WAC 246-976-430 Trauma registry—Provider responsibilities. (1) A trauma care provider shall protect the confidentiality of data in their possession and as it is transferred to the department.

(2) A verified prehospital agency that transports trauma patients must:

(a) Provide an initial report of patient care to the receiving facility at the time the trauma patient is delivered as described in WAC 246-976-455.

(b) Within 24 hours after the trauma patient is delivered, send a complete patient care report to the receiving facility to include the data shown in Table A.

Table A:
Prehospital Patient Care Report Elements for the Washington Trauma Registry

Data Element	Prehospital-Transport:	Inter-Facility:
Incident Information		
Transporting emergency medical services (EMS) agency number	X	X
Unit en route date/time	X	
Patient care report number	X	X
First EMS agency on scene identification number	X	
Crew member level	X	X
Method of transport	X	X
Incident county	X	
Incident zip code	X	
Incident location type	X	
Patient Information		
Name	X	X
Date of birth, **or** age	X	X
Sex	X	X
Cause of injury	X	
Use of safety equipment	X	
Extrication required	X	
Transportation		
Facility transported from (code)		X
Times		
Unit notified by dispatch date/time	X	X
Unit arrived on scene date/time	X	X
Unit left scene date/time	X	X
Vital Signs		
Date/time of first vital signs taken	X	
First systolic blood pressure	X	
First respiratory rate	X	
First pulse	X	
First oxygen saturation	X	
First Glasgow coma score (GCS) with individual component values (eye, verbal, motor, total, and qualifier)	X	
Treatment		
Procedure performed	X	

(3) A designated trauma service must:

(a) Have a person identified as responsible for trauma registry activities, and who has completed the department trauma registry training course within 18 months of hire. For level I-III trauma services the person identified must also complete the abbreviated injury scale (AIS) course within 18 months of hire;

(b) Report data elements for all patients defined in WAC 246-976-420;

(c) Report patients with a discharge date for each calendar quarter in a department-approved format by the end of the following quarter;

(d) Have procedures in place for internal monitoring of data validity, which may include methods to reabstract data for accuracy; and

(e) Correct and resubmit records that fail the department's validity tests as described in WAC 246-976-420(7) within three months of notification of errors.

(4) A designated trauma rehabilitation service must provide data, as identified in subsection (7) of this section, to the trauma registry in a format determined by the department upon request.

(5) A designated trauma service must submit the following data elements for trauma patients:

(a) Record identification data elements must include:

(i) Identification (ID) of reporting facility;

(ii) Date and time of arrival at reporting facility;

(iii) Unique patient identification number assigned to the patient by the reporting facility.

(b) Patient identification data elements must include:

(i) Name;

(ii) Date of birth;

(iii) Sex;

(iv) Race;

(v) Ethnicity;

(vi) Last four digits of the patient's Social Security number;

(vii) Home zip code.

(c) Prehospital data elements must include:

(i) Date and time of incident;

(ii) Incident zip code;

(iii) Mechanism/type of injury;

(iv) External cause codes;

(v) Injury location codes;

(vi) First EMS agency on-scene identification (ID) number;

(vii) Transporting agency ID and unit number;

(viii) Transporting agency patient care report number;

(ix) Cause of injury;

(x) Incident county code;

(xi) Work related;

(xii) Use of safety equipment;

(xiii) Procedures performed.

(d) Prehospital vital signs data elements (from first EMS agency on scene) must include:

(i) Time;

(ii) First systolic blood pressure;

(iii) First respiratory rate;

(iv) First pulse rate;

(v) First oxygen saturation;

(vi) First GCS with individual component values (eye, verbal, motor, total, and qualifiers);

(vii) Intubated at time of first vital sign assessment;
(viii) Pharmacologically paralyzed at time of first vital sign assessment;
(ix) Extrication.
(e) Transportation data elements must include:
(i) Date and time unit dispatched;
(ii) Time unit arrived at scene;
(iii) Time unit left scene;
(iv) Transportation mode;
(v) Transferred in from another facility;
(vi) Transferring facility ID number.
(f) Emergency department (ED) data elements must include:
(i) Readmission;
(ii) Direct admit;
(iii) Time ED physician was called;
(iv) Time ED physician was available for patient care;
(v) Trauma team activated;
(vi) Level of trauma team activation;
(vii) Time of trauma team activation;
(viii) Time trauma surgeon was called;
(ix) Time trauma surgeon was available for patient care;
(x) Vital signs in ED, which must also include:
(A) First systolic blood pressure;
(B) First temperature;
(C) First pulse rate;
(D) First spontaneous respiration rate;
(E) Controlled rate of respiration;
(F) First oxygen saturation measurement;
(G) Lowest systolic blood pressure (SBP);
(H) GCS score with individual component values (eye, verbal, motor, total, and qualifiers);
(I) Whether intubated at time of ED GCS;
(J) Whether pharmacologically paralyzed at time of ED GCS;
(K) Height;
(L) Weight;
(M) Whether mass casualty incident disaster plan implemented.
(xi) Injury scores must include:
(A) Injury severity score;
(B) Revised trauma score on admission;
(C) Pediatric trauma score on admission;
(D) Trauma and injury severity score.
(xii) ED procedures performed;
(xiii) Blood and blood components administered;
(xiv) Date and time of ED discharge;
(xv) ED discharge disposition, including:
(A) If transferred, ID number of receiving hospital;
(B) Was patient admitted to hospital?
(C) If admitted, the admitting service;
(D) Reason for transfer (sending facility).
(g) Diagnostic and consultative data elements must include:
(i) Whether the patient received aspirin in the four days prior to the injury;
(ii) Whether the patient received any oral antiplatelet medication in the four days prior to the injury, such as clopidogrel (Plavix), or other antiplatelet medication, and, if so, include:
(A) Whether the patient received any oral anticoagulation medication in the four days prior to the injury, such as warfarin

(Coumadin), dabigatran (Pradaxa), rivaroxaban (Xarelto), or other anticoagulation medication, and, if so, include:

(B) The name of the anticoagulation medication.

(iii) Date and time of head computed tomography scan;

(iv) Date and time of first international normalized ratio (INR) performed at the reporting trauma service;

(v) Results of first INR performed at the reporting trauma service;

(vi) Date and time of first partial thromboplastin time (PTT) performed at the reporting trauma service;

(vii) Results of first PTT performed at the reporting trauma service;

(viii) Whether any attempt was made to reverse anticoagulation at the reporting trauma service;

(ix) Whether any medication (other than Vitamin K) was first used to reverse anticoagulation at the reporting trauma service;

(x) Date and time of the first dose of anticoagulation reversal medication at the reporting trauma service;

(xi) Elapsed time from ED arrival;

(xii) Date of rehabilitation consult;

(xiii) Blood alcohol content;

(xiv) Toxicology results;

(xv) Whether a brief substance abuse assessment, intervention, and referral for treatment done at the reporting trauma service;

(xvi) Comorbid factors/preexisting conditions;

(xvii) Hospital events.

(h) Procedural data elements:

(i) First operation information must include:

(A) Date and time operation started;

(B) Operating room (OR) procedure codes;

(C) OR disposition.

(ii) For later operations information must include:

(A) Date and time of operation;

(B) OR procedure codes;

(C) OR disposition.

(i) Admission data elements must include:

(i) Date and time of admission order;

(ii) Date and time of admission or readmission;

(iii) Date and time of admission for primary stay in critical care unit;

(iv) Date and time of discharge from primary stay in critical care unit;

(v) Length of readmission stay(s) in critical care unit;

(vi) Other in-house procedures performed (not in OR).

(j) Disposition data elements must include:

(i) Date and time of facility discharge;

(ii) Most recent ICD diagnosis codes/discharge codes, including nontrauma diagnosis codes;

(iii) Disability at discharge (feeding/locomotion/expression);

(iv) Total ventilator days;

(v) Discharge disposition location;

(vi) If transferred out, ID of facility the patient was transferred to;

(vii) If transferred to rehabilitation, facility ID;

(viii) Death in facility.

(A) Date and time of death;

(B) Location of death;

(C) Autopsy performed;
(D) Organ donation requested;
(E) Organs donated.
(ix) End-of-life care and documentation;
(A) Whether the patient had an end-of-life care document before injury;
(B) Whether there was any new end-of-life care decision documented during the inpatient stay at the reporting trauma service;
(C) Whether the patient receive a consult for comfort care, hospice care, or palliative care during the inpatient stay at the reporting trauma service;
(D) Whether the patient received any comfort care, in-house hospice care, or palliative care during the inpatient stay (i.e., was acute care withdrawn) at the reporting trauma service;
(k) Financial information must include:
(i) Total billed charges;
(ii) Payer sources (by category);
(iii) Reimbursement received (by payer category).
(6) Designated trauma rehabilitation services must provide the following data upon request by the department for patients identified in WAC 246-976-420(3).
(a) Data submission elements will be based on the current inpatient rehabilitation facility patient assessment instrument (IRF-PAI). All individual data elements included in the IRF-PAI categories below and defined in the data dictionary must be submitted upon request:
(i) Identification information;
(ii) Payer information;
(iii) Medical information;
(iv) Function modifiers (admission and discharge);
(v) Functional measures (admission and discharge);
(vi) Discharge information;
(vii) Therapy information.
(b) In addition to IRF-PAI data elements each rehabilitation service must submit the following information to the department:
(i) Admit from (facility ID);
(ii) Payer source (primary and secondary);
(iii) Total charges;
(iv) Total remitted reimbursement.

[Statutory Authority: RCW 43.70.040 and 70.168.090. WSR 24-15-130, § 246-976-430, filed 7/23/24, effective 9/30/24. Statutory Authority: RCW 70.168.060, 70.168.070, and 70.168.090. WSR 19-07-040, § 246-976-430, filed 3/14/19, effective 4/14/19. Statutory Authority: RCW 70.168.060 and 70.168.090. WSR 14-19-012, § 246-976-430, filed 9/4/14, effective 10/5/14; WSR 09-23-083, § 246-976-430, filed 11/16/09, effective 12/17/09; WSR 02-02-077, § 246-976-430, filed 12/31/01, effective 1/31/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-430, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-430, filed 12/23/92, effective 1/23/93.]