

WAC 246-976-700 Trauma service standards.

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(1) A written trauma scope of service outlining the trauma care resources and capabilities available twenty-four hours every day for:	X	X	X	X	X	X	X	X
(a) Adult and pediatric trauma patient care;	X	X	X	X	X			
(b) Pediatric trauma patient care.						X	X	X
(2) A trauma medical director responsible for the organization and direction of the trauma service who:	X	X	X	X	X	X	X	X
(a) Is currently certified in advanced trauma life support (ATLS);	X	X	X			X	X	X
(b) Is a board-certified general surgeon;	X	X						
(c) Is a board-certified general surgeon or general surgeon trained in advanced cardiac life support (ACLS);			X					
(d) Is a board-certified general surgeon, emergency physician, a general surgeon ACLS trained with current certification in advanced trauma life support (ATLS) or a physician ACLS trained and current certification in ATLS;				X				
(e) Is a board-certified general surgeon, emergency physician, a physician ACLS trained with current certification in ATLS, or a physician assistant or advanced registered nurse practitioner ACLS trained who is currently certified in ATLS;					X			
(f) Is a board-certified pediatric surgeon or a board-certified general surgeon with special competence in the care of pediatric patients;						X	X	
(g) Is a board-certified general surgeon with special competence in the care of pediatric patients or a general surgeon ACLS trained and with special competence in the care of pediatric patients;								X
(h) Must complete thirty-six hours in three years of verifiable, external, trauma-related continuing medical education (CME);	X	X				X	X	
(i) Meets the pediatric education requirement (PER) as defined in subsection (27) of this section;	X	X	X	X	X	X	X	X
(j) Must have responsibility and authority for determining each general surgeon's ability to participate on the trauma call panel based on an annual review, conducted in conjunction with medical staffing and with authority through the trauma quality improvement program and hospital policy;	X	X	X			X	X	X
(k) Is a member of and actively participates in a regional or national trauma organizations.	X	X				X	X	
(3) A trauma program manager or trauma service coordinator responsible for the overall operation of trauma service who:	X	X	X	X	X	X	X	X
(a) Is a registered nurse;	X	X	X	X	X	X	X	X
(b) Has taken ACLS;	X	X	X	X	X	X	X	X
(c) Has successfully completed a trauma nursing core course (TNCC) or a department approved equivalent course, and successfully completes thirty-six hours of trauma-related education every three years in either external continuing education or in an internal education process conducted by the trauma program. The trauma education must include, but is not limited to, the following topics:	X	X	X	X	X	X	X	X
(i) Mechanism of injury;	X	X	X	X	X	X	X	X
(ii) Shock and fluid resuscitation;	X	X	X	X	X	X	X	X
(iii) Initial assessment;	X	X	X	X	X	X	X	X
(iv) Stabilization and transport.	X	X	X	X	X	X	X	X

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A facility with a designated trauma service must have:								
(d) Has taken pediatric advanced life support (PALS) or emergency nursing pediatric course (ENPC), and thereafter meets the PER contact hours as defined in subsection (27) of this section;	X	X	X	X	X			
(e) Has current PALS or ENPC certification;						X	X	X
(f) Has attended a trauma program manager orientation course provided by the department or a department approved equivalent, within the first eighteen months in the role;	X	X	X	X	X	X	X	X
(g) Is responsible for the overall supervision of the trauma registry and the quality of data submitted to the registry.	X	X	X	X	X	X	X	X
(4) A multidisciplinary trauma quality improvement program that must:	X	X	X	X	X	X	X	X
(a) Be led by the multidisciplinary trauma service committee:	X	X	X	X	X	X	X	X
(i) The trauma medical director serves as chair of the multidisciplinary trauma service committee;	X	X	X	X	X	X	X	X
(ii) The trauma medical director must attend a minimum of fifty percent of the peer review committee meetings;	X	X	X	X	X	X	X	X
(iii) The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program to ensure compliance with trauma service standards.	X	X	X	X	X	X	X	X
(b) 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;	X	X	X	X	X	X	X	X
(c) Have membership representation and participation that reflects the facility's trauma scope of service;	X	X	X	X	X	X	X	X
(d) 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;	X	X	X	X	X	X	X	X
(e) 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;	X	X	X	X	X	X	X	X
(f) Have a current trauma quality improvement plan that outlines the trauma service's quality improvement process;	X	X	X	X	X	X	X	X
(g) Have a process to monitor and track compliance with the trauma care standards using audit filters and benchmarks;	X	X	X	X	X	X	X	X
(h) Have a process to evaluate the care provided to trauma patients and to resolve identified prehospital, physician, nursing, or system issues;	X	X	X	X	X	X	X	X
(i) Have a process in which outcome measures are documented within the trauma quality improvement program's written plan which must be reviewed and updated at least annually. Outcome measures will include, at a minimum:								
(i) Mortality (with and without opportunities for improvement);								
(ii) Trauma surgeon response time (level I-III);								
(iii) Undertriage rate;	X	X	X	X	X	X	X	X
(iv) Emergency department length of stay greater than three hours for patients transferred out;								
(v) Missed injuries;								
(vi) Complications.								

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A facility with a designated trauma service must have:								
(j) Have a process for correcting problems or deficiencies;	X	X	X	X	X	X	X	X
(k) Have a process for problem resolution, outcome improvements, and assurance of safety. This process must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation;	X	X	X	X	X	X	X	X
(l) Have a process to continuously evaluate compliance with full and modified (if used) trauma team activation criteria as follows:	X	X	X	X	X	X	X	X
(i) The attending surgeon's arrival within fifteen minutes for level II and thirty minutes for level III services for patients with appropriate activation criteria must be monitored by the hospital's trauma quality improvement program;	X	X	X			X	X	X
(ii) All trauma team activations must be categorized by the level of response activation and quantified by number and percentage;	X	X	X	X	X	X	X	X
(iii) Trauma surgeon response time to full activations and for back-up call response must be determined and monitored. Variances should be documented and reviewed for reason for delay, opportunities for improvement, and corrective actions; and	X	X	X			X	X	X
(iv) Rates of undertriage must be monitored and reviewed quarterly.	X	X	X	X	X	X	X	X
(m) Have assurance from other hospital quality improvement committees, including peer review if conducted separately from the multidisciplinary trauma service committee, that resolution was achieved on trauma-related issues. The following requirements must also be satisfied:	X	X	X	X	X	X	X	X
(i) Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion;	X	X	X	X	X	X	X	X
(ii) A process must be in place to ensure that the trauma program manager receives feedback from peer review for trauma-related issues;	X	X	X	X	X	X	X	X
(iii) All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review;	X	X	X	X	X	X	X	X
(iv) 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; and	X	X	X	X	X	X	X	X
(v) The multidisciplinary trauma peer review committee must systematically review significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement.	X	X	X	X	X	X	X	X
(n) Have a process to ensure the confidentiality of patient and provider information, in accordance with RCW 70.41.200 and 70.168.090;	X	X	X	X	X	X	X	X
(o) Have a process to communicate with and provide feedback to referring trauma services and trauma care providers;	X	X	X	X	X	X	X	X
(p) Be able to integrate trauma quality improvement into the hospital's quality improvement program for level III, IV, V trauma services or level III pediatric trauma services with a total annual trauma volume of less than one hundred patients; however, trauma care must be formally addressed in accordance with the quality improvement requirements in this subsection. In that case, the trauma medical director is not required to serve as chair;			X	X	X			X

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A facility with a designated trauma service must have:								
(q) 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 that is transferring trauma patients, the trauma service must review each case for timeliness and appropriateness of care;	X	X	X	X	X	X	X	X
(r) Be a multidisciplinary trauma quality improvement program that transcends normal department hierarchies and includes:	X	X	X	X	X	X	X	X
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 at peer review committee meetings.	X	X	X			X	X	X
(s) Use risk-adjusted data for benchmarking and performance improvement:	X	X	X	X	X	X	X	X
(i) The risk-adjusted benchmarking system to measure performance must be the American College of Surgeons Trauma Quality Improvement Program (TQIP);	X	X				X	X	
(ii) Data must be collected in compliance with the National Trauma Data Standard (NTDS) and submitted to the National Trauma Data Bank® (NTDB®) every year in a timely fashion so that data can be aggregated and analyzed at the national level;	X	X				X	X	
(iii) Use risk-adjusted data provided by the state for the purposes of benchmarking and performance improvement.			X	X	X			X
(5) Written trauma service standards of care to ensure appropriate care throughout the facility for:	X	X	X	X	X	X	X	X
(a) Adult and pediatric trauma patients;	X	X	X	X	X			
(b) Pediatric trauma patients.						X	X	X
(6) Participation in the regional quality improvement program as defined in WAC 246-976-910.	X	X	X	X	X	X	X	X
(7) Participation in the Washington state trauma registry as defined in WAC 246-976-430.	X	X	X	X	X	X	X	X
(8) Written transfer-in guidelines consistent with the facility's designation level and trauma scope of service. The guidelines must identify the type, severity and complexity of injuries the facility can safely accept, admit, and provide with definitive care.	X	X	X	X	X	X	X	X
(9) Written transfer-out guidelines consistent with the facility's designation level and trauma scope of service. The guidelines must identify the type, severity and complexity of injuries that exceed the resources and capabilities of the trauma service.	X	X	X	X	X	X	X	X
(a) Collaborative treatment and transfer guidelines reflecting facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma services that receive these patients;			X	X	X			
(b) The decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network, health maintenance organization, a preferred provider organization, or the patient's ability to pay;	X	X	X	X	X	X	X	X
(c) Acute transfers out must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review; and	X	X	X	X	X	X	X	X

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A facility with a designated trauma service must have:								
(d) Trauma patients must not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service. The quality improvement program should monitor adherence to this guideline.	X	X	X			X	X	X
(10) Written interfacility transfer agreements with all trauma services that receive the facility's trauma patients. Agreements must include 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. All trauma patients must be transported by a trauma verified prehospital transport agency.	X	X	X	X	X	X	X	X
(11) 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.	X	X	X	X	X	X	X	X
(12) A written diversion protocol for the emergency department to divert trauma patients from the field to another trauma service when resources are temporarily unavailable. The process must include:	X	X	X	X	X	X	X	X
(a) Trauma service and patient criteria used to decide when diversion is necessary;	X	X	X	X	X	X	X	X
(b) How the divert status will be communicated to the nearby trauma services and prehospital agencies;	X	X	X	X	X	X	X	X
(c) How the diversion will be coordinated with the appropriate prehospital agency;	X	X	X	X	X	X	X	X
(d) A method of documenting/tracking when the trauma service is on trauma divert, including the date, time, duration, reason, and decision maker;	X	X	X	X	X	X	X	X
(e) Assurance that the decision to divert patients from the emergency department is communicated to the trauma surgeon on-call;	X	X	X			X	X	X
(f) Involvement of the trauma surgeon in the decision regarding diversion each time the center goes on bypass;	X	X				X	X	
(g) Routine monitoring, documenting and reporting of trauma center diversion hours, including the reason for initiating the diversion policy. Trauma center diversion must not exceed five percent of the time.	X	X	X			X	X	X
(13) A trauma team activation protocol consistent with the facility's trauma scope of service. The protocol must:	X	X	X	X	X	X	X	X
(a) Define the physiologic, anatomic, and mechanism of injury criteria used to activate the full and modified (if used) trauma teams;	X	X	X	X	X	X	X	X
(b) Identify members of the full and modified (if used) trauma teams consistent with the provider requirements of this chapter;	X	X	X	X	X	X	X	X
(c) Define the process to activate the trauma team. The process must:	X	X	X	X	X	X	X	X
(i) Consistently apply the trauma service's established criteria;	X	X	X	X	X	X	X	X
(ii) Use information obtained from prehospital providers or an emergency department assessment for patients not delivered by a prehospital agency;	X	X	X	X	X	X	X	X
(iii) 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;	X	X	X	X	X	X	X	X
(iv) Include a method to upgrade a modified activation to a full activation when newly acquired information warrants additional capabilities and resources;	X	X	X	X	X	X	X	X

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A facility with a designated trauma service must have:								
(v) Include the mandatory presence of a general surgeon for full trauma team activations. The general surgeon assumes leadership and overall care using professional judgment regarding the need for surgery or transfer;	X	X	X			X	X	X
(vi) Include the mandatory presence of a general surgeon if general surgery services are included in the facility's trauma scope of service. The general surgeon assumes leadership and overall care using professional judgment regarding the need for surgery or transfer;				X				
(vii) For trauma team activations in pediatric designated trauma services (within five minutes for level I, twenty minutes for level II or thirty minutes for level III), one of the following pediatric physician specialists must respond:						X	X	X
(A) A pediatric surgeon;								
(B) A pediatric emergency medicine physician;								
(C) A pediatric intensivist;								
(D) A pediatrician;								
(E) A postgraduate year two or higher pediatric resident.								
(viii) Require multisystem injured patients to be admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.	X	X	X					
(14) Emergency care services available twenty-four hours every day with:	X	X	X	X	X	X	X	X
(a) An emergency department (except for level V clinics);	X	X	X	X	X	X	X	X
(b) The ability to resuscitate and stabilize adult and pediatric trauma patients in a designated resuscitation area;	X	X	X	X	X			
(c) The ability to resuscitate and stabilize pediatric trauma patients in a designated resuscitation area;						X	X	X
(d) A medical director, who:	X	X	X			X	X	X
(i) Is board-certified in emergency medicine, board-certified in general surgery, or is board-certified in another relevant specialty practicing emergency medicine as their primary practice;	X	X	X					
(ii) Is board-certified in pediatric emergency medicine, board-certified in emergency medicine with special competence in the care of pediatric patients, board-certified in general surgery 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.						X	X	X
(e) Emergency physicians who:	X	X	X	X	X	X	X	X
(i) Are board-certified in emergency medicine or board-certified in a relevant specialty practicing emergency medicine as their primary practice. 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 arrival of the general surgeon;	X	X						

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(ii) Are board-certified in pediatric emergency medicine, are board-certified in emergency medicine with special competence in the care of pediatric patients, or are board-certified in a relevant specialty practicing emergency medicine as their primary practice 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 to provide leadership and care until arrival of the general surgeon;						X	X	
(iii) Are board-certified in emergency medicine or another relevant specialty practicing emergency medicine as their primary practice or physicians practicing emergency medicine as their primary practice with current certification in ACLS and ATLS;			X					
(iv) Are board-certified in pediatric emergency medicine, are board-certified in emergency medicine or surgery, with special competence in the care of pediatric patients, are board-certified in a relevant specialty practicing emergency medicine as their primary practice, with special competence in the care of pediatric patients, or are physicians with current certification in ATLS who are practicing emergency medicine as their primary practice with special competence in the care of pediatric patients;								X
(v) Are board-certified in emergency medicine or another relevant specialty and practicing emergency medicine as their primary practice or physicians with current certification in ACLS and ATLS. A physician assistant (PA) or advanced registered nurse practitioner (ARNP) current in ACLS and ATLS may initiate evaluation and treatment upon the patient's arrival in the emergency department until the arrival of the physician;				X				
(vi) Are board-certified or qualified in emergency medicine, surgery, or other relevant specialty and practicing emergency medicine as their primary practice or are physicians with current certification in ACLS and ATLS, or are PAs or ARNPs with current certification in ACLS and ATLS;					X			
(vii) Are available within five minutes of notification of the patient's arrival in the emergency department;	X	X	X			X	X	X
(viii) Are on-call and available within twenty minutes of notification of the patient's arrival in the emergency department;				X	X			
(ix) 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;	X	X	X	X	X			
(x) Are currently certified in ATLS. This requirement applies to all emergency physicians and residents who care for pediatric patients in the emergency department except this requirement does not apply to physicians who are board-certified in pediatric emergency medicine, board-certified in emergency medicine, or board-certified in another relevant specialty and practicing emergency medicine as their primary practice;						X	X	X
(xi) Meet the PER as defined in subsection (27) of this section;	X	X	X	X	X	X	X	X

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(xii) If the liaison or designee from emergency medicine, must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(xiii) If they are emergency physicians who participate on the trauma team, they must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(xiv) Nonboard-certified emergency physicians and advanced practitioners who participate in the initial care or evaluation of trauma activated patients in the emergency department must have current ATLS certification;	X	X	X	X	X	X	X	X
(xv) Must be able to provide initial resuscitative care to known trauma activated patients;	X	X	X			X	X	X
(xvi) Have completed appropriate orientation, credentialing, initial ED management/evaluation processes, and skill maintenance for advanced practitioners who participate in the initial assessment of trauma patients.	X	X	X	X	X	X	X	X
(f) Emergency care registered nurses (RNs) who:	X	X	X	X	X	X	X	X
(i) Are in the emergency department and available within five minutes of notification of patient's arrival;	X	X	X			X	X	X
(ii) Are in-house and available within five minutes of notification of the patient's arrival;				X	X			
(iii) Have current certification in ACLS;	X	X	X	X	X			
(iv) Have successfully completed TNCC or a department approved equivalent course;	X	X	X	X	X	X	X	X
(v) Have completed twelve hours of trauma related education every designation period. The trauma education must include, but is not limited to, the following topics:								
(A) Mechanism of injury;	X	X	X	X		X	X	X
(B) Shock and fluid resuscitation;								
(C) Initial assessment;								
(D) Stabilization and transport.								
(vi) Meet the PER as defined in subsection (27) of this section.	X	X	X	X	X	X	X	X
(g) Standard emergency equipment for the resuscitation and life support of adult and pediatric trauma patients, including:	X	X	X	X	X	X	X	X
(i) Immobilization devices:	X	X	X	X	X	X	X	X
(A) Back board;	X	X	X	X	X	X	X	X
(B) Cervical injury;	X	X	X	X	X	X	X	X
(C) Long-bone.	X	X	X	X	X	X	X	X
(ii)(A) Infusion control device:	X	X	X	X	X	X	X	X
(B) Rapid infusion capability.	X	X	X			X	X	X
(iii) Intraosseous devices;	X	X	X	X	X	X	X	X
(iv) Sterile surgical sets:	X	X	X	X	X	X	X	X
(A) Thoracostomy with closed drainage devices;	X	X	X	X	X	X	X	X

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A facility with a designated trauma service must have:								
(B) Emergency transcutaneous airway;	X	X	X	X	X	X	X	X
(C) Bedside ultrasound;	X	X	X	X		X	X	X
(D) Thoracotomy;	X	X	X			X	X	X
(v) Thermal control equipment:	X	X	X	X	X	X	X	X
(A) Blood and fluid warming;	X	X	X	X	X	X	X	X
(B) Thermometer capable of detecting hypothermia;	X	X	X	X	X	X	X	X
(C) Patient warming and cooling.	X	X	X	X	X	X	X	X
(vi) Other equipment:	X	X	X	X	X	X	X	X
(A) 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
(B) 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, and oral/nasal airways.	X	X	X	X	X	X	X	X
(15) Respiratory therapy services, with a respiratory care practitioner available within five minutes of notification of patient's arrival.	X	X	X			X	X	X
(16) Diagnostic imaging services (except for level V clinics) with:	X	X	X	X	X	X	X	X
(a) A radiologist in person or by teleradiology, who is:	X	X	X			X	X	X
(i) On-call and available within twenty minutes of the trauma team leader's request;	X	X				X	X	
(ii) On-call and available within thirty minutes of the trauma team leader's request;			X					X
(iii) Board certified or eligible for certification by an appropriate radiology board according to current requirements for licensed radiologists who take trauma call.	X	X				X	X	
(b) Personnel able to perform routine radiological capabilities who are:	X	X	X	X	X	X	X	X
(i) Available within five minutes of notification of the patient's arrival;	X	X				X	X	
(ii) On-call and available within twenty minutes of notification of the patient's arrival.			X	X	X			X
(c) A technologist able to perform computerized tomography who is:	X	X	X			X	X	X
(i) Available within five minutes of the trauma team leader's request;	X					X		
(ii) On-call and available within twenty minutes of the trauma team leader's request.		X	X				X	X
(d) A radiologic peer review process that reviews routine interpretations of images for accuracy. Determinations related to trauma patients must be communicated to the trauma program quality committee;	X	X	X			X	X	X
(e) Angiography with a technologist on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(f) Magnetic resonance imaging with a technologist on-call and available within sixty minutes of the trauma team leader's request;	X	X				X	X	
(g) Sonography with a technologist on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(h) Interventional radiology services on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	

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(i) Radiologists who are involved, at a minimum, in protocol development and trend analysis that relate to diagnostic imaging;	X	X	X			X	X	X
(j) Facilities that have a mechanism in place to view radiographic imaging from referring hospitals that are within their catchment area.	X	X				X	X	
(17) Clinical laboratory services (except for level V clinics), with:								
(a) Lab services available within five minutes of notification of the patient's arrival;	X	X	X			X	X	X
(b) Lab services on-call and available within twenty minutes of notification of the patient's arrival;				X	X			
(c) Blood gases and pH determination;	X	X	X	X		X	X	X
(d) Coagulation studies;	X	X	X	X	X	X	X	X
(e) Drug or toxicology measurements;	X	X	X	X	X	X	X	X
(f) Microbiology;	X	X	X	X	X	X	X	X
(g) Serum alcohol determination;	X	X	X	X	X	X	X	X
(h) Serum and urine osmolality;	X	X				X	X	
(i) Standard analysis of blood, urine, and other body fluids.	X	X	X	X	X	X	X	X
(18) Blood and blood-component services (except for level V clinics) with:								
(a) Ability to obtain blood typing and crossmatching;	X	X	X	X	X	X	X	X
(b) Autotransfusion;	X	X	X			X	X	X
(c) Blood and blood components available from in-house or through community services, to meet patient needs;	X	X	X	X	X	X	X	X
(d) Blood storage capability;	X	X	X	X		X	X	X
(e) Noncrossmatched blood available on patient arrival in the emergency department;	X	X	X	X	X	X	X	X
(f) Policies and procedures for massive transfusion.	X	X	X	X		X	X	X
(19) General surgery services with:								
(a) Surgeons who meet the following requirements:	X	X	X			X	X	X
(i) Are board-certified in general surgery and available within fifteen minutes of notification of the patient's arrival when the full trauma team is activated. This requirement can be met by a postgraduate year four or higher surgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the general surgeon. In this case the general surgeon must be available within fifteen minutes of notification of patient's arrival;	X							
(ii) Are board-certified in pediatric surgery or board-certified in general surgery with special competence in the care of pediatric patients and are available within fifteen minutes of notification of the patient's arrival when the full trauma team is activated. This requirement can be met by a post graduate year four or higher pediatric surgery resident or a general surgery resident with special competence in the care of pediatric patients. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the pediatric or general surgeon. In this case the pediatric or general surgeon must be available within fifteen minutes of notification of patient's arrival;						X		

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(iii) Are board-certified in general surgery. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is fifteen minutes or more. Otherwise the surgeon must be in the emergency department within fifteen minutes of notification of patient's arrival. This requirement can be met by a postgraduate year four or higher surgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the general surgeon;		X						
(iv) Are board-certified in pediatric surgery or board-certified in general surgery with special competence in the care of pediatric patients. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is fifteen minutes or more. Otherwise the surgeon must be in the emergency department within fifteen minutes of notification of patient's arrival. This requirement can be met by a postgraduate year four or higher pediatric surgery resident or a general surgical resident with special competence in the care of pediatric patients. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the pediatric or general surgeon;							X	
(v) Are board-certified or trained in ACLS and currently certified in ATLS. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is thirty minutes or more. Otherwise the surgeon must be in the emergency department within thirty minutes of notification of patient's arrival;			X					
(vi) Are board-certified or board-qualified with special competence in the care of pediatric patients. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is thirty minutes or more. Otherwise the surgeon must be in the emergency department within thirty minutes of notification of patient's arrival;								X
(vii) Are trained in ACLS and currently certified in ATLS. This requirement applies to all surgeons and residents caring for trauma patients except this requirement does not apply to surgeons who are board certified in general surgery;	X	X	X					
(viii) Are currently certified in ATLS. This requirement applies to all surgeons and residents caring for pediatric trauma patients except this requirement does not apply to surgeons who are board certified in pediatric or general surgery;						X	X	X
(ix) Meet the PER as defined in subsection (27) of this section;	X	X	X			X	X	X
(x) Have privileges in general surgery;	X	X	X					
(xi) Maintain at least eighty percent attendance at activations with a mechanism for documenting this attendance record, as required for full trauma activations. The expectation is for one hundred percent attendance at activations;	X	X	X			X	X	X
(xii) The attending surgeon is expected to be present in the operating room for all operations. A mechanism for documenting this presence is required;	X	X	X			X	X	X
(xiii) A surgeon from the trauma call panel must participate in the hospital's disaster planning process;	X	X	X			X	X	X
(xiv) Each member of the group of general surgeons must attend at least fifty percent of the peer review committee meetings;	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(xv) 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.			X					X
(b) A published schedule for first call with a written plan for surgery coverage if the surgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma service's total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma service's trauma quality improvement program. In addition:	X	X	X			X	X	X
(i) Surgical commitment is required for a properly functioning trauma center;	X	X	X			X	X	X
(ii) The trauma surgeon on call must be dedicated to a single trauma center while on duty;	X	X				X	X	
(iii) The liaison from general surgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(iv) Other general surgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.	X	X				X	X	
(c) General surgery services that meet all level III general surgery service standards if the facility's trauma scope of service includes general surgery services twenty-four hours every day or transfer trauma patients who need general surgery services to a designated trauma service with general surgery services available.				X				
(20) Neurosurgery services with neurosurgeons who meet the following requirements:	X	X				X	X	
(a) Are board-certified, and available within five minutes of the trauma team leader's request;	X					X		
This requirement can be met by a postgraduate year four or higher neurosurgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the neurosurgeon. In this case the neurosurgeon must be available within thirty minutes of the trauma team leader's request.	X					X		
(b) Are board-certified or board-qualified and on-call and available within thirty minutes of the trauma team leader's request;		X					X	
(c) Are board-certified or board-qualified and on-call and available within thirty minutes of the trauma team leader's request if the facility's trauma scope of service includes neurosurgery services twenty-four hours every day or transfer trauma patients who need neurosurgery services to a designated trauma service with neurosurgery services available;			X	X				X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(d) The liaison from neurosurgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(e) Other neurosurgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(f) The facility must have a predefined and thoroughly developed neurotrauma diversion plan that is implemented when the neurosurgeon on call becomes encumbered. A neurotrauma diversion plan must include the following:	X	X				X	X	
(i) Emergency medical services notification of neurosurgery advisory status/divert;	X	X				X	X	
(ii) A thorough review of each instance by the quality improvement program; and	X	X				X	X	
(iii) Monitoring of the efficacy of the process by the quality improvement program.	X	X				X	X	
(g) A published schedule for first call with a written plan for neurosurgery coverage is required, for when the neurosurgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality improvement program;	X	X				X	X	
(h) If one neurosurgeon covers two trauma services within the same limited geographic area, there must be a contingency plan.	X	X				X	X	
(21) Surgical services on-call and available within thirty minutes of the trauma team leader's request for:	X	X	X			X	X	X
(a) Cardiac surgery;	X					X		
(b) Microsurgery;	X					X		
(c) Obstetric surgery or for level III trauma services, a plan to manage the pregnant trauma patient;	X	X	X			X	X	X
(d) Orthopedic surgery including the following:	X	X	X			X	X	X
(i) Orthopedic team members must have dedicated call at their institution or have an effective backup call system;	X	X				X	X	
(ii) If the on-call orthopedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available;	X	X				X	X	
(iii) If the orthopedic surgeon is not dedicated to a single facility while on call, then a published backup schedule is required;			X					X
(iv) A published schedule for first call with a written plan for orthopedic surgery coverage is required for when the orthopedic surgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality;	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(v) The liaison from orthopedic surgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(vi) Other orthopedic surgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.	X	X				X	X	
(e) Orthopedic surgery services on-call and available within thirty minutes of the trauma team leader's request if the facility's trauma scope of service includes orthopedic surgery services twenty-four hours every day or transfer trauma patients who need orthopedic surgery services to a designated trauma service with orthopedic surgery services available;				X				
(f) Thoracic surgery;	X	X				X	X	
(g) Urologic surgery;	X	X				X	X	
(h) Vascular surgery.	X	X				X	X	
(22) Surgical services on-call for patient consultation or management at the trauma team leader's request for:	X	X				X	X	
(a) Cranial facial surgery;	X	X				X	X	
(b) Gynecologic surgery;	X	X				X	X	
(c) Ophthalmic surgery;	X	X				X	X	
(d) Plastic surgery.	X	X				X	X	
(23) Anesthesiology services with board-certified anesthesiologists or certified registered nurse anesthetists (CRNAs) who meet the following requirements:	X	X	X			X	X	X
(a) Are available within five minutes of the trauma team leader's request;	X					X		
(b) Are on-call and available within twenty minutes of the trauma team leader's request;		X					X	
(c) Are on-call and available within thirty minutes of the trauma team leader's request;			X					X
(d) Are ACLS trained except this requirement does not apply to physicians board-certified in anesthesiology;	X	X	X			X	X	X
(e) Are highly experienced and committed to the care of injured patients; who organize and supervise the anesthetic care of injured patients; and who serve as the designated liaison to the trauma program;	X	X				X	X	
(f) When anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending anesthesiologist on call must be advised, available within thirty minutes at all times, and present for all operations;	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(g) A published schedule for first call, with a written plan for anesthesia coverage is required for when the anesthesia provider on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality improvement program;	X	X	X			X	X	X
(h) Meet the PER as defined in subsection (27) of this section;	X	X	X			X	X	X
(i) Meet all level III anesthesiology service standards if the facility's trauma scope of service includes surgery services twenty-four hours every day or transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(24) Operating room services with:	X	X	X			X	X	X
(a) Hospital staff responsible for opening and preparing the operating room available within five minutes of notification;	X	X	X			X	X	X
(b) Operating room staff on-call and available within fifteen minutes of notification;	X	X				X	X	
(c) Operating room staff on-call and available within thirty minutes of notification;			X					X
(d) A written plan to mobilize additional surgical team members for trauma patient surgery;	X	X	X			X	X	X
(e) Delays in operating room availability routinely monitored. Any case that is associated with a significant delay or adverse outcome must be reviewed for reasons for delay and opportunity for improvement;	X	X	X			X	X	X
(f) Standard surgery instruments and equipment needed to perform operations on adult and pediatric patients, including:	X	X	X			X	X	X
(i) Blood recovery and transfusion;	X	X	X			X	X	X
(ii) Bronchoscopy equipment;	X	X	X			X	X	X
(iii) Cardiopulmonary bypass;	X	X				X	X	
(iv) Craniotomy set;	X	X				X	X	
(v) Endoscopy equipment;	X	X	X			X	X	X
(vi) Rapid infusion capability;	X	X	X			X	X	X
(vii) Thermal control equipment:	X	X	X			X	X	X
(A) Blood and fluid warming;	X	X	X			X	X	X
(B) Patient warming and cooling.	X	X	X			X	X	X
(g) Operating room services that meet all level III operating room service standards if the facility's trauma scope of care includes surgery services twenty-four hours every day or transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(25) Post anesthesia care (PACU) services with:	X	X	X			X	X	X
(a) At least one registered nurse available twenty-four hours every day;	X					X		
(b) At least one registered nurse on-call and available twenty-four hours every day;		X	X				X	X
(c) Registered nurses who are ACLS trained;	X	X	X			X	X	X
(d) PACU equipment to monitor and resuscitate patients, including:								
(i) Pulse oximetry;								

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(ii) End-tidal carbon dioxide detection;	X	X	X			X	X	X
(iii) Arterial pressure monitoring;								
(iv) Patient rewarming.								
(e) Post anesthesia care services that meet all level III post anesthesia care service standards if the facility's trauma scope of care includes general surgery services twenty-four hours every day or transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(26) Critical care services with:	X	X	X			X	X	
(a) A critical care medical director who is:	X	X	X			X	X	
(i) Board-certified in:	X							
(A) Surgery and critical care;	X							
(B) Pediatric critical care.						X		
(ii) Board-certified in critical care or board-certified in surgery, internal medicine, or anesthesiology with special competence in critical care;		X	X					
(iii) Board-certified in critical care with special competence in pediatric critical care or is board-certified in surgery, internal medicine, or anesthesiology with special competence in pediatric critical care;							X	
(iv) Responsible for coordinating with the attending physician for trauma patient care.	X	X	X			X	X	
(b) Physician coverage of critically ill trauma patients in the intensive care unit (ICU) by appropriately trained physicians who meet the following requirements:	X	X	X			X	X	X
(i) Must be available in-house within fifteen minutes, twenty-four hours per day;	X					X		
(ii) Must be available within fifteen minutes, twenty-four hours per day;		X					X	
(iii) Must be available within thirty minutes with a formal plan in place for emergency coverage.			X					X
(c) For all levels of trauma service, the quality improvement program must ensure timely and appropriate ICU coverage is provided;	X	X	X			X	X	X
(d) The timely response of credentialed providers to the ICU must be continuously monitored as part of the quality improvement program;	X	X	X			X	X	X
(e) A designated ICU physician liaison or designee to the trauma service. This liaison must attend at least fifty percent of the multidisciplinary peer review meetings with documentation by the trauma quality improvement program;	X	X	X			X	X	X
(f) The physician liaison or designee from the ICU must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(g) Other ICU physicians who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(h) Critical care registered nurses who:	X	X	X			X	X	
(i) Are ACLS trained;	X	X	X					
(ii) Have special competence in pediatric critical care;						X	X	
(iii) Have completed a minimum of six contact hours of trauma specific education every three-year designation period;	X	X				X	X	
(iv) Have completed a minimum of three contact hours of trauma specific education every three-year designation period.			X					
(i) A physician directed code team;	X	X	X			X	X	
(j) Pediatric patient isolation capacity;						X	X	
(k) General surgery consults for critical care trauma patients or if intensivists are the primary admitting nonsurgical physician caring for trauma patients, the intensivists must complete a minimum of twelve hours of external or internal trauma critical care specific CME every three-year designation period;	X	X	X			X	X	X
(l) Standard critical care equipment for adult and pediatric trauma patients, including:	X	X	X			X	X	
(i) Cardiac devices:	X	X	X			X	X	
(A) Cardiac pacing capabilities;	X	X	X			X	X	
(B) Cardiac monitor with at least two pressure monitoring modules (cardiac output and hard copy recording), with the capability to continuously monitor heart rate, respiratory rate, and temperature.	X	X	X			X	X	
(ii) Intracranial pressure monitoring devices;	X	X				X	X	
(iii) Intravenous supplies:	X	X	X			X	X	
(A) Infusion control device;	X	X	X			X	X	
(B) Rapid infusion capability.	X	X	X			X	X	
(iv) Sterile surgical sets:	X	X	X			X	X	
(A) Thoracostomy;	X	X	X			X	X	
(B) Emergency surgical airway;	X	X	X			X	X	
(C) Bedside ultrasound;	X	X	X			X	X	
(D) Thoracotomy.	X	X	X			X	X	
(v) Thermal control equipment:	X	X	X			X	X	
(A) Blood and fluid warming;	X	X	X			X	X	
(B) Devices for assuring warmth during transport;	X	X	X			X	X	
(C) Expanded scale thermometer capable of detecting hypothermia;	X	X	X			X	X	
(D) Patient warming and cooling.	X	X	X			X	X	
(m) A written policy to transfer all pediatric trauma patients who need critical care services to a pediatric designated trauma service with critical care services available;	X	X	X					
(n) Surgical collaboration to set and implement policies and administrative decisions impacting trauma patients admitted to the ICU;	X	X	X			X	X	X
(o) Critical care services that meet all level III critical care service standards, if the facility's trauma scope of service includes critical care services for trauma patients twenty-four hours every day or transfer trauma patients who need critical care services to a designated trauma service with critical care services available;				X				

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(p) Critical care services that meet all level II pediatric critical care service standards if the facility's trauma scope of care includes pediatric critical care services for trauma patients twenty-four hours every day or transfer pediatric trauma patients who need critical care services to a designated pediatric trauma service, with pediatric critical care services available.								X
(27) Pediatric education requirement (PER):	X	X	X	X	X	X	X	X
(a) The pediatric trauma medical director and the liaisons from neurosurgery, orthopedic surgery, emergency medicine, and critical care medicine must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;						X	X	
(b) PER must be met by the following providers who are directly involved in the initial resuscitation and stabilization of pediatric trauma patients:	X	X	X	X	X	X	X	X
(i) Emergency department physicians;	X	X	X	X	X	X	X	X
(ii) Emergency department registered nurses;	X	X	X	X	X	X	X	X
(iii) Physician assistants or ARNPs who participate in the initial care or evaluation of trauma activated patients in the emergency department;	X	X	X	X	X	X	X	X
(iv) Emergency medicine or surgical residents who initiate care prior to the arrival of the emergency physician;	X	X				X	X	
(v) General surgeons;	X	X	X			X	X	X
(vi) Surgical residents who initiate care prior to the arrival of the general surgeon;	X	X				X	X	
(vii) Anesthesiologists and CRNAs;	X	X	X			X	X	X
(viii) General surgeons, anesthesiologists, and CRNAs if the facility's trauma scope of service includes general surgery services twenty-four hours every day;				X				
(ix) Intensivists involved in the resuscitation, stabilization and in-patient care of pediatric trauma patients.						X	X	X
(c) PER must be met by completing pediatric specific contact hours as defined below:	X	X	X	X	X	X	X	X
(i) Five contact hours per provider during each three-year designation period;	X	X	X	X	X			
(ii) Seven contact hours per provider during each three-year designation period;						X	X	X
(iii) Contact hours should include, but are not limited to, the following topics:	X	X	X	X	X	X	X	X
(A) Initial stabilization and transfer of pediatric trauma;	X	X	X	X	X	X	X	X
(B) Assessment and management of pediatric airway and breathing;	X	X	X	X	X	X	X	X
(C) Assessment and management of pediatric shock, including vascular access;	X	X	X	X	X	X	X	X
(D) Assessment and management of pediatric head injuries;	X	X	X	X	X	X	X	X
(E) Assessment and management of pediatric blunt abdominal trauma.	X	X	X	X	X	X	X	X
(iv) Contact hours may be accomplished through one or more, but not limited to, the following methods:	X	X	X	X	X	X	X	X
(A) Review and discussion of individual pediatric trauma cases within the trauma quality improvement program;	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(B) Staff meetings;	X	X	X	X	X	X	X	X
(C) Classes, formal or informal;	X	X	X	X	X	X	X	X
(D) Web-based learning;	X	X	X	X	X	X	X	X
(E) Certification in ATLS, PALS, APLS, ENPC, or other department approved equivalents;	X	X	X	X	X	X	X	X
(F) Other methods of learning which appropriately communicates the required topics listed in this section.	X	X	X	X	X	X	X	X
(28) Acute dialysis services or must transfer trauma patients needing dialysis.	X	X	X	X	X	X	X	X
(29) A burn center, in accordance with the American Burn Association, to care for burn patients or must transfer burn patients to a burn center, in accordance with the American Burn Association transfer guidelines.	X	X	X	X	X	X	X	X
(30) Services on-call for consultation or patient management:	X	X	X			X	X	X
(a) Cardiology;	X	X				X	X	
(b) Gastroenterology;	X	X				X	X	
(c) Hematology;	X	X				X	X	
(d) Infectious disease specialists;	X	X				X	X	
(e) Internal medicine;	X	X	X					
(f) Nephrology;	X	X				X	X	
(g) Neurology;	X	X				X	X	
(h) Pediatric neurology;						X	X	
(i) Pathology;	X	X	X			X	X	X
(j) Pediatrician;	X	X				X	X	X
(k) Pulmonology;	X	X				X	X	
(l) Psychiatry or a plan for management of the psychiatric trauma patient.	X	X				X	X	
(31) Ancillary services available for trauma patient care:	X	X	X	X	X	X	X	X
(a) Adult protective services;	X	X	X	X	X			
(b) Child protective services;	X	X	X	X	X	X	X	X
(c) Chemical dependency services;	X	X	X			X	X	X
(d) Nutritionist services;	X	X	X	X		X	X	X
(e) Occupational therapy services;	X	X	X			X	X	X
(f) Pastoral or spiritual care;	X	X	X	X	X	X	X	X
(g) Pediatric therapeutic recreation/child life specialist;						X	X	
(h) Pharmacy services, with an in-house pharmacist;	X					X		
(i) Pharmacy services;		X	X	X	X		X	X
(j) Physical therapy services;	X	X	X	X		X	X	X
(k) Psychological services;	X	X	X			X	X	X
(l) Social services;	X	X	X	X		X	X	X
(m) Speech therapy services.	X	X	X			X	X	X
(32) A trauma care outreach program, including:	X	X				X	X	
(a) Telephone consultations with physicians of the community and outlying areas;	X	X				X	X	
(b) On-site consultations with physicians of the community and outlying areas.	X	X				X	X	
(33) Injury prevention, including:	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:	X	X	X			X	X	X
(a) A public injury prevention education program to include:	X	X	X	X	X	X	X	X
(i) An employee in a leadership position that has injury prevention as part of their job description;	X	X	X	X	X	X	X	X
(ii) Registry data used to identify injury prevention priorities that are appropriate for local implementation;	X	X	X	X	X	X	X	X
(iii) Trauma centers that have an organized and effective approach to injury prevention and prioritize those efforts based on local trauma registry and epidemiologic data.	X	X	X	X	X	X	X	X
(b) Participation in community or regional injury prevention activities that include partnerships with other community organizations;	X	X	X	X	X	X	X	X
(c) A written plan for drug and alcohol screening and brief intervention and referral for treatment;	X	X	X	X	X	X	X	X
(d) Screening and brief intervention for drug and alcohol use. All patients who have screened positive must receive an intervention by appropriately trained staff and this intervention must be documented.	X	X	X	X	X	X	X	X
(34) A formal trauma education training program for:	X	X				X	X	
(a) Allied health care professional;	X	X				X	X	
(b) Community physicians;	X	X				X	X	
(c) Nurses;	X	X				X	X	
(d) Prehospital personnel;	X	X				X	X	
(e) Staff physicians.	X	X				X	X	
(35) Provisions to allow for initial and maintenance training of invasive manipulative skills for prehospital personnel.	X	X	X	X		X	X	X
(36) Residency programs that must:	X					X		
(a) Be accredited by the Accreditation Council of Graduate Medical Education;	X					X		
(b) Be committed to training physicians in trauma management.	X					X		
(37) A trauma research program conducting research applicable to the adult and pediatric trauma patient population, including:	X					X		
(a) At a minimum, a trauma research program that publishes twenty peer-reviewed articles in journals included in Index Medicus or PubMed within a three-year period;	X					X		
(b) These publications must result from work related to the trauma center or the trauma system in which the trauma center participates;	X					X		
(c) Of the twenty articles, at least one must be authored or co-authored by members of the general surgery trauma team;	X					X		
(d) At least one article each from three of the following disciplines is required: Basic sciences, neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, and nursing;	X					X		
(e) In combined level I adult and pediatric centers, half of the required research must be pediatric research;	X					X		
(f) The administration of a level I trauma center must demonstrate support for the research program by including the provision of basic laboratory space, sophisticated research equipment, advanced information systems, biostatistical support, salary support for basic and translational scientists, or seed grants for less experienced faculty.	X					X		
(38) For joint trauma service designation (when two or more hospitals apply to share a single trauma designation):	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
	I	II	III	IV	V	I P	II P	III P
A facility with a designated trauma service must have:								
(a) A single, joint multidisciplinary trauma quality improvement program in accordance with the trauma quality improvement standards defined in subsection (4) of this section;	X	X	X			X	X	X
(b) A set of common policies and procedures adhered to by all hospitals and providers in the joint trauma service;	X	X	X			X	X	X
(c) A predetermined, published hospital rotation schedule for trauma care.	X	X	X			X	X	X
(39) Trauma centers must meet the disaster-related requirements of the facility's accrediting agency.	X	X	X	X	X	X	X	X
(40) Organ procurement activities, including:	X	X	X			X	X	X
(a) An established relationship with a recognized organ procurement organization (OPO);	X	X	X			X	X	X
(b) A written policy in place for notification of the regional OPO;	X	X	X			X	X	X
(c) The trauma center must review its organ donation rate annually;	X	X	X			X	X	X
(d) Written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death.	X	X	X			X	X	X

[Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 18-24-082, § 246-976-700, filed 12/3/18, effective 1/3/19. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070. WSR 09-23-085, § 246-976-700, filed 11/16/09, effective 12/17/09.]