

# ***PATIENT CARE PROCEDURES***

**Northwest Regional Emergency Medical Services & Trauma Care Council**



*REVISED By:*

*Northwest Region EMS & Trauma Care Council Training Education & Development Committee*

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## **INTRODUCTION**

The Northwest Region's Patient Care Procedures are designed to serve as a guide to Medical Program Directors, trauma verified EMS agencies, 9-1-1 centers and EMS personnel as to how and when to activate the Northwest Region's Trauma System. These procedures apply to Clallam, Jefferson, Kitsap and Mason Counties.

The following Regional Patient Care Procedures are intended as an approach toward the rapid treatment of major trauma patients in the Northwest Region.

## **OBJECTIVE OF THE TRAUMA SYSTEM**

The objective of the Northwest Region EMS & Trauma System is to identify and transport patients, based on medical need, to the most appropriate hospital facility in an expedient manner.

Major trauma patients from the following categories are considered at high risk for morbidity and mortality therefore need immediate transfer or transport to the appropriate Level I or Level II trauma center.

### ***Central Nervous System Injuries***

Head injury with any of the following:

- Open, penetrating, or depressed skull fracture
- CSF leak
- Severe coma
- Deterioration in Glasgow Coma Score of 2 or more points
- Lateralizing signs
- Unstable spine
- Spinal cord injury

### ***Chest***

Suspected great vessel or cardiac injuries

Major chest wall injury

Patient who may require positive pressure ventilation

### ***Pelvis***

Pelvic ring disruption with shock requiring more than 5 units transfusion

Evidence of continued hemorrhage

Compound/open pelvic injury with head injury

### ***Multiple System Injury***

Severe facial injury with head injury

Chest injury with head injury

Abdominal or pelvic injury with head injury

Burns with head injury

### ***Specialized Problems***

Burns over 20 percent of the patient's body surface area involving airway

Carbon monoxide poisoning

Barotrauma

## **OBJECTIVE OF THE TRAUMA SYSTEM (continued)**

### ***Secondary Deterioration (Late Sequelae)***

Patient requiring mechanical ventilation

Sepsis

Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation system(s))

Osteomyelitis

EMT's and/or Paramedics shall use the State of Washington's Prehospital Trauma Triage (Destination) Procedures [Addendum 1] and be knowledgeable of the steps required to activate the Trauma System. In general, major trauma patients who meet the major trauma criteria listed above should be immediately transported or transferred to Harborview Medical Center in Seattle.

## **ACTIVATION OF TRAUMA SYSTEM**

Upon evaluation of the patient(s) and determination of the need for a trauma team, the Paramedic, EMT, or appropriate medical personnel shall contact medical control at the nearest or most appropriate designated trauma center and request the activation of the Trauma System.

Once identified, trauma patients should be banded, treated, transported and trauma data collected as quickly as possible. In all cases, the goal of the Northwest Region Trauma System is to have all trauma patients delivered to the most appropriate medical receiving facility within 60 minutes from the time of arrival of EMS on scene of the trauma incident.

## **DESIGNATED TRAUMA CENTERS**

Washington State Department of Health has designated five trauma centers in the Northwest Region to receive major trauma patients.

Those trauma centers and their designation levels are:

<b><u>Location</u></b>	<b><u>Facility</u></b>	<b><u>Level</u></b>
Clallam County	Forks Community Hospital	IV
	Olympic Medical Center	III
Jefferson County	Jefferson Health Care	IV
Kitsap County	Harrison Medical Center Bremerton	III
Mason County	Mason General Hospital	IV

## DATA COLLECTION

### WAC 246-976-420 Trauma registry -- Department responsibilities.

- (1) **Purpose:** The department maintains a trauma registry, as required by RCW [70.168.060](#) [Addendum 2] and [70.168.090](#)[Addendum 3]. The purpose of this registry is to:
  - (a) Provide data for injury surveillance, analysis, and prevention programs;
  - (b) Monitor and evaluate the outcome of care of major trauma patients, in support of statewide and regional quality assurance and system evaluation activities;
  - (c) Assess compliance with state standards for trauma care;
  - (d) Provide information for resource planning, system design and management;
  - (e) Provide a resource for research and education.
- (2) **Confidentiality:** It is essential for the department to protect information regarding specific patients and providers. Data elements related to the identification of individual patient's, provider's, and facility's care outcomes shall be confidential, shall be exempt from RCW [42.17.250](#) through [42.17.450](#), and shall not be subject to discovery by subpoena or admissible as evidence.
  - (a) The department may release confidential information from the trauma registry in compliance with applicable laws and regulations. No other person may release confidential information from the trauma registry without express written permission from the department.
  - (b) The department may approve requests for trauma registry data from qualified agencies or individuals, consistent with applicable statutes and rules. The department may charge reasonable costs associated with such requests.
  - (c) The data elements indicated as confidential in Tables E, F and G below are considered confidential.
  - (d) The department will establish criteria defining situations in which additional registry information is confidential, in order to protect confidentiality for patients, providers, and facilities.
  - (e) This paragraph does not limit access to confidential data by approved regional quality assurance programs established under chapter [70.168](#) RCW and described in WAC [246-976-910](#).
- (3) **Inclusion criteria:**
  - (a) The department will establish inclusion criteria to identify those injured patients that designated trauma services must report to the trauma registry.

These criteria will include:

    - (i) All patients who were discharged with ICD diagnosis codes of 800.0 - 904.99, 910 - 959.9 (injuries), 994.1 (drowning), 994.7 (asphyxiation), or 994.8 (electrocution) and:
      - (A) For whom the hospital trauma resuscitation team was activated; or
      - (B) Who were dead on arrival at your facility; or
      - (C) Who were dead at discharge from your facility; or
      - (D) Who were transferred by ambulance into your facility from another facility; or
      - (E) Who were transferred by ambulance out of your facility to another acute care facility; or
      - (F) Adult patients (age fifteen or greater) who were admitted as inpatients to your facility and have a length of stay greater than two days or forty-eight hours; or
      - (G) Pediatric patients (ages under fifteen years) who were admitted as inpatients to your facility, regardless of length of stay; or
    - (ii) All patients who meet the requirements of the state of Washington prehospital

trauma triage procedures described in WAC [246-976-930](#)(3);

(b) For all licensed rehabilitation services, these criteria will include all patients who were included in the trauma registry for acute care.

(4) **Other data:** The department and regional quality assurance programs may request data from medical examiners and coroners in support of the registry.

(5) **Data linking:** To link data from different sources, the department will establish procedures to assign a unique identifying number (trauma band number) to each trauma patient. All providers reporting to the trauma registry must include this trauma number.

(6) **Data submission:** The department will establish procedures and format for providers to submit data electronically. These will include a mechanism for the reporting agency to check data for validity and completeness before data is sent to the registry.

(7) **Data quality:** The department will establish mechanisms to evaluate the quality of trauma registry data. These mechanisms will include at least:

(a) Detailed protocols for quality control, consistent with the department's most current data quality guidelines.

(b) Validity studies to assess the timeliness, completeness and accuracy of case identification and data collection. The department will report quarterly on the timeliness, accuracy and completeness of data.

(8) **Registry reports:**

(a) Annually, the department will report:

(i) Summary statistics and trends for demographic and related information about trauma care, for the state and for each EMS/TC region;

(ii) Outcome measures, for evaluation of clinical care and system-wide quality assurance and quality improvement programs.

(b) Semiannually, the department will report:

(i) Trends, patient care outcomes, and other data, for each EMS/TC region and for the state, for the purpose of regional evaluation;

(ii) On all patient data entered into the trauma registry during the reporting period;

(iii) Aggregate regional data to the regional EMS/TC council, excluding any confidential or identifying data.

(c) The department will provide:

(i) Provider-specific raw data to the provider that originally submitted it;

(ii) Periodic reports on financial data;

(iii) Registry reports to all providers that have submitted data;

(iv) For the generation of quarterly reports to all providers submitting data to the registry, for the purpose of planning, management, and quality assurance.

### **WAC 246-976-430 Trauma registry -- Provider responsibilities.**

(1) Trauma care providers, prehospital and hospital, must place a trauma ID band on trauma patients, if not already in place from another agency.

(2) All trauma care providers must protect the confidentiality of data in their possession and as it is transferred to the department.

(3) All trauma care providers must correct and resubmit records which fail the department's validity tests described in WAC [246-976-420](#)(6). You must send corrected records to the department within three months of notification.

(4) Licensed prehospital services that transport trauma patients must:

(a) Assure personnel use the trauma ID band.

(b) Report data as shown in Table E for trauma patients defined in WAC [246-976-420](#). Data is to be reported to the receiving facility in an approved format within ten

days.

(5) Designated trauma services must:

- (a) Assure personnel use the trauma ID band.
- (b) Report data elements shown in Table F for all patients defined in WAC [246-976-420](#).
- (c) Report patients discharged in a calendar quarter in an approved format by the end of the following quarter. The department encourages more frequent data reporting.

(6) Designated trauma rehabilitation services must:

- (a) Report data on all patients who were included in the trauma registry for acute care.
- (b) Report either:
  - (i) Data elements shown in Table G; or
  - (ii) If the service submits data to the uniform data set for medical rehabilitation, provide a copy of the data to the department.

<b>TABLE E: Prehospital Data Elements for the Washington Trauma Registry</b>			
<b>Data Element</b>	<b>Type of patient</b>	<b>Pre-Hosp Transport</b>	<b>Inter-Facility</b>
Note: (C) identifies elements that are confidential. See WAC <a href="#">246-976-420</a> (2)(c).			
<b>Incident Information</b>			
Agency identification number (C)		X	X
Date of response (C - day only)		X	X
Run sheet number (C)		X	X
First agency on scene identification number (C)		X	
Level of personnel		X	X
Mode of transport		X	X
Incident county code		X	
Incident location (type)		X	
Incident response area type		X	
<b>Patient Information</b>			
Patient's trauma identification band number (C)		X	X
Name (C)		X	X
Date of birth (C), or Age		X	X
Sex		X	X
Mechanism of injury		X	
Safety restraint or device used		X	
<b>Transportation</b>			
Transported from (code) (C - if hospital ID)		X	X
Reason for destination decision		X	X

	Type of patient	Pre-Hosp Transport	Inter-Facility
<b>Times</b>			
Transporting agency dispatched		X	X
Transporting agency arrived at scene		X	X
Transporting agency departed from scene		X	X
<b>Vital Signs</b>			
Time		X	X
Systolic blood pressure		X	X
Respiratory rate		X	X
Pulse		X	X
Glasgow coma score (three components)		X	X
Pupils		X	X
Vitals from 1st agency on scene?		X	
<b>Trauma Triage Criteria</b>			
Vital signs, consciousness level		X	
Anatomy of injury		X	
Biomechanics of injury		X	
Other risk factors		X	
Gut feeling of medic		X	
Prehospital trauma system activation?		X	
<b>Other Severity Measures</b>			
Respiratory quality		X	
Consciousness		X	
Time (interval) for extrication		X	
<b>Treatment</b>			
EMS interventions		X	X

**TABLE F: Hospital Data Elements for the Washington Trauma Registry**

All licensed hospitals must submit the following data for patients identified in WAC [246-976-420\(3\)](#):

Note: (C) identifies elements that are confidential. See WAC [246-976-420\(2\)](#).

**Record Identification**

- Identification of reporting facility (C);
- Date and time of arrival at reporting facility (C - day only);
- Unique patient identification number assigned to the patient by the reporting facility (C);
- Patient's trauma identification band number (C);

**Patient Identification**

Name (C);  
Date of birth (C - day only);  
Sex;  
Race;  
Social Security number (C);  
Home zip code;

**Prehospital Incident Information**

Date and time of incident (C - day only);  
Prehospital trauma system activated?;  
First agency on-scene ID number;  
Arrival via EMS system?;  
Transporting (reporting) agency ID number;  
Transporting agency run number (C);  
Mechanism of injury;  
Respiratory quality;  
Consciousness;  
Incident county code;  
Incident location type;  
Response area type;  
Occupational injury?;  
Safety restraint/device used;

**Earliest Available Prehospital Vital Signs**

Time;  
Systolic blood pressure;  
Respiratory rate;  
Pulse rate;  
Glasgow coma score (three components);  
Pupils;  
Vitals from 1st on-scene agency?;  
Extrication time over twenty minutes?;  
Prehospital procedures performed;

**Prehospital Triage**

Vital signs/consciousness;  
Anatomy of injury;  
Biomechanics of injury;  
Other risk factors;  
Gut feeling of medic;

**Transportation Information**

Time transporting agency dispatched;  
Time transporting agency arrived at scene;  
Time transporting agency left scene;  
Transportation mode;  
Personnel level;  
Transported from;  
Reason for destination;

**ED or Admitting Information**

Time ED physician called;  
ED physician called "code"?;  
Time ED physician available for patient care;

Time trauma team activated;  
Level of trauma team activation;  
Time trauma surgeon called;  
Time trauma surgeon available for patient care;  
Vital Signs in ED

Patient dead on arrival at your facility?;  
First and last systolic blood pressure;  
First and last temperature;  
First and last pulse rate;  
First and last spontaneous respiration rate;  
Lowest systolic blood pressure;  
Glasgow coma scores (eye, verbal, motor);

**Injury Severity scores**

Prehospital Index (PHI) score;  
Revised Trauma Score (RTS) on admission;  
For pediatric patients:  
Pediatric Trauma Score (PTS) on admission;  
Pediatric Risk of Mortality (PRISM) score on admission;  
Pediatric Risk of Mortality - Probability of Survival (PRISM P(s));  
Pediatric Overall Performance Category (POPC);  
Pediatric Cerebral Performance Category (PCPC):

ED procedures performed;  
ED complications;  
Time of ED discharge;  
ED discharge disposition, including  
If admitted, the admitting service;  
If transferred out, ID of receiving hospital

**Diagnostic and Consultative Information**

Date and time of head CT scan;  
Date of physical therapy consult;  
Date of rehabilitation consult;  
Blood alcohol content;  
Toxicology screen results;  
Drugs found;  
Co-morbid factors/Preexisting conditions;

**Surgical Information**

For the first operation:  
Date and time patient arrived in operating room;  
Date and time operation started;  
OR procedure codes;  
For later operations:  
Date of operation  
OR Procedure Codes

**Critical Care Unit Information**

Date and time of admission for primary stay in critical care unit;  
Date and time of discharge from primary stay in critical care unit;  
Length of readmission stay(s) in critical care unit;

**Other procedures performed (not in OR)**

**Discharge Status**

Date and time of facility discharge (**C - day only**);

Most recent ICD diagnosis codes/discharge codes, including nontrauma codes;  
E-codes, primary and secondary;  
Glasgow Score at discharge;  
Disability at discharge (Feeding/Locomotion/Expression)

**Discharge disposition**

If transferred out, ID of facility patient was transferred to (C)

If patient died in your facility

Date and time of death (C - day only);

Was an autopsy done?;

Was case referred to coroner or medical examiner?

Did coroner or medical examiner accept jurisdiction?

Was patient evaluated for organ donation?

**Financial Information (All Confidential)**

For each patient

Total billed charges;

Payer sources (by category);

Reimbursement received (by payer category);

Annually, submit ratio-of-costs-to-charges, by department.

**TABLE G: Data Elements for Designated Rehabilitation Services**

Designated trauma rehabilitation services must submit the following data for patients identified in WAC [246-976-420\(3\)](#).

Note: (C) identifies elements that are confidential. WAC [246-976-420\(2\)](#)

**Rehabilitation services, Levels I and II**

**Patient Information**

Facility ID (C)

Facility Code

Patient Code

Trauma tag/identification Number (C)

Date of Birth (C - day only)

Social Security Number (C)

Patient Name (C)

Patient Sex

**Care Information**

Date of Admission (C - day only)

Admission Class

Date of Discharge (C - day only)

Impairment Group Code

ASIA Impairment Scale

**Diagnosis (ICD-9) Codes**

Etiologic Diagnosis

Other significant diagnoses

Complications/comorbidities

Diagnosis for transfer or death

**Other Information**

Date of onset

Admit from (Type of facility)  
Admit from (ID of facility)  
Acute trauma care by (ID of facility)  
Prehospital living setting  
Prehospital vocational category  
Discharge-to-living setting

**Functional Independence Measure (FIM) - One set on admission and one on discharge**

Self Care  
Eating  
Grooming  
Bathing  
Dressing - Upper  
Dressing - Lower  
Toileting  
Sphincter control  
Bladder  
Bowel  
Transfers  
Bed/chair/wheelchair  
Toilet  
Tub/shower  
Locomotion  
Walk/wheelchair  
Stairs  
Communication  
Comprehension  
Expression  
Social cognition  
Social interaction  
Problem solving  
Memory

**Payment Information (all confidential)**

Payer source - primary and secondary  
Total Charges  
Remitted reimbursement by category

**Rehabilitation, Level III**

**Patient Information**

Facility ID (C)  
Patient number (C)  
Trauma tag/identification Number (C)  
Social Security Number (C)  
Patient Name (C)

**Care Information**

Date of Admission (C - day only)

**Impairment Group Code**

**Diagnosis (ICD-9) Codes**

Etiologic Diagnosis  
Other significant diagnoses

Complications/co-morbidities

**Other Information**

Admit from (Type of facility)

Admit from (ID of facility) (C)

Acute trauma care given by (ID of facility) (C)

Inpatient trauma rehabilitation given by (ID of facility) (C)

Discharge-to-living setting

**Payment Information (all confidential)**

Payer source - primary and secondary

Total Charges

Remitted reimbursement by category

Data shall arrive at the DOH registry in an approved format no later than ninety days after the end of the quarter.

**DEFINITIONS**

**WAC 246-976-010 Definitions.** Definitions in RCW [18.71.200](#), [18.71.205](#), [18.73.030](#), and [70.168.015](#) apply to this chapter. In addition, unless the context plainly requires a different meaning, the following words and phrases used in this chapter mean:

**"ACLS"** means advanced cardiac life support, a course developed by the American Heart Association.

**"Activation of the trauma system"** means mobilizing resources to care for a trauma patient in accordance with regional patient care procedures. When the prehospital provider identifies a major trauma patient, using approved prehospital trauma triage procedures, he or she notifies both dispatch and medical control from the field.

**"Adolescence"** means the period of physical and psychological development from the onset of puberty to maturity, approximately twelve to eighteen years of age.

**"Advanced first aid,"** for the purposes of RCW [18.73.120](#), [18.73.150](#), and [18.73.170](#), means a course of at least twenty-four hours of instruction, which includes at least:

- CPR;
- Airway management;
- Trauma/wound care;
- Immobilization.

**"Agency response time"** means the interval from agency notification to arrival on the scene. It is the combination of activation and enroute times defined under system response times in this section.

**"Aid service"** means an agency licensed by the department to operate one or more aid vehicles, consistent with regional and state plans.

**"Airway technician"** means a person who:

- Has been trained in an approved program to perform endotracheal airway management and other authorized aids to ventilation under written or oral authorization of an MPD or approved physician delegate; and

- Has been examined and certified as an airway technician by the department or by the University of Washington's school of medicine

**"ALS"** means advanced life support.

**"Ambulance service"** means an agency licensed by the department to operate one or more ground or air ambulances. Ground ambulance service operation must be consistent with regional and state plans. Air ambulance service operation must be consistent with the state plan.

**"Approved"** means approved by the department of health.

**"ATLS"** means advanced trauma life support, a course developed by the American College of Surgeons.

**"Attending surgeon"** means a physician who is board-certified or board-qualified in general surgery, and who has surgical privileges delineated by the facility's medical staff. The attending surgeon is responsible for care of the trauma patient, participates in all major therapeutic decisions, and is present during operative procedures.

**"Available"** for designated trauma services described in WAC [246-976-485](#) through [246-976-890](#) means physically present in the facility and able to deliver care to the patient within the time specified. If no time is specified, the equipment or personnel must be available as reasonable and appropriate for the needs of the patient.

**"BLS"** means basic life support.

**"Basic life support"** means emergency medical services requiring basic medical treatment skills as defined in chapter [18.73](#) RCW.

**"Board certified"** means that a physician has been certified by the appropriate specialty board recognized by the American Board of Medical Specialties. For the purposes of this chapter, references to "board certified" include physicians who are board-qualified.

**"Board-qualified"** means physicians who have graduated less than five years previously from a residency program accredited for the appropriate specialty by the accreditation council for graduate medical education.

**"BP"** means blood pressure.

**"Certification"** means the department recognizes that an individual has met predetermined qualifications, and authorizes the individual to perform certain procedures.

**"CME"** means continuing medical education.

**"Consumer"** means an individual who is not associated with the EMS/TC system, either for pay or as a volunteer, except for service on the steering committee, licensing and certification committee, or regional or local EMS/TC councils.

**"Continuing medical education (CME)"** means ongoing education after initial certification to maintain and enhance skill and knowledge.

**"CPR"** means cardiopulmonary resuscitation.

**"Dispatch"** means to identify and direct an emergency response unit to an incident location.

**"E-code"** means external cause code, an etiology included in the International Classification of Diseases (ICD).

**"ED"** means emergency department.

**"Emergency medical services and trauma care (EMS/TC) system"** means an organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with a medical emergency or injury requiring immediate medical or surgical intervention to prevent death or disability. The emergency medical service and trauma care system includes prevention activities, prehospital care, hospital care, and rehabilitation.

**"EMS"** means emergency medical services.

**"EMS/TC"** means emergency medical services and trauma care.

**"EMT"** means emergency medical technician.

**"General surgeon"** means a licensed physician who has completed a residency program in surgery and who has surgical privileges delineated by the facility.

**"ICD"** means the international classification of diseases, a coding system developed by the World Health Organization.

**"ILS"** means intermediate life support.

**"Injury prevention"** means any combination of educational, legislative, enforcement, engineering and emergency response initiatives used to reduce the number and severity of injuries.

**"Interfacility transport"** means medical transport of a patient between recognized medical treatment facilities requested by a licensed health care provider.

**"Intermediate life support (ILS) technician"** means a person who:

- Has been trained in an approved program to perform specific phases of advanced cardiac and trauma life support as specified in this chapter, under written or oral direction of an MPD or approved physician delegate; and
- Has been examined and certified as an ILS technician by the department or by the University of Washington's school of medicine.

**"Intravenous therapy technician"** means a person who:

- Has been trained in an approved program to initiate IV access and administer intravenous solutions under written or oral authorization of an MPD or approved physician delegate; and
- Has been examined and certified as an intravenous therapy technician by the department or by

the University of Washington's school of medicine.

**"IV"** means intravenous.

**"Licensing and certification committee (L&C committee)"** means the emergency medical services licensing and certification advisory committee created by RCW [18.73.040](#).

**"Local council"** means a local EMS/TC council authorized by RCW [70.168.120\(1\)](#).

**"Local medical community"** means the organized local medical society existing in a county or counties; or in the absence of an organized medical society, majority physician consensus in the county or counties.

**"Medical control"** means MPD authority to direct the medical care provided by certified EMS personnel in the prehospital EMS system.

**"Medical control agreement"** means a written agreement between two or more MPDs, using similar protocols that are consistent with regional plans, to assure continuity of patient care between counties, and to facilitate assistance.

**"MPD"** means medical program director.

**"Must"** means shall.

**"Ongoing training and evaluation program"** or "ongoing training and evaluation program or "OTEP" or "OTEP program" or "OTEP method" is a program of education for EMS personnel that is approved by the MPD and the department to meet the education requirements and core topic content for recertification. OTEP includes cognitive, affective and psychomotor evaluations following completion of each topic presentation to determine student competence of topic content.

**"PALS"** means pediatric advanced life support, a course developed by the American Heart Association.

**"Paramedic"** means a person who:

- Has been trained in an approved program to perform all phases of prehospital emergency medical care, including advanced life support, under written or oral authorization of an MPD or approved physician delegate; and
- Has been examined and certified as a paramedic by the department or by the University of Washington's school of medicine.

**"Pediatric education requirement" or "PER"** means the pediatric education and training standards required for certain specialty physicians and nurses who care for pediatric patients in designated trauma services as identified in WAC 246-976-886 and 246-976-887.

**"Physician"** means an individual licensed under the provisions of chapters [18.71](#) or [18.57](#) RCW.

**"Physician with specific delineation of surgical privileges"** means a physician with surgical privileges delineated for emergency/life-saving surgical intervention and stabilization of a trauma

patient prior to transfer to a higher level of care. Surgery privileges are awarded by the facility's credentialing process.

**"Postgraduate year"** means the classification system for residents who are undergoing postgraduate training. The number indicates the year the resident is in during his/her post medical school residency program.

**"Practical skills examination"** means a test conducted in an initial course, or a test or series of evaluations during a recertification period, to determine competence in each of the practical skills specified by the department.

**"Prehospital agencies"** means providers of prehospital care or interfacility ambulance transport.

**"Prehospital index"** means a scoring system used to activate a hospital trauma resuscitation team.

**"Prehospital patient care protocols"** means the written procedures adopted by the MPD under RCW [18.73.030](#)(13) and [70.168.015](#) (26) which direct the out-of-hospital emergency care of the emergency patient which includes the trauma care patient. These protocols are related only to delivery and documentation of direct patient treatment.

**"Prehospital trauma care services"** means agencies that are verified to provide prehospital trauma care.

**"Prehospital trauma triage procedures"** means the method used by prehospital providers to evaluate injured patients and determine whether to activate the trauma system from the field. It is described in WAC [246-976-930](#)(2).

**"Public education"** means education of the population at large, targeted groups or individuals, in preventive measures and efforts to alter specific injury-related behaviors.

**"Quality assurance (QA)"** means an organized quality assessment and improvement program to audit and evaluate care provided in EMS/TC systems, with the goal of improving patient outcomes.

**"Regional council"** means the regional EMS/TC council established by RCW [70.168.100](#).

**"Regional patient care procedures (RPCP)"** means procedures adopted by a regional council under RCW [18.73.030](#)(14) and [70.168.015](#) (23), and approved by the department. Regional patient care procedures do not relate to direct patient care.

**"Regional plan"** means the plan defined in WAC [246-976-960](#) (1)(b) that has been approved by the department.

**"Registered nurse"** means an individual licensed under the provisions of chapter [18.79](#) RCW.

**"Response area"** means a service coverage zone identified in an approved regional plan.

**"Rural"** means unincorporated or incorporated areas with total populations less than ten thousand people, or with a population density of less than one thousand people per square mile.

**"Senior EMT instructor (SEI)"** means an individual approved to be responsible for the quality of instruction and the conduct of basic life support training courses.

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

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

**"Specialized training"** means approved training of certified EMS personnel to use a skill, technique, or equipment that is not included in the standard course curriculum.

**"State plan"** means the emergency medical services and trauma care system plan described in RCW [70.168.015\(7\)](#), adopted by the department under RCW [70.168.060\(10\)](#).

**"Steering committee"** means the EMS/TC steering committee created by RCW [70.168.020](#).

**"Suburban"** means an incorporated or unincorporated area with a population of ten thousand to twenty-nine thousand nine hundred ninety nine or any area with a population density of one thousand to two thousand people per square mile.

**"System response time"** for trauma means the interval from discovery of an injury until the patient arrives at a designated trauma facility. It includes:

"Discovery time": The interval from injury to discovery of the injury;

"System access time": The interval from discovery to call received;

"911 time": The interval from call received to dispatch notified, including the time it takes the call answerer to:

- Process the call, including citizen interview; and
- Give the information to the dispatcher

"Dispatch time": The interval from call received by the dispatcher to agency notification;

• "Activation time": The interval from agency notification to start of response;

• "Enroute time": The interval from the end of activation time to the beginning of on-scene time;

• "Patient access time": The interval from the end of enroute time to the beginning of patient care;

• "On scene time": The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;

• "Transport time": The interval from leaving the scene to arrival at a health care facility;

**"Training agency"** means an organization or individual that is approved to be responsible for specified aspects of training of EMS personnel.

**"Training physician"** means a physician delegated by the MPD and approved by the department to be responsible for specified aspects of training of EMS personnel.

**"Trauma rehabilitation coordinator"** means a person designated to facilitate early rehabilitation interventions and the trauma patient's access to a designated rehabilitation center.

**"Urban"** means:

- An incorporated area over thirty thousand; or
- An incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square mile.

**"Wilderness"** means any rural area not readily accessible by public or private maintained road.

## **PATIENT CARE PROCEDURE – Dispatch**

### ***Standard***

Provide timely care to all trauma patients so major trauma patients are provided appropriate medical treatment within the “golden hour” of trauma treatment.

As outlined in the Regional Trauma System Plan, “Dispatch Time” is defined as “the time from when the call is received by dispatch to the time the agency is notified” (WAC 246-976-010) [See Definitions].

As outlined in the Regional Trauma System Plan, “Response Time” is measured from “the time the call is received by the trauma verified service to the time of arrival on-scene”.

For major trauma patients, the following time guidelines are to be used (measured from the time the call is received by the trauma verified service to the time of arrival on-scene):

#### First Response (80 percent of the time)

Urban Areas	8 minutes
Suburban Areas	15 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

#### Transport Response Time (80 percent of the time)

Urban Areas	10 minutes
Suburban Areas	20 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

### ***Procedure***

A licensed ambulance and/or aid service shall be dispatched to all emergency and trauma incidents in the Northwest Region.

The highest level trauma verified ambulance in the response area should be dispatched to transport all known or suspected major trauma patients who meet, or are suspected to meet, the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1].

## **PATIENT CARE PROCEDURE – Response Times**

### ***Standard***

All licensed ambulance and aid services shall respond to emergency medical and trauma incidents in a timely manner in accordance with the Northwest Region Plan and State WAC 246-976-390(10) [Addendum 4] and WAC 246-976-390(11) -Verification of Trauma Care Services [Addendum 5].

The Northwest Region EMS Council has identified the following urban, suburban, rural-suburban, rural and wilderness/marine/frontier areas response times in the Northwest Region Trauma Plan.

#### First Response (80 percent of the time)

Urban Areas	8 minutes
Suburban Areas	15 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

#### Transport Response Time (80 percent of the time)

Urban Areas	10 minutes
Suburban Areas	20 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

### ***Procedure***

In all major trauma cases, the Golden Hour shall be a dispatch/response/transport goal whenever possible.

A trauma verified service should proceed in an emergency mode to all suspected major trauma incidents until which time they have been advised of injury status to the patients involved.

## **PATIENT CARE PROCEDURE – Triage and Transport**

### ***Standard***

All licensed ambulance/transport and aid services shall comply with the Northwest Region EMS & Trauma System Plan, Simple Triage and Rapid Treatment (START Triage) Protocol [Appendix 6] and the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1] and transport trauma patients to the most appropriate designated trauma center.

When a destination facility is placed on divert status, field personnel shall transport to the next closest – equal or higher designated trauma facility.

### ***Procedure***

The first trauma care providing agency to determine that the patient needs definitive medical care or meets the State of Washington Trauma Triage (Destination) Procedures [Addendum 1] criteria, shall ensure immediate contact with a Level I or Level II trauma designated facility or the agency's on-line medical control.

The receiving facility must be provided with the following information, as outlined in the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1]:

1. Identification of the EMS agency;
2. Patient's age, if known (or approximate age);
3. Patient's chief complaint(s) or problem;
4. Identification of the biomechanics and anatomy of the injury;
5. Basic vital signs (palpable pulse, where palpable, and rate of respiration);
6. Level of consciousness (Glasgow Coma Score or other means);
7. Other factors that require consultation with the base station;
8. Number of patients (if known); and
9. Estimated time of transport of the patient(s) to the nearest and highest level of trauma designated facility.
10. Estimated time of transport of the patient(s) from the scene to the nearest Level I or II facility

The first EMS person to determine that a patient meets the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1] criteria shall attach a Washington State Trauma Registry Band to the patient's wrist or ankle.

An air ambulance transport should be considered for transport by agencies in the Northwest Region when transport by ground will be greater than 30 minutes, unless weather conditions do not allow for such use, as outlined in the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1].

## **PATIENT CARE PROCEDURE – Transport guidelines**

### ***Standard***

All EMS Agencies should follow their Medical Program Director's patient care protocols and /or guidelines for the care and transport of medical and non-major trauma patients. If it is unclear as to where a medical or non-major trauma patient should be transported, contact medical control at your nearest resource hospital for directions; otherwise follow off-line medical control of patients as outlined in your standing orders, patient care protocols, and/or guidelines provided by your Medical Program Director. For the care and transport of identified Major trauma patients EMS Agencies should use the most current State of Washington Prehospital Trauma Triage (Destination) Procedures according to the Department of Health [Addendum 1].

### ***Procedure***

MPD's, in the development of their patient care protocols and/or guidelines for the care and transport of medical and non-major trauma patients, who do not meet State of Washington Prehospital trauma Triage (Destination) Procedures shall consider:

- A. Patient's desire or choice of medical facility within the region as to where they want to be transported and/or treated. Or, In the case of an unconscious patient, the wishes of the patient's family or personal physician.
- B. The type of treatment and the ability of a receiving hospital to treat such medical or non-major trauma (i.e., high risk OB patients, potential ICU/CCU patients, unstable co-morbid medical patients, etc.).
- C. Level, severity, and type of injuries.
- D. Ability of the receiving hospital to adequately treat the medical or non-major trauma patient.

In all cases, unless proper medical care and resources dictate otherwise, the choice of the patient is paramount in the development of standing orders, patient care protocols, and/or guidelines for EMS transport agencies.

## **DATA COLLECTION**

Trauma verified ambulance and aid services shall collect and leave documentation in the form of Northwest Region approved MIR forms or approved electronic computer submission to the Hospital the patient was transported.

## **PATIENT CARE PROCEDURE – Interfacility Transport**

### ***Standard***

All designated trauma facilities shall have transfer agreements for the identification and transfer of trauma patients.

All interfacility transfers shall be in compliance with current OBRA/COBRA and EMTALA regulations and must be consistent with RCW 70.170.060(2) [Addendum 7].

### ***Procedure***

This is part of the Trauma Center Designation process and is addressed in the designation application process. The Northwest Region will use the procedures outlined by each facility in their designation application.

## **Interfacility transfer of A major Trauma Patient**

When a major trauma patient must be transferred from a lower level Trauma Center to a higher level center (Level IV to Level I, for example), the transferring physician must contact the receiving physician who must accept the transfer of the patient prior to the patient leaving the sending facility.

The transferring physician and facility will ensure the appropriate level of care during transport of the major trauma patient to the receiving Trauma Center.

The receiving facility must accept or be available to accept the major trauma patient prior to the patient leaving the sending facility.

The receiving facility will be given the following information on the patient by fax, phone, or other appropriate means:

- a. Brief History
- b. Pertinent physical
- c. Summary of any treatment done prior to the transfer
- d. Response to therapy and current condition

All appropriate documentation must be available at the receiving facility upon arrival of the patient to the receiving facility (it may be sent with the patient, faxed to the hospital, or relayed by other appropriate means).

The transferring physician's orders shall be followed during transport. Should the patient's condition change during transport the pre-determined on-line or off-line medical control for the transporting agency shall be utilized.

Further orders may be given by the receiving physician.

MPD approved protocols should be followed during transport, unless direct medical orders by the sending or receiving physician are given to the contrary.

All ground interfacility transports must be conducted by a trauma-verified service for trauma system patients.

### **PATIENT CARE PROCEDURE – *Transport of Patients Outside of Base Area***

#### ***Standard***

All licensed ambulance and aid services shall comply with the Northwest Region EMS & Trauma System Plan and the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1] as defined in WAC 246-976-390 - Verification of Trauma Care Services [Addendum 4] and transport trauma patients to the most appropriate designated trauma center or facility.

#### ***Procedure***

Patients transferred out of any local base coverage area (from either the base hospital or the field) are initially the responsibility of local on-line medical control. Prehospital personnel will follow local prehospital protocols. Initial orders, which are consistent with local prehospital protocols, will be obtained from base station on-line medical control.

When the transport service crosses into destination jurisdiction, the destination on-line medical control shall be contacted and given the following information:

1. Brief history
2. Pertinent physical findings
3. Summary of treatment (per protocols and per orders from base medical control)
4. Response to treatment
5. Current condition

The destination medical control physician may add further orders provided they are within the capabilities of the transport personnel.

The nearest trauma center base station will be contacted during the transport should the patient's condition deteriorate and/or assistance is needed. The transport unit may divert to the closest trauma center as dictated by the patient's condition.

### **PATIENT CARE PROCEDURE – *Activation of Air Ambulance for Field Response to Major Trauma***

#### ***Standard***

All licensed ambulance and aid services shall comply with the Northwest Region EMS & Trauma System Plan and the State of Washington Prehospital Trauma Triage (Destination) Procedures as defined in WAC 246-976-390 - Verification of Trauma Care Services [Addendum 5] and transport trauma patients to the most appropriate designated trauma center or facility.

#### ***Procedure***

The decision to activate air ambulance service for field response to major trauma shall be made by the highest certified responder from the scene with on-line medical control consultation. Where Incident Command System (ICS) is used, the commander shall be an integral part of this process.

Air ambulance services requested to respond into the Northwest Region will follow their policies for accepting a field mission and their Rotary Wing Primary Service Area criteria [Addendum 8].

## **REGIONAL CARE OF THE CRITICALLY ILL AND INJURED CHILD - Triage and Transfer Guidelines**

(Adopted by the Governor's EMS & Trauma Care Steering Committee on July 19, 1995)

*Consideration should be given to early transfer of a child to the regional pediatric trauma center when required surgical or medical subspecialty care of resources are unavailable. These include, but are not limited to the following:*

1. **Hemodynamically stable children with documented visceral injury being considered for "observational" management.** Although the efficacy of this approach in selected cases has been well documented, two significant caveats always apply:
  - a) Hemodynamic *instability* mandates immediate operative intervention, and
  - b) Non-operative care is safe only in an environment that provides both close clinical observation *by a surgeon* experienced in the management of childhood trauma and immediately available operative care.
2. **Children with abnormal mental status.** In all but the infant, outcome from closed head injury has been shown to be significantly better for the child than for the adult. Although the quality and timeliness of initial resuscitation are the most important *determinants of outcome* from brain injury, continued comprehensive management in specialized units with multi-disciplinary pediatric critical care teams may provide a more rapid and complete recovery.
3. **Infants and small children.** Severely injured infants and small children are the most vulnerable and, frequently, the least stable trauma victims, because they require the special resources and environment of a regional pediatric trauma center, transfer should occur as soon as safely feasible.
4. **Children with injuries requiring complex or extensive reconstruction.** These services are traditionally most available in hospitals capable of functioning as a regional pediatric trauma center. It is especially important that children with impairments requiring long-term follow-up and supportive care have this provided or at least coordinated by the regional pediatric trauma center. Longitudinal follow-up of the injury-related disability is an essential requirement of the regional pediatric trauma center's trauma registry.
5. **Children with polysystem trauma requiring organ system support.** This is especially important for those patients requiring ventilatory, cardiovascular, renal, or nutritional support. Because these problems usually occur synchronously and require precise interdisciplinary coordination, they are best managed in comprehensive facilities such as regional pediatric trauma centers.

*After airway management and primary resuscitation, consider the following points for transfer guidelines. A collaborative discussion is required between the transferring and receiving attending physicians.*

1. Altered level of consciousness, mental status or declining trauma score (after primary resuscitation and airway management);
2. Head injury requiring CT Scan and/or neurosurgical consultation, for example: with lateralizing signs, seizures, loss of consciousness;
3. Major thoracic injury, e.g.: hemothorax, pulmonary contusion, possible great vessel injury, cardiac tamponade, flail chest;
4. Inability to evaluate abdomen due to mental status or lack of resources such as CT or peritoneal lavage;
5. Suspicion of foreign body in lower airway or main stem bronchi;
6. Unstable spinal fracture, suspected or actual spinal cord injury;
7. Primary accidental hypothermia with core temperature of 32 degrees C or less; or hypothermia with multi-system injury and core temperature of 34 degrees C or less;
8. High risk fractures such as: pelvic fracture, long bone injuries with neurovascular involvement (compromise);
9. Significant penetrating injuries to head, neck, thorax, abdomen or pelvis;
10. Need for mechanical ventilation;
11. Evidence of onset of organ failure, for example: acute respiratory distress syndrome, cardiac, renal or hepatic failure;
12. Cardiac dysrhythmias, cardiac pacing, supraventricular tachycardia, or continuous infusion of one or more inotropic or cardiovascular agents, need for invasive monitoring;
13. Near drowning or asphyxiation with deteriorating mental status or progressive respiratory distress;
14. Burns of greater than 15% of the body (20% of age 10 or greater), 2<sup>nd</sup> degree or greater involving:
  - a. The face, mouth and throat;
  - b. Singed nasal hair;
  - c. Brassy or sooty cough;
  - d. Deep or excessive burns of the hands, feet, joints and/or perineum;
  - e. Electrical injury (including lightning); and/or
  - f. Chemical burns with threat of functional or cosmetic compromise.  
Should be transferred to a Regional Burn Center.

Referral to these centers must be protocol-driven and continuously monitored by the quality improvement process. Access to such care must be expeditious and must reflect ONLY medical need.

Adopted from: Resources for Equal Care of the Injured Patient: 1993  
Committee on Trauma: American College of Surgeons

## ADDENDUM 1

### STATE OF WASHINGTON PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURE

#### Purpose

The purpose of the Triage Procedure is to ensure that major trauma patients are transported to the most appropriate hospital facility. This procedure has been developed by the Prehospital Technical Advisory Committee (TAC), endorsed by the Governor's EMS and Trauma Care Steering Committee, and in accordance with RCW 70.168 and WAC 246-976 adopted by the Department of Health (DOH).

The procedure is described in the schematic with narrative. Its purpose is to provide the prehospital provider with quick identification of a major trauma victim. If the patient is a major trauma patient, that patient or patients must be taken to the highest level trauma facility within 30 minutes transport time, by either ground or air. To determine whether an injury is major trauma, the prehospital provider shall conduct the patient assessment process according to the trauma triage procedures.

#### Explanation of Process

A. **Any certified EMS and Trauma person can identify a major trauma patient and activate the trauma system.** This may include requesting more advanced prehospital services or aero-medical evacuation.

B. **The first step (1) is to assess the vital signs and level of consciousness.** The words "Altered mental status" mean anyone with an altered neurologic exam ranging from completely unconscious, to someone who responds to painful stimuli only, or a verbal response which is confused, or an abnormal motor response.

The "and/or" conditions in Step 1 mean that any one of the entities listed in Step 1 can activate the trauma system.

Also, the asterisk (\*) means that if the airway is in jeopardy and the on-scene person cannot effectively manage the airway, the patient should be taken to the nearest medical facility or consider meeting up with an ALS unit. These factors are true regardless of the assessment of other vital signs and level of consciousness.

C. **The second step (2) is to assess the anatomy of injury.** The specific injuries noted require activation of the trauma system. Even in the assessment of normal vital signs or normal levels of consciousness, the presence of any of the specific anatomical injuries does require activation of the trauma system.

Please note that steps 1 and 2 also require notifying Medical Control.

D. **The third step (3) for the prehospital provider is to assess the biomechanics of the injury and address other risk factors.** The conditions identified are reasons for the provider to contact and consult with Medical Control regarding the need to activate the system. They do not automatically require system activation by the prehospital provider.

Other risk factors, coupled with a "gut feeling" of severe injury, means that Medical Control should be consulted and consideration given to transporting the patient to the nearest trauma facility.

Please note that certain burn patients (in addition to those listed in Step 2) should be considered for immediate transport or referral to a burn center/unit.

#### **Patient Care Procedures**

To the right of the attached schematic you will find the words "according to DOH-approved regional patient care procedures." These procedures are developed by the regional EMS and Trauma council in conjunction with local councils. They are intended to further define how the system is to operate. They identify the level of medical care personnel who participate in the system, their roles in the system, and participation of hospital facilities in the system. They also address the issue of inter-hospital transfer, by transfer agreements for identification, and transfer of critical care patients.

In summary, the Prehospital Trauma Triage Procedure and the Regional Patient Care Procedures are intended to work in a "hand in glove" fashion to effectively address EMS and Trauma patient care needs. By functioning in this manner, these two instruments can effectively reduce morbidity and mortality.

If you have any questions on the use of either instrument, you should bring them to the attention of your local or regional EMS and Trauma council or contact 1-800-458-5281.

1994/Disc 1/triage.exp

STATE OF WASHINGTON  
 PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURES  
 EFFECTIVE DATE 1/95

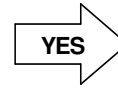
- Prehospital triage is based on the following 3 steps: **Steps 1 and 2 require prehospital EMS personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 is determined by medical control\*\***

**STEP 1**  
**ASSESS VITAL SIGNS & LEVEL OF CONSCIOUSNESS**

- Systolic BP <90\*
- HR >120\*
- \* for pediatric (<15y) pts. use BP <90 or capillary refill >2 sec.
- \* for pediatric (<15y) pts. use HR <60 or >120

**Any of the above vital signs associated with signs and symptoms of shock**  
 and/or

- Respiratory Rate <10 >29 associated with evidence of distress  
 and/or
- Altered mental status



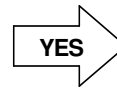
1. Take patient to the highest level trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.
2. Apply "Trauma ID Band" to patient.

\*\*If prehospital personnel are unable to effectively manage airway, consider rendezvous with ALS, or intermediate stop at nearest facility capable of immediate definitive airway management.



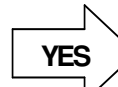
**STEP 2**  
**ASSESS ANATOMY OF INJURY**

- Penetrating injury of head, neck, torso, groin; OR
- Combination of burns ≥ 20% or involving face or airway; OR
- Amputation above wrist or ankle; OR
- Spinal cord injury; OR
- Flail chest; OR
- Two or more obvious proximal long bone fractures.



**STEP 3**  
**ASSESS BIOMECHANICS OF INJURY AND OTHER RISK FACTORS**

- Death of same car occupant; OR
- Ejection of patient from enclosed vehicle; OR
- Falls > 20 feet; OR
- Pedestrian hit at ≥ 20 mph or thrown 15 feet
- High energy transfer situation
  - Rollover
  - Motorcycle, ATV, bicycle accident
  - Extrication time of > 20 minutes
- Extremes of age <15 >60
- Hostile environment (extremes of heat or cold)
- Medical illness (such as COPD, CHF, renal failure, etc.)
- Second/third trimester pregnancy
- Gut feeling of medic



**CONTACT MEDICAL CONTROL FOR DESTINATION DECISION**



1. Take patient to the highest level trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.
2. Apply "Trauma ID Band" to patient



**TRANSPORT PATIENT PER REGIONAL PATIENT CARE PROCEDURES**

## ADDENDUM 2

***RCW 70.168.060 - Department duties – Timelines.*** The department, in consultation with and having solicited the advice of the Steering Committee shall:

- (16) By July 1991, design and establish the state-wide trauma care registry as authorized in RCW 70.168.090 to
  - (a) assess the effectiveness of emergency medical services and trauma care delivery, and
  - (b) modify standards and other system requirements to improve the provision of emergency medical services and trauma care

## ADDENDUM 3

***RCW 70.168.090 – State-wide data registry – Quality assurance program – Confidentiality.***

- (1) By July 1991, the department shall establish a state-side data registry to collect and analyze data on the incidence, severity, and causes of trauma, including traumatic brain injury. The department shall collect additional data on traumatic brain injury should additional data requirements be enacted by the legislature. The registry shall be used to improve the availability and delivery of prehospital and hospital trauma care services. Specific data elements of the registry shall be defined by rule by the department. To the extent possible, the department shall coordinate data collection from hospitals for the trauma registry with the state-wide hospital data system authorized in chapter 70.170 RCW. Every hospital, facility, or health care provider authorized to provide level I, II, III, IV, or V trauma care services, level I, II, or III pediatric trauma care services, level I, level I-pediatric, II or III trauma-related rehabilitative services, and prehospital trauma-related services in the state shall furnish data to the registry. All other hospitals and prehospital providers shall furnish trauma data as required by the department by rule.

The department may respond to requests for data and other information from the registry for special studies and analysis consistent with requirements for confidentiality of patient and quality assurance records. The department may require requestors to pay any or all of the reasonable costs associated with such requests that might be approved.

## ADDENDUM 4

***WAC 246-976-390 – Verification of trauma care services***

- (10) Verified aid services must meet the following minimum agency response times for all major trauma responses to response areas as defined by the department and identified in the regional plan:
  - (a) To urban response areas: Eight minutes or less, eighty percent of the time;
  - (b) To suburban response areas: Fifteen minutes or less, eighty percent of the time;
  - (c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
  - (d) To wilderness response areas: As soon as possible.

## ADDENDUM 5

### ***WAC 246-976-390 – Verification of trauma care services***

(11) Verified ground ambulance services must meet the following minimum agency response times for all major trauma responses to response areas as defined by the department and identified in the regional plan:

- (a) To urban response areas: Ten minutes or less, eighty percent of the time;
- (b) To suburban response areas: Twenty minutes or less, eighty percent of the time;
- (c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
- (d) To wilderness response areas: As soon as possible.

(12) Verified air ambulance services must meet minimum agency response times as identified in the state plan.

## ADDENDUM 6

### ***Simple Triage and Rapid Treatment Triage Protocol (START Triage)***

1. **RPM** method of identifying immediate patients:  
**R**espirations; **P**erfusion; **M**ental status
2. Triage Criteria
  - A. Immediate (RED)  
Respiration >30 per minute or absent until head repositioned, or radial pulse absent or capillary refill >2 seconds, or can not follow simple commands
  - B. Delayed (YELLOW)  
Respiration's present and <30 per minute, and radial pulse present and can follow simple commands ■ The saying is 30 – 2 – can do, represents a delayed patient
  - C. Minor (GREEN)  
Anyone that can get up and walk when you instruct them to do so
  - D. Deceased (BLACK)  
Anyone not breathing after you open the airway
3. This system is limited to use in the incident where needs exceed resources immediately available
4. Frequently reassess patients and perform a more in-depth triage as more rescuers become available

## ADDENDUM 7

### ***RCW 70.170.060 – Charity care – Prohibited and required hospital practices and policies***

(2) No hospital shall adopt or maintain practices or policies which would deny access to emergency care based on ability to pay. No hospital which maintains an emergency department shall transfer a patient with an emergency medical condition or who is in active labor unless the transfer is performed at the request of the patient or is due to the limited medical resources of the transferring hospital. Hospitals must follow reasonable procedures in making transfers to other hospitals including confirmation of acceptance of the transfer by the receiving hospital.

EMTALA federal guidelines will also be followed.