a board-certified general surgeon, emergency physician, a general surgeon ACLS trained with current certification in ATLS or a physician ACLS trained and current certification in ATLS.

Level: V

☐ Is an emergency physician or a physician assistant or advanced registered nurse practitioner ACLS trained who is current in ATLS.

Level: All

☐ Meets the pediatric education requirement (PER) (five hours) every three-year designation period.

Level: I and II

☐ Completes thirty-six hours in three years of verifiable, external, trauma-related continuing medical education (CME).

Level: All

Is the TMD compensated for providing trauma service and quality improvement leadership?

☐ Yes ☐ No

Section Item 2: ☐ A pediatric trauma medical director responsible for the organization and direction of the [pediatric] trauma service, (skip to Item 3 if not applicable) who:

Level: I and II

☐ Is a board-certified pediatric surgeon, current in ATLS; or a board-certified general surgeon with special competence in the care of pediatric patients, Current in ATLS or;

Level III

☐ Is a general surgeon, with special competence in the care of pediatric patients, who is ACLS trained and current in ATLS;

Level: All

☐ Who meets the pediatric education requirement (PER) (seven hours) every three-year designation period.

Is the TMD compensated for providing trauma service and quality improvement leadership?

☐ Yes ☐ No

Section Item 3: ☐ A trauma program manager, or ☐ trauma service coordinator responsible for the overall operation of the [adult] trauma service who:

Level: All

☐ Is a registered nurse

☐ Has taken ACLS

Has taken ☐ PALS, or ☐ ENPC, [for adult trauma service] and;

☐ Thereafter meets the PER contact hours (☐ five or ☐ seven hours) every three-year designation period. Current certification in PALS or ENPC meets the PER for adult trauma service]

Section Item 4: The [adult] trauma program manager has attended:

Level: All

☐ A trauma program manager orientation course provided by the department, or:

☐ A department-approved equivalent, within the first 18 months in the role.

Section Item 5: The [adult] trauma program manager has successfully completed:

Level: All

☐ TNCC, or a department approved equivalent course.

☐ Thirty-six hours of trauma-specific education every three-year designation period in either external continuing education or in an internal education process conducted by the trauma program.

Level: All

(Note: Maintenance of TNCC no longer meets the complete continuing education requirement for the TPM, but the hours do count towards the thirty-six-hour total).

Section Item 6: ☐ A trauma program manager, or ☐ trauma service coordinator responsible for the overall operation of the [pediatric] trauma service who: (Skip to Response Item 1 if not pediatric designated or if your service does not have a separate pediatric TPM).

Level: Pediatric, All

☐ Is a registered nurse

☐ Has taken ACLS

Has current ☐ PALS, or ☐ ENPC certification

Section Item 7: The [pediatric] trauma program manager has attended:

Level: Pediatric, All

☐ A trauma program manager orientation course provided by the department, or

☐ A department-approved equivalent, within the first 18 months in the role.

Section Item 8: The [pediatric] trauma program manager has successfully completed:

Level: Pediatric, All

☐ PALS or ENPC, or a department approved equivalent course, and there after:

- ☐ Maintains PALS
- ☐ Maintains ENPC
- ☐ Completes 7 hours of continuing pediatric trauma education every three-year designation period.

Section Item 9:

Level: Pediatric, All

The pediatric trauma program manager has successfully completed:

☐ TNCC, or a department approved equivalent course.

☐ Thirty-six hours of trauma-specific education every three-year designation period in either external continuing education or in an internal education process conducted by the trauma program.

Level: All

(Note: Maintenance of TNCC no longer meets the complete continuing education requirement for the TPM, but the hours do count towards the thirty-six-hour total).

Respond to the following items:

Insert required documents in the following pages. Label each with the corresponding Section number and Item number.

Response Item 1: List below only the significant trauma service accomplishments during the past three-year designation cycle. Use bulleted format. Response is limited to 1,500 characters with spaces.

Response Item 2: In the following pages, insert the clearly labeled adult and/or pediatric trauma medical director job descriptions.

Response Item 3: In the following pages, insert the clearly labeled adult and/or pediatric trauma program manager job descriptions.

Response Item 4: In the following pages, insert the clearly labeled organizational chart showing how the individuals who serve as adult and pediatric TMDs and TPMs report to an administrator.

Response Item 5: In the following pages, insert the clearly labeled organizational chart or diagram showing which departmental lead position the trauma service reports to. The chart must show the trauma service, the facility's governing entity (CEO, administrator), and/or board.

Response Item 6: Designation Grant Expenditure Plan: The intent of the trauma designation participation grant is to help offset the costs of 24/7 readiness and participating in the trauma system. The expectation is that these funds are allotted to any expense needed to support the sustainability of your trauma service. This could include costs for trauma staff FTEs, trauma physician call payments, trauma-related accreditation fees, or trauma care-specific equipment, supplies, or training and education. It is expected that costs associated with meeting trauma program WAC requirements will be high priority.

In the following pages, insert a list of top priorities for how your trauma service will use its annual participation grants for the next three years of designation (one full designation cycle). You do not need to submit dollar amounts, just a brief plan (list) of allotments, arranged by priority.

Trauma Quality Improvement Program

The purpose of this section is to demonstrate the trauma facility's approach to the rigorous and continuous improvement of its system of trauma care in WAC 246-976-700. Quality Improvement (QI) includes documentation of the evaluation of care quality, the identification of areas for improvement, and efficient correction to achieve the best possible outcomes for patients.

A multidisciplinary trauma quality improvement program that must:

Level: All

Section Item 1: ☐ Be led by the multidisciplinary trauma service committee with the trauma medical director(s) as chair of the committee.

Section Item 2: ☐ Demonstrate a continuous quality improvement process supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement.

Section Item 3: ☐ Have membership representation and participation that reflects the facility's trauma scope of service.

Section Item 4: ☐ Have an organizational structure that facilitates the process of quality improvement, with a reporting relationship to the hospital's administrative team and medical executive committee that ensures adequate evaluation of all aspects of trauma care.

Section Item 5: ☐ Have authority to establish trauma care standards and implement patient care policies, procedures, guidelines, and protocols throughout the hospital and the trauma service must use clinical practice guidelines, protocols, and algorithms derived from evidence-based validated resources.

Section Item 6: ☐ Have a process to monitor and track compliance with the trauma care standards using audit filters and benchmarks.

Section Item 7: ☐ Have a process in which outcome measures are documented within the trauma quality improvement programs written plan which must be reviewed and updated at least annually. Outcome measures will include, at a minimum:

- ☐ Mortality (with and without opportunities for improvement)
- ☐ Trauma surgeon response time (If general surgery services are provided)
- ☐ Undertriage rate
- ☐ Emergency department length of stay greater than three hours for patients transferred out.
- ☐ Missed injuries
- ☐ Complications

Section Item 8: ☐ Have a process to evaluate the care provided to trauma patients and to resolve identified pre-hospital, physician, nursing, or system issues.

Section Item 9: ☐ Have a process for correcting problems or deficiencies.

Section Item 10: ☐ Have a process to analyze, evaluate, and measure the effect of corrective actions to determine whether issue resolution was achieved.

Section Item 11: ☐ Have a process to continuously evaluate compliance with full and modified (if used) trauma team activation criteria.

Section Item 12: ☐ Have assurance from other hospital quality improvement committees, including peer review if conducted separately from the trauma committee, that resolution was achieved on trauma related issues. The following requirements must also be satisfied:

- ☐ Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion;
- ☐ A process must be in place to ensure that the trauma program manager receives feedback from peer review for trauma-related issues;
- ☐ All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review;
- ☐ This effort must involve the participation and leadership of the trauma medical director and any departments, such as: General surgery, emergency medicine, orthopedics, neurosurgery, anesthesia, critical care, lab and radiology;
- ☐ The multidisciplinary trauma peer review committee must systematically review significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement.

Section Item 13: ☐ Have a process to ensure the confidentiality of patient and provider information, in accordance with RCW 42.56 and RCW 70.168.090.

Section Item 14: ☐ Have a process to communicate with, and provide feedback to, referring trauma services and trauma care providers.

Section Item 15: ☐ Have a current trauma quality improvement plan that outlines the trauma service's quality improvement process, as defined in this subsection.

Section Item 16: ☐ Participation in the regional quality improvement program as defined in WAC 246-976-910.

Section Item 17: ☐ Use risk-adjusted data for the purposes of benchmarking and performance improvement. For level I and II trauma services, the risk-adjusted benchmarking system must be the American College of Surgeons Trauma Quality Improvement Program (TQIP).

Level: III, IV, V

Section Item 18: ☐ Trauma services with a total annual trauma volume of fewer than 100 patients may integrate trauma quality improvement into the hospital's quality improvement program; however, trauma care must be formally addressed in accordance with the quality improvement requirements above. In this case, the trauma medical director is not required to serve as chair.

Level: All

Section Item 19: ☐ Have a pediatric-specific trauma quality improvement program for a trauma service admitting at least one hundred pediatric trauma patients annually. For a trauma service admitting less than one hundred pediatric trauma patients annually, **or**

☐ Trauma services that are transferring pediatric trauma patients, the trauma service must review each case for timeliness and appropriateness of care.

Respond to the following items:

Insert required documents in the following pages. Label each with the corresponding Section number and Item number.

Response Item 1: Include an organizational chart or diagram that shows the Multidisciplinary Trauma Quality Improvement Committee's (MTQIC) reporting structure within the facility. The chart should show the facility's governing entity and how each MTQIC reports to that entity—along with the relationship to the Medical Executive Committee, the departmental committees of Surgery, Emergency Medicine, Critical Care, and other major departments or service line committees.

Response Item 2: Submit the most recent Trauma QI Program Plan with date of MTQIC approval. The plan must demonstrate process and flow, and can be easily applied to issue, action, and resolution. See Exhibits for an example.

Response Item 3: Provide MTQIC attendance records for the most recent two-year period, with legible names, and each representative's title and department or service (See Exhibits for a table example). For level I-III services, the requirement is that there are Identified medical staff representatives or their designees from departments of general surgery, emergency medicine, orthopedics, neurosurgery, anesthesiology, critical care, and radiology who must participate actively in the multidisciplinary trauma quality improvement program with at least fifty percent attendance.

Response Item 4: ☐ Yes ☐ No Has lack of attendance at MTQIC been an issue? If No, skip to Item 7.

Response Item 5: ☐ Yes ☐No If Item 4 is Yes, has lack of attendance at MTQIC been addressed?

Response Item 6: ☐ Yes ☐No Has improvement in MTQIC attendance been noted?

Response Item 7: ☐ Yes ☐ No ☐N/A If trauma peer review is conducted separately from MTQIC, provide attendance records from the most recent two-year period, with legible names or each representative's title and department or service. For level I and II trauma services, the program must be able to demonstrate a minimum of 50% attendance from all the general surgeons who participate on the trauma panel. For level III trauma services, If at least fifty percent of the general surgeons did not attend the peer review committee meetings, then the trauma service must be able to demonstrate that there is a formal process for communicating information from the committee meetings to the group of general surgeons.

Response Item 8: Process and outcome measures, referred to as audit filters, require defined criteria and metrics. In the following pages, insert a clearly labeled summary of results for each adult and/or pediatric audit filter (outcome measures) used to review trauma care during the current designation cycle. This summary should include, at a minimum, the results for the WAC required outcome measures prescribed in WAC 246-976-700(4)(i)(i-vi) (Section Item 7). Dashboard summaries require a bulleted explanation of results. See Exhibits for an example.

Response Item 9: Insert clearly labeled case summaries, from the current designation cycle:

- Level IV and V: 1 completed trauma QI issue review from the categories below.
- Level I-III: 3 completed trauma QI issue reviews for adult trauma patients.
- Dual designated facilities should have a total of six completed case summaries; three adult and three pediatric.
- Pediatric-only designated facilities should submit three pediatric case summaries.

These summaries should include:

☐ A system issue affecting trauma care in the facility.
☐ A physician or nursing trauma practice issue in the facility.
☐ A trauma patient death in the facility. This should be an unexpected or preventable death, or a non-preventable death with opportunities for improvement.

For Item 9, mark submitted documents as confidential. Include all auditing and tracking documents used.

Each QI review in Item 9 must include the following (check the boxes below to indicate each is included in both Item responses):

☐ Issue identification
☐ Discussion and conclusions
☐ Action plans: Goals, audit filter or quality indicator developed, steps to goal
☐ Implementation details of action plan
☐ Evaluation and measurement results
☐ Adjustments or re-evaluation
☐ Issue resolution (loop closure, the positive outcome of QI efforts from MTQIC minutes).

Response Item 10: For level III-V trauma services, submit a summary that demonstrates how the trauma program is using the state provided risk-adjusted data reports to improve outcomes. For level I and II trauma services, submit the most recent TQIP reports available.

Response Item 11: List all Washington state regional QI meetings for the past two years of your current designation—indicate the TMDs and TPMs attendance. Attendance is required in accordance with WAC 246-976-910.

Response Item 12: List how the trauma service participates in regional QI meetings (check all that apply):

☐ Share findings from the facility trauma program's QI processes to benefit regional partners.
☐ Contribute to problem-solving of regional system issues.
☐ Maintain currency of the facility's specialty physician availability on a state- or region-wide website (e.g., WaTRAC, RAMSES, etc.)
☐ Maintain currency of the facility's bed availability on a state- or region-wide website (e.g., WaTRAC, RAMSES, etc.)
☐ Use state or regional trauma data to drive regional QI priorities.
☐ Other: Explain; limit response to 750 characters. _____

Response Item 13: ☐ Yes ☐ No Does the trauma service have a process to receive feedback from receiving facilities on a trauma patient transferred-out to an acute care facility?

Response Item 14: ☐ Yes ☐ No Does the trauma service use that feedback information in the trauma QI program? Check all that apply:

☐ Review data accuracy
☐ Determine loop closure
☐ Identify missed diagnoses
☐ Check compliance with facility's clinical guidelines, standards, protocols, or procedures
☐ Evaluate appropriateness of transfer
☐ In QI case review
☐ Review patient outcomes
☐ Other. Explain; limit response to 500 characters. _____

Response Item 15: ☐ Yes ☐No ☐ N/A Does the trauma service provide feedback to referring (sending) facilities?

Response Item 16: ☐ Yes ☐No If received or obtained, is the receiving facility's injury severity scores (ISS) entered into the patient record in the collector trauma registry software?

Response Item 17: ☐ Yes ☐No Does the receiving facility's ISS information trigger a re-review in the trauma QI program?

Response Item 18: Check all that apply. The trauma QI Plan includes:

- ☐ A process to continuously evaluate compliance with full trauma team activation criteria.
- ☐ Measurement of compliance to FTTA criteria
- ☐ FTTA issue identification
- ☐ FTTA action plans
- ☐ Implementation of FTTA action plan
- ☐ Re-evaluation of FTTA compliance measurement
- ☐ MTQIC's conclusion of the outcome's effectiveness for loop closure

Response Item 19: ☐ Yes ☐ No Is under-triage measured for full TTAs?

Response Item 20: ☐ Yes ☐ No Is over-triage measured for all TTAs? If over-triage is not currently measured for all TTAs, the trauma program will demonstrate over-triage in the next trauma designation application.

Response Item 21: ☐ Yes ☐ No Does the trauma service use modified TTAs?

Response Item 22: ☐ Yes ☐ No Is under-triage measured for modified TTAs?

Response Item 23: In the response field provided, detail the methodology used to determine undertriage:

Trauma Registry

This section demonstrates compliance with WAC 246-976-420, 246-976-430, and 246-976-700 requirements for trauma registry case selection, data abstraction, data entry, data validation, and submission of trauma registry data to the Department of Health.

The designated trauma facility's responsibilities include:

Level: All

Section Item 1: ☐ All trauma care providers must protect the confidentiality of data in their possession and as it is transferred to the department.

Section Item 2: ☐ Has a person identified as responsible for coordination of trauma registry activities.

Level: I-III, Adult and Pediatric

☐ The registrar has completed the abbreviated injury scale (AIS) course within eighteen months of hire. If this requirement has not been completed, at the end of this section, submit a plan of correction with anticipated course completion date.

Section Item 3: ☐ Report data elements shown in WAC 246-976-430 for all patients defined in WAC 246-976-420.

Section Item 4: ☐ Report patients in a calendar quarter in a department-approved format by the end of the following quarter.

Section Item 5: ☐ All trauma care providers must correct and resubmit records which fail the department's validity tests described in WAC 246-976-420.

Section Item 6: ☐ You must send corrected records to the department within three months of notification.

Respond to the following items:

Insert required documents in the following pages. Label each with the corresponding Section number and Item number.

Response Item 1: Include the trauma registrar (TR) job description, including any training and certifications required (such as collector software, ICD10 coding, AIS coding, anatomy, medical terminology, other software for generating reports, TOPIC, CSTR, CAISS, etc.). This document should include a description of how the TR supports the trauma QI program.

Response Item 2: Include an organization chart showing to whom the TR reports.

Response Item 3: Check the functions that the TR performs:

- ☐ Case finding
- ☐ Data abstraction
- ☐ Data entry
- ☐ Data validation
- ☐ Error correction
- ☐ Record submission
- ☐ Report writing
- ☐ QI screening
- ☐ QI data analysis
- ☐ Other (limit response to 100 characters): _____

Response Item 4: ☐ Yes ☐ No Trauma registry records have been submitted to the department on-time over the past 12 months. (The standard is to report patients in a calendar quarter in a department-approved format by the end of the following quarter)

Response Item 5: The majority of trauma registry records are completed:

- ☐ Concurrently (begun while patient is in hospital and finalized within seven days of discharge.)
- ☐ Within one month of patient discharge
- ☐ Within two months of patient discharge
- ☐ Within three months of patient discharge
- ☐ More than three months after patient discharge

Response Item 6: The trauma registry data is used:

- ☐ To educate physicians, nurses, and staff
- ☐ To conduct trauma quality improvement activities
- ☐ To identify records for enhanced trauma fund payments for physicians
- ☐ To identify records for enhanced trauma fund payments for the hospital
- ☐ To prioritize injury prevention education
- ☐ To support outreach and marketing
- ☐ To measure resource utilization
- ☐ To support clinical research
- ☐ In financial analysis
- ☐ For strategic planning
- ☐ Other: (limit response to 100 characters) _____

Response Item 7: Provide a summary of the process that the program uses to validate its registry. Include any details regarding the percentage of records and data points reviewed.

Trauma Patient Transfer and Diversion

This section demonstrates compliance with WAC 246-976-700 requirements for trauma patient transfer and diversion.

Level: All

Section Item 1: ☐ Written transfer-in guidelines consistent with the facility's designation level and trauma scope of service. If you do not accept patient transfers in, skip to Section Item 3.

Section Item 2: ☐ The guidelines must identify the type, severity and complexity of injuries the facility can safely accept, admit, and provide with definitive care.

Section Item 3: ☐ Written transfer-out guidelines consistent with the facility's designation level and trauma scope of service.

Section Item 4: ☐ The guidelines must identify the type, severity and complexity of injuries that exceed the resources and capabilities of the trauma service.

Section Item 5: ☐ Interfacility transfer agreements with all trauma services that receive the facility's trauma patients.

Section Item 6: ☐ Agreements must have a process to identify medical control during the interfacility transfer, and address the responsibilities of the trauma service, the receiving hospital, and the verified prehospital transport agency.

Section Item 7: ☐ All trauma patients must be transported by a trauma verified prehospital transport agency.

Section Item 8: ☐ An air medical transport plan addressing the receipt or transfer of trauma patients with a heli-stop, landing zone, or airport located close enough to permit the facility to receive or transfer trauma patients by fixed-wing or rotary-wing aircraft.

Section Item 9: ☐ A written diversion protocol for the ED to divert trauma patients from the field to another trauma service when resources are temporarily unavailable.

Section Item 10: The process must include (check the boxes below to indicate each is included):

- ☐ Trauma service and patient criteria used to decide when diversion is necessary;
- ☐ How divert status will be communicated to nearby trauma services & prehospital agencies;
- ☐ How diversion will be coordinated with the appropriate prehospital agency;
- ☐ A method of documenting and tracking when the trauma service is on trauma divert, including the date, time, duration, reason, and decision maker.

Respond to the following items:

Insert required documents in the following pages. Label each with the corresponding Section number and Item number.

Response Item 1: Provide the trauma transfer-out guideline(s) for adult patients and for pediatric patients with needs exceeding the facility's capabilities listed in the trauma scope of service. Include the receiving facilities for specific injury types (e.g., burns, neurotrauma, spine, hand, etc.), and for specific populations (e.g., pediatric, geriatric, etc.). (The state pediatric transfer guideline can be found here: Pediatric Consultation & Transfer Guideline.) As a Level I, this may be where you would send your patients if a mass casualty occurred.

Response Item 2: Provide a summary of issues regarding patients transferred-out from your facility for both adult and pediatric patients, (e.g., patients transferred to a non-trauma designated facility, double-transfers, inappropriate transfers, transfers with ED LOS >3 hours.) (Limit response to 1,000 characters): _____.

Response Item 3: ☐ Yes ☐ No Does the trauma service QI review all adult and pediatric patients transferred out?

Response Item 4: Explain what was done to develop relationships with facilities that receive this facility's trauma patients (Limit response to 500 characters): _____

Response Item 5: ☐ Yes ☐ No Does the trauma service QI review all patients transferred in? Skip to Section 8 if your facility does not receive trauma patients transferred in.

Response Item 6: ☐ Yes ☐ No Does the trauma service reach out to other facilities that could potentially transfer trauma patients to this facility?

Response Item 7: What percentage of the time was the facility on trauma divert in the most recent 12-months? _____

Trauma Team Activation

The intent of this section is to demonstrate compliance with WAC 246-976-700 regarding activation of the trauma team, patient criteria, general surgeon response, trauma team membership, and monitoring of activations.

Level: All

Section Item 1: ☐ A trauma team activation protocol consistent with the facility's trauma scope of service. The protocol must:

☐ Define the physiologic, anatomic, and mechanism of injury criteria used to activate the full and modified (if used) trauma teams.

☐ Identify members of the full and modified (if used) trauma teams consistent with the provider requirements of this chapter.

Section Item 2: ☐ Define the process to activate the trauma team. The process must:

☐ Consistently apply the trauma service's established criteria.

☐ Use information obtained from prehospital providers or an emergency department assessment for patients not delivered by a prehospital agency.

☐ Be applied regardless of time post injury or previous care, whether delivered by prehospital or other means and whether transported from the scene or transferred from another facility.

☐ Include a method to initiate and/or upgrade a trauma activation when newly acquired information warrants additional capabilities and resources.

Section Item 3: ☐ Yes ☐No Staff and providers have easy access to the activation tool/form with criteria for all TTAs.

Level: I-III

Section Item 4: ☐ For full trauma team activations, include the mandatory presence of a general surgeon. The general surgeon assumes leadership and overall care using professional judgment regarding the need for surgery and/or transfer.

Level: Pediatrics, All

Section Item 5: For trauma team activations in pediatric designated trauma services, one of the following pediatric physician specialists must respond (within five minutes for level I). Check all that apply; skip to response item 1 if not pediatric designated.

- ☐ A pediatric surgeon;
- ☐ A pediatric emergency medicine physician;
- ☐ A pediatric intensivist;
- ☐ A pediatrician;
- ☐ A postgraduate year two or higher pediatric resident.

Respond to the following items:

Insert required documents in the following pages. Label each with the corresponding Section number and Item number.

Note: Only facilities with general surgeons are expected to have full trauma team activations (FTTA). Facilities with no general surgeons can have only modified trauma team activations (MTTA). Facilities with general surgeons can chose to have MTTA as well as FTTA.

Response Item 1: Provide the adult and/or pediatric trauma team activation (TTA) protocol(s), outlining the full and modified teams and responses for both. Include the items below in the protocol. Check the boxes indicating items included:

- ☐ Staff/providers authorized to activate the trauma team.
- ☐ Adult and pediatric trauma patient physiologic, anatomic, and/or mechanism of injury criteria for full and modified TTA. (Consider the Department of Health FTTA Criteria guideline as a basis to develop FTTA criteria. See Glossary).
- ☐ List members of the full trauma team required to respond for the activation.
- ☐ List members of the modified trauma team (if used) required to respond for the activation.
- ☐ Procedure to upgrade to a full trauma team activation when newly acquired information warrants additional resources.
- ☐ How a “walk-in” patient is evaluated to determine the need for TTA.
- ☐ How a patient transferred-in from another facility is evaluated for TTA (if applicable).

Emergency Department Services

The purpose of this section is to show compliance with WAC 246-976-700 emergency department standards.

Level: All

Section Item 1: ☐ Emergency care services available 24 hours every day, with:

Section Item 2: ☐ An emergency department.

Level: Adult, I-V

Section Item 3: ☐ The ability to resuscitate and stabilize adult and pediatric trauma patients in a designated resuscitation area.

Level: Adult, All

Section Item 4: ☐ A medical director, who:

- ☐ Is board-certified in emergency medicine, or
- ☐ Is board-certified in general surgery or
- ☐ Is board-certified in another relevant specialty practicing emergency medicine as their primary practice
- ☐ Physician ACLS trained with current certification in ATLS
- ☐ Physician assistant or advanced registered nurse practitioner ACLS trained who maintains ATLS certification.

Level: Pediatric, All

☐ A medical director, who (skip to item 6 if not applicable:

- ☐ Is board-certified in pediatric emergency medicine or
- ☐ Board-certified in emergency medicine with special competence in the care of pediatric patients or
- ☐ Board-certified in general surgery with special competence in the care of pediatric patients or
- ☐ A general surgeon ACLS trained with current certification in ATLS and with special competence in the care of pediatric patients
- ☐ Board-certified in a relevant specialty practicing emergency medicine as their primary practice with special competence in the care of pediatric patients.

Level: Adult, All

Section Item 5: ☐ Emergency physicians [for the adult trauma service] who:

- ☐ Are board-certified in emergency medicine or
- ☐ Board-certified in a relevant specialty practicing emergency medicine as their primary practice or
- ☐ Physician practicing emergency medicine as their primary practice with current certification in ACLS and ATLS or
- ☐ Physician assistant or advanced registered nurse practitioner ACLS trained who maintains ATLS certification.
- ☐ This requirement can be met by a postgraduate year two or higher emergency medicine or general surgery resident working under the direct supervision of the attending emergency physician. The resident must be available within five minutes of notification of the patient's arrival to provide leadership and care until the arrival of the general surgeon.
- ☐ Are available within five minutes of notification of the patient's arrival in the emergency department.
- ☐ Are currently certified in ACLS and ATLS. This requirement applies to all emergency physicians and residents who care for trauma patients in the emergency

department except this requirement does not apply to physicians who are board-certified in emergency medicine or board-certified in another relevant specialty and practicing emergency medicine as their primary practice.

☐ Meet the PER [five hours contact hours during each three-year designation period. Current certification in ATLS, PALS, or APLS, and other options, meet PER.]

Level: Pediatric, All

Section Item 6: ☐ Emergency physicians [for the pediatric acute trauma service] (skip to Section Item 8 if not applicable) who:

☐ Are board-certified in pediatric emergency medicine or

☐ Board-certified in emergency medicine with special competence in the care of pediatric patients, or

☐ Board-certified in a relevant specialty practicing emergency medicine as their primary practice with special competence in the care of pediatric patients.

☐ Physician ACLS trained with current certification in PALS/ATLS, with special competence in the care of pediatric patients

☐ This requirement can be met by a postgraduate year two or higher emergency medicine or general surgery resident with special competence in the care of pediatric trauma patients and working under the direct supervision of the attending emergency physician.

☐ The resident must be available within five minutes of notification of the patient's arrival in the emergency department to provide leadership and care until the arrival of the general surgeon.

☐ Are currently certified in PALS/ATLS. This requirement applies to all emergency physicians and residents who care for pediatric trauma patients in the emergency department except this requirement does not apply to physicians who are board-certified in pediatric emergency medicine or board-certified in another relevant specialty and practicing emergency medicine as their primary practice.

☐ Meet the PER [seven hours contact hours during each three-year designation period. Current certification in ATLS, PALS, or APLS, and other options, meet PER.]

Level: All

Section Item 7: ☐ Emergency care registered nurses (RNs), who:

☐ Are in the emergency department and available within five minutes of notification of the patient’s arrival.

☐ Have current certification in ACLS.

☐ Meet the PER [☐ five or ☐ seven contact hours during each three-year designation period. Current certification in PALS or ENPC, and other options, meet PER]

☐ Have successfully completed a trauma nurse core course (TNCC), or a department approved equivalent course;

[The department interpretation for the below standard is: once TNCC (or department approved equivalent) is completed, ED RN’s need only to complete one of the below trauma-specific education options every three-year designation period.]

☐ Have completed 12 hours of trauma related education every designation period. The trauma education must include, but is not limited to, the following topics:

☐ Mechanism of injury

☐ Shock and fluid resuscitation

☐ Initial assessment

☐ Stabilization and transport

Or

☐ Maintain current TNCC (ENPC or PALS for pediatric designation) certification.

Level: All

Section Item 8: ☐ Standard emergency equipment for the resuscitation and life support of adult and pediatric trauma patients, including:

Section Item 9: Immobilization devices:

- ☐ Backboard.
- ☐ Cervical collar.
- ☐ Splint material.

Infusion control device:

- ☐ Rapid infusion capability (Adult/Pediatrics, level I-III).
- ☐ Intraosseous devices.
- ☐ Sterile surgical sets:
- ☐ Chest tubes with closed drainage devices.
- ☐ Emergency transcutaneous airway.
- ☐ Thoracotomy (Adult/Pediatrics, level I-III).

Thermal control equipment:

- ☐ Blood and fluid warming.
- ☐ Devices for assuring warmth during transport.
- ☐ Thermometer capable of detecting hypothermia.
- ☐ Patient warming and cooling.
- ☐ 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.

☐ Pediatric emergency airway equipment readily available or transported in-house with the pediatric patient for evaluation, treatment, or diagnostics, including:

- ☐ Bag-valve masks.
- ☐ Face masks.
- ☐ Oral/nasal airways.

Respond to the following items:

Insert required documents in the following pages. Label each with the corresponding Section number and Item number.

Response Item 1: Include the cervical spine clearance policy/guideline/protocol including the below nursing and provider responsibilities, throughout the ED and inpatient stay. Check the boxes indicating items included:

- ☐ MTQIC approval date
- ☐ Criteria used to identify a patient at risk for cervical spine injury.
- ☐ How the patient is protected from further injury.
- ☐ The method to assess cervical spine injury in an alert vs. altered level of consciousness patient.
- ☐ Who decides that cervical spine injury is ruled out.
- ☐ Who removes the patient's cervical spine precautions.
- ☐ How cervical spine injury clearance is documented.
- ☐ The care provided for a patient with diagnosed cervical spine injury.

Response Item 2: Include the policy, guideline, or protocol for **adult and pediatric** trauma resuscitation (either as combined or separate documents.) The document must show the MTQIC approval date.

Response Item 3: Include the policy, guideline, or protocol for **adult and pediatric** burn patient care (either as combined or separate documents). The document must show the MTQIC approval date.

Response Item 4: Include the guideline or protocol for reversal of anti-coagulants in traumatic brain-injured patients. The document must show the MTQIC approval date.

Response Item 5: Include the massive transfusion policy, protocol, or procedure.

Emergency Department Physician—Education and Training

Base responses to the items below on a snapshot of any one recent week.

Board-certified ED physicians: If education requirements are not met, in the following pages include an educational plan that will meet compliance within six months.	
Number of ED physicians board-certified in emergency medicine:	
Number of physicians board-certified in a relevant specialty whose primary practice is emergency medicine:	
Percentage who have accomplished the pediatric education requirement (PER's):	
Non-board-certified ED physicians and advanced practitioners: If education requirements are not met, in the following pages include an educational plan that will meet compliance within six months.	
Number of non-board-certified physicians who participate in the initial care or evaluation of trauma activated patients:	
Number of advanced practitioners who participate in the initial care or evaluation of trauma activated patients:	
Percentage of non-board-certified physicians and/or advanced practitioners who are current in ATLS and ACLS	
Percentage of non-board-certified physicians and/or advanced practitioners who have accomplished PER's:	
ED resident physicians, not board-certified: If education requirements are not met, in the following pages include an educational plan that will meet compliance within six months.	
Number of ED residents:	
Percentage of ED residents who are current in ACLS and ATLS:	
Percentage of ED residents who have accomplished PER's:	

Emergency Department Registered Nurse Education and Training

If education requirements are not met, then in the following pages include an educational plan that will meet compliance within six months.

Total number of ED RNs:	
Percentage who are current in ACLS:	
Percentage who have passed TNCC:	
Percentage of ED RNs who are current in TNCC, or who have completed 12 hours of trauma education:	
Percentage of ED RNs who have completed PER:	

Diagnostic Imaging

This section demonstrates compliance with WAC 246-976-700 requirements for diagnostic imaging personnel and resources.

Diagnostic imaging services, with:

Level: Adult/Pediatric, I-III

Section Item 1: A radiologist:

- ☐ In person, or by
- ☐ Teleradiology,
  - ☐ Who is on-call and available within 20 minutes of the trauma team leader's request.
  - ☐ Who is on-call and available within 30 minutes of the trauma team leader's request.
  - ☐ N/A-Not required for level IV and V trauma services.

Level: All

Section Item 2: ☐ Personnel able to perform routine radiological capabilities, who are:

- ☐ available within five minutes of notification of the patient's arrival.
- ☐ on-call and available within 20 minutes of the trauma team leader's request.

Level: Adult/Pediatric, I-III

Section Item 3: ☐ A technologist able to perform computerized tomography, who is

- ☐ available within five minutes of the trauma team leader's request.
- ☐ on-call and available within 20 minutes of the trauma team leader's request.
- ☐ N/A-Not required for level IV and V trauma services

Level: Adult/Pediatric, I, II

Section Item 4: ☐ Angiography with a technologist on-call and available within 30 minutes of the trauma team leader's request.

- ☐ N/A-Not required for level III-V trauma services

Level: Adult/Pediatric, I, II

Section Item 5: ☐ Magnetic resonance imaging with a technologist on-call and available within 60 minutes of the trauma team leader's request.

- ☐ N/A-Not required for level III-V trauma services

Level: Adult/Pediatric, I, II

Section Item 6: ☐ Sonography with a technologist on-call and available within 30 minutes of the trauma team leader's request.

- ☐ N/A-Not required for level III-V trauma services

Level: Adult/Pediatric, I, II

Section Item 7: ☐ Interventional radiology services on-call and available within 30 minutes of the trauma team leader's request.

- ☐ N/A-Not required for level III-V trauma services

Level: Adult/Pediatric I, II, III

Section Item 8: ☐ A radiologic peer review process in place that reviews routine interpretations of images for accuracy, with determinations related to trauma patients communicated back to the trauma program quality committee.

Response Item 1: Submit the overall error read rates from your facilities radiologic peer review process.