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Health, Department of

Trauma Program, Wyoming

Chapter 4: Facility Standards

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Chapter 4

FACILITY STANDARDS

Section 1. Regional Trauma Centers. To be designated a Regional Trauma Center (RTC), a licensed general acute care hospital shall have at least the following:

(a) Hospital Organization.

(i) Trauma Service. The trauma service shall be established and recognized by the medical staff and its bylaws and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service must come under the organization and direction of a general surgeon or emergency physician who is trained, experienced, and committed to the care of the injured patient. All patients with multiple system trauma or major injury must be evaluated by the trauma service. The surgeon or emergency physician responsible for the overall care of each patient must be specifically identified.

(ii) Trauma Program Director. The director must be a board certified surgeon or a board certified emergency physician with demonstrated competency in trauma care. The director shall develop a quality improvement process and, through this process, shall be responsible for all trauma patients and administrative authority for the hospital's trauma program. The director shall be given administrative support to implement the requirements specified by the Wyoming Trauma Plan. The director shall work with the credentialing process of the hospital and participate with the credentialing committee to recommend participation on the trauma team⁴. The trauma director or his designee shall be actively involved with trauma care development at the community, state, and national level.

(iii) Trauma Team. The hospital shall have a policy describing the respective roles of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its staff. The team leader shall be a qualified surgeon or emergency physician who is clinically capable in all aspects of trauma care. Suggested composition of the trauma team may include:

- (A) Surgeons;
- (B) Anesthesiologists;
- (C) Emergency physicians;

⁴ It is strongly recommended that the director be an instructor in the American College of Surgeons Advanced Trauma Life Support (ATLS) course and maintain current ATLS certification or maintain certification of attendance to an American College of Emergency Physicians (ACEP) accredited trauma conference every two (2) years, maintain personal involvement in care of the injured, be educated in trauma care, and involved in professional organizations.

- (D) Laboratory technicians;
- (E) Registered nurses;
- (F) Physician specialists as dictated by clinical needs;
- (G) Prehospital care providers;
- (H) Radiology technicians;
- (I) Respiratory therapists; and
- (J) Social services/pastoral care.

(iv) **Qualifications for Surgeons on the Trauma Team.** As a general rule, all surgeons on the trauma team shall be board certified in a surgical specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association. An exception to this rule is Oral and Maxillofacial Surgery. These physicians shall be board certified by the American Board of Oral and Maxillofacial Surgery⁵. The surgeons shall participate in the multi disciplinary trauma committee and the quality improvement process. All general surgeons participating on the trauma team shall be current in ATLS and be involved in continuing education specific to trauma sufficient to maintain quality patient care. This includes all residents.

(v) **Trauma Nurse Coordinator.** A RTC shall have a registered nurse working in the role of trauma nurse coordinator. Working in conjunction with the trauma director, the trauma nurse coordinator shall organize the program and all systems necessary for the multi disciplinary approach throughout the continuum of trauma care. The trauma nurse coordinator shall coordinate optimal patient care for all injured patients⁶.

(vi) **Multi Disciplinary Trauma Committee.** The purpose of the committee is to provide oversight and leadership to the entire trauma program. The major focus shall be quality improvement activities, policy development, communication among all team members, development of standards of care, education, and outreach programs and working with appropriate groups for injury prevention. The clinical managers (or designees) of the organizational areas involved with trauma care shall play

⁵ It is understood that many boards require a practice period, and that complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after successful completion of residency, that individual is unacceptable for inclusion on the trauma team.

⁶ Recommended credentials for this position include: Certified Emergency Nurse (CEN), Trauma Nurse Core Course (TNCC) (or equivalent education), demonstrated expertise in trauma care, five (5) or more years clinical nursing experience, experience with hospital quality assurance programs including a trauma registry, experience in education program development and membership in professional organizations.

an active role with the committee. The committee shall include representatives from each of the following areas, unless the hospital has no such organizational area defined:

- (A) Administration;
- (B) Anesthesia;
- (C) Emergency Department;
- (D) Family Practice Residency Program;
- (E) Intensive Care;
- (F) General Surgery;
- (G) Laboratory;
- (H) Medical Records;
- (I) Neurosurgery;
- (J) Nursing;
- (K) Operating Room;
- (L) Orthopedics;
- (M) Pediatrics;
- (N) Prehospital care providers;
- (O) Radiology;
- (P) Rehabilitation;
- (Q) Respiratory Therapy; and
- (R) Trauma Nurse Coordinator.

(b) Clinical Components.

(i) A RTC shall have the following medical specialists available to the injured patient:

- (A) Emergency Medicine in house twenty-four (24) hours per day;

(B) Trauma/General Surgery; and

(C) Anesthesia.

(ii) The following specialists shall be on call and promptly available from inside or outside the hospital:

(A) Cardiology;

(B) Internal Medicine;

(C) Neurologic Surgery;

(D) Obstetrics/Gynecological Surgery;

(E) Ophthalmic Surgery;

(F) Oral/Maxillofacial;

(G) Plastic Surgery/ENT;

(H) Orthopedic Surgery;

(I) Pediatrics;

(J) Physical Medicine and Rehabilitation;

(K) Pulmonary/Intensive Care Medicine;

(L) Radiology;

(M) Thoracic Surgery;

(N) Urologic Surgery; and

(O) Vascular Surgery.

(iii) It is desirable to have the following specialists available to a RTC:

(A) Cardiac Surgery;

(B) Hand Surgery;

(C) Infectious Disease; and

(D) Microvascular Surgery.

(iv) The staff specialist on call shall be notified at the discretion of the trauma surgeon or emergency physician and will be promptly available. This availability will be monitored continuously by the quality improvement program. The specialist involved for consultation to the trauma patient shall be appropriately board certified and have an awareness of the unique problems of trauma patients.

(v) A general/trauma surgeon shall be qualified and have privileges to provide thoracic surgical care to patients with thoracic injuries. In instances where this is not feasible, the hospital shall apply for a waiver from the OEMS which at its sole discretion can grant such a waiver.

(vi) Policies and procedures shall be in place to notify the patient's primary physician of the patient's condition.

(c) Facility Standards.

(i) Emergency department.

(A) The hospital shall have an emergency department, division, service, or section staffed so that trauma patients are assured immediate and appropriate initial care. The emergency physician shall be in house twenty-four (24) hours per day and immediately available at all times, capable of evaluating trauma patients, providing initial resuscitation, and performing necessary surgical procedures not requiring general anesthesia.

(B) The emergency department medical director shall be board certified in emergency medicine⁷.

(C) The emergency medicine physician shall activate the trauma team based on predetermined criteria⁸. He will provide team leadership and care for the trauma patient until the arrival of the trauma surgeon in the resuscitation area. The emergency department shall have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director or his designee shall participate with the multi

⁷ It is highly recommended that the emergency medical physician be currently certified in ATLS or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years. It is recommended that the emergency medicine physician participating with the trauma team should be board certified in a specialty recognized by the American Board of Medical Specialties, the Canadian Board, or the American Osteopathic Association. It is understood that many boards require a practice period, and the complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after completion of a residency, that individual is unacceptable as the medical director of the emergency department.

⁸ Each facility may develop local written protocol for the activation of the trauma team.

disciplinary trauma committee and the trauma quality improvement process.

(D) General/Trauma Surgeon.

(I) A general/trauma surgeon shall be available on call twenty-four (24) hours per day to respond to the emergency department as requested. The trauma surgeon on call shall be promptly available to respond to the trauma patient. Local criteria shall be established to define conditions requiring the trauma surgeon's immediate hospital presence. The trauma surgeon's participation in major therapeutic decisions and presence in the emergency department for major resuscitation is highly recommended. The trauma surgeon's presence at operative procedures is mandatory. A system shall be developed to assure early notification of the on call surgeon and compliance with this criteria and their appropriateness must be monitored by the hospital's trauma quality improvement process. The surgeon shall maintain current certification in ATLS.

(II) The surgeon shall, in conjunction with the emergency physician, make key decisions about management of the trauma patient's care and determine if the patient needs transport to a higher level of care. If transfer is required, either the surgeon or emergency physician shall be accountable to coordinate the process with the receiving physician at the receiving facility. Generally, if an injured patient requiring surgery is to be admitted to the RTC, the surgeon shall be the admitting physician and will coordinate the patient care while hospitalized. Guidelines shall be written at the local level to determine which types of patients should be admitted to the RTC and which patients should be considered for transfer to a higher level of care.

(E) Nursing Personnel.

(I) Emergency nurses shall have special expertise in trauma care⁹.

(II) There shall be a minimum of two (2) registered nurses available in house twenty-four (24) hours per day to staff the emergency department to meet the needs of the trauma patient.

(ii) Surgical Suites. The surgical team is not required to be in house twenty-four (24) hours per day. This requirement may be met by a technician or nurse who is capable of responding to the trauma resuscitation area, anticipating the operative needs of the patient, initiating the call process for on call staff, and preparing the operating room for the patient. A team shall be on call with a well-defined mechanism/criteria for notification.

(A) Nursing Personnel. Surgical nurses shall participate in the

⁹ It is highly recommended that emergency nurses demonstrate successful completion of TNCC (or equivalent education), evidence of continuing education in trauma nursing, and participation in the ongoing quality improvement process of the trauma program.

care of the trauma patient and be competent in the surgical stabilization of the major trauma patient. Surgical nurses shall be trained in principles of resuscitation, mechanism of injury theory, multiple systems trauma, and knowledge of surgical instrumentation. The surgical nurses are integral members of the trauma team and shall participate in the ongoing quality improvement process of the trauma program and shall be represented on the multi disciplinary trauma committee.

(B) Policies and Procedures. Policies and procedures shall be in place for the following:

(I) Prioritized room availability for the emergency trauma patient during a busy operating schedule;

(II) Notification of on call surgical teams for both single and multiple patient admission;

(III) Managing death in the operating room and facilitating the organ procurement process;

(IV) Preservation of evidence;

(V) Patient monitoring by a registered nurse while the patient is in transport to the radiology suite or intensive care unit (ICU) from the operating room; and

(VI) In hospital access of blood and blood products to the operating room.

(C) Anesthesia. Anesthesia shall be promptly available with a mechanism established to ensure early notification of the on call anesthesiologist. Local criteria shall be established to determine when the anesthesiologist shall be immediately available for airway emergencies and operative management. The anesthesiologist participating on the trauma team shall be appropriately board certified or board eligible, have the necessary educational background in the care of the trauma patient, and participate in the multi disciplinary trauma committee and the quality improvement process.

(iii) Intensive Care Unit. The RTC shall have an ICU which meets the requirements of licensure in the state of Wyoming. Additionally the ICU shall have:

(A) Medical Director. The medical director for the ICU is responsible for the quality care and administration of the ICU. The trauma program director or his designee will work collaboratively with the ICU medical director to set policy and establish standards of care to meet the unique needs of the trauma patient.

(B) Physician Coverage. Trauma patients admitted to the ICU

shall be admitted under the care of a general surgeon or a qualified board certified physician who is knowledgeable about the care of ICU patients. Guidelines may be written for the rare exception to this rule (e.g., isolated head injury that the neurosurgeon agrees to manage). In addition to overall responsibility for patient care by the primary surgeon or ICU physician, there shall be in house physician coverage for intensive care at all times. This coverage may be provided by a physician who is approved by the director of the ICU. This coverage is for emergencies only (e.g., an unexpected extubation of an ICU patient) and is to ensure the patient's immediate needs are met while the identified surgeon or physician is contacted.

(C) Nursing Personnel. RTCs shall provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses shall show evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient¹⁰. ICU nurses are an integral part of the trauma team and as such, shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(iv) Post Anesthesia Recovery Room (PAR room). A RTC shall have a PAR room with staff on call twenty-four (24) hours per day and available to the postoperative trauma patient. PAR room staffing shall be as required for the critical needs of the trauma patient. Frequently it is advantageous to bypass the PAR room and directly admit to the ICU. In this instance, these requirements may be met by the ICU. PAR room nurses shall provide evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient. PAR room nurses are an integral part of the trauma team and as such, shall be represented in the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(d) Clinical Support Services.

(i) A RTC shall have the following service capabilities:

(A) Radiological Service. A radiological service shall have a licensed radiological technician in house and immediately available at all times for general radiological procedures, angiography, imaging services, sonography, and computerized tomography (CT), for both head and body. If a technician is not in house twenty-four (24) hours per day for CT, angiography or sonography, the quality improvement process must document and monitor that the procedure is promptly available. A board certified radiologist shall administer the department and participate actively in the trauma quality improvement process. Written policy shall delineate the prioritization/availability of the CT scanner for trauma patients;

(B) Clinical Laboratory Service. Sufficient numbers of clinical

¹⁰ It is highly recommended that nurses in the ICU demonstrate special expertise in critical care by acquisition and maintenance of a CCRN certification.

laboratory technologists shall be promptly available at all times. A clinical laboratory service shall have the following services available twenty-four (24) hours per day:

(I) Comprehensive blood bank or access to a community central blood bank and adequate storage facilities;

(II) Standard analysis of blood, urine, and other body fluids;

(III) Blood gas and pH determinations. (This function may be performed by providers other than the clinical laboratory service, when applicable); and

(IV) Massive transfusion policy.

(C) Alcohol screening is required and drug screening is highly recommended.

(D) Social Service/Pastoral Care Support. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout the continuum of recovery. Adequate numbers of trained personnel shall be readily available to trauma patients and their families. Programs shall be available to meet the unique needs of the trauma patients and their families.

(E) Rehabilitation. At the earliest stage possible after admission to the trauma center, each RTC shall address a plan for integration of rehabilitation into the acute and primary care of the trauma patient,. Designated hospitals shall identify a mechanism to initiate rehabilitation services and/or consultation upon admission as well as policies regarding coordination of the multi disciplinary rehabilitation team. Policies shall be in place to address the coordination of transfers between acute care facilities and rehabilitation facilities. Transfer agreements shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry.

(F) Outreach. As a RTC, the trauma program shall develop programs for consultation with physicians in the region. Additionally, the trauma center shall provide leadership in professional education programs for prehospital care providers, nurses, and physicians in the hospitals and clinics in their region.

(G) Prevention/Public Outreach. The RTC shall take a leadership role in coordination of appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan shall take into consideration public awareness of the trauma system, access to the system, public support of the system, as well as specific prevention strategies. Substance abuse is consistently linked with traumatic injury and should be a key focus for prevention. Prevention

programs shall be specific to the needs of the region. Trauma registry data shall be utilized to identify injury trends and focus prevention needs.

(H) Transfer Protocol. RTCs shall work collaboratively with the referral trauma facilities in their region and develop interfacility transfer protocols. These guidelines shall address criteria to identify high risk trauma patients that could benefit from a higher level of trauma care. All trauma facilities shall provide services to the trauma patient regardless of their ability to pay. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations. Transfer protocols shall be written for specialty referral centers such as burn or spinal cord injury centers if the services are not available at the trauma center. The transfer agreement shall include a feedback loop so the primary provider has a good understanding of the patient outcome.

(I) Quality Improvement/Evaluation.

(I) All designated facilities shall participate in the trauma registry and submit data to OEMS as requested. The RTCs shall assist other facilities in their referral area in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records.

(II) Each RTC shall develop an internal quality improvement plan that, at a minimum, addresses the following key components¹¹:

(1) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

(2) Clearly stated goals and objectives of the quality improvement plan;

(3) The development of standards of care;

(4) A process to delineate privileges for all physicians participating in trauma care;

(5) Participation in the trauma statewide registry;

(6) Established quality indicators (audit filters). The plan must include, at a minimum, the recommended audit filters by the ACS and the JCAHO. The plan shall define adverse outcomes by using an explicit list of well-defined complications;

(7) A systematic informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

¹¹ It is highly recommended that the plan incorporate autopsy information on all trauma patients. Complete anatomical diagnosis of injury is essential to the quality of trauma care.

(8) A method for computing survival probability and comparing patient outcomes.

(III) The RTCs shall be required to take a lead role in the statewide WTC and the RAC of their TSA.

Section 2. Area Trauma Hospitals. An Area Trauma Hospital (ATH) is an acute care facility with the commitment, medical staff, personnel, and specialty training necessary to provide primary care to the trauma patient. An ATH shall provide initial resuscitation of the trauma patient and immediate operative intervention to control hemorrhage and to assure maximal stabilization prior to referral to a higher level of care. In many instances, patients will be maintained in the ATH unless the medical needs of the patient require a higher level of care. The decisions to transfer a patient rests with the physician attending the trauma patient. All ATHs shall work collaboratively with the Regional Trauma Centers, Community Trauma Hospitals and Trauma Receiving Facilities to develop transfer protocols and a well-defined transfer sequence.

(a) Hospital Organization.

(i) Trauma Program. The trauma program shall be established and recognized by the medical staff and hospital administration. The trauma program shall come under the overall organization and direction of a general surgeon or emergency physician who is trained, experienced, and committed to the care of the injured patient.

(ii) Trauma Program Director. The director must be a board certified surgeon or a board certified emergency physician with demonstrated competency in trauma care. The director shall develop a quality improvement process and through this process, shall be responsible for all trauma patients and administrative authority for the hospital's trauma program. The director must be given administrative support to implement the requirements specified by the Wyoming Trauma Plan. The director shall work with the credentialing process of the hospital and participate with the credentialing committee to recommend participation on the trauma team.¹²

(iii) Trauma Team. The hospital shall have a policy describing the respective roles of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its staff. The team leader shall be a qualified physician who is clinically capable in all aspects of trauma resuscitation. Suggested composition of the trauma team may include:

(A) Surgeons, General, and Orthopedic;

¹² It is strongly recommended that the director be an instructor in the American College of Surgeons Advanced Trauma Life Support (ATLS) course, maintain current ATLS certification or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years, and maintain personal involvement in care of the injured, education in trauma care, and involvement in professional organizations.

- (B) Anesthesiologists;
- (C) Emergency physicians;
- (D) Family physicians;
- (E) Laboratory technicians;
- (F) Registered nurses;
- (G) Physician specialists as dictated by clinical needs;
- (H) Prehospital care providers;
- (I) Radiology technicians;
- (J) Respiratory therapists; and
- (K) Social services/pastoral care.

(iv) **Qualifications for Surgeons on the Trauma Team.** As a general rule, all surgeons on the trauma team should be board certified in a surgical specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association. An exception to this rule is Oral and Maxillofacial Surgery. These physicians should be board certified by the American Board of Oral and Maxillofacial Surgery.¹³ The surgeons shall participate in the multi disciplinary trauma committee and the quality improvement process. All general surgeons participating on the trauma team should be current in ATLS and be involved in continuing education specific to trauma sufficient to maintain quality patient care. This includes all residents.

(v) **Trauma Nurse Coordinator.** An ATH shall have a registered nurse working in the role of a trauma nurse coordinator. Working in conjunction with the trauma program director, the trauma nurse coordinator shall organize the program and all systems necessary for the multi disciplinary approach throughout the continuum of trauma care. The trauma nurse coordinator is responsible for coordinating optimal patient care for all injured patients.¹⁴

¹³ It is understood that many boards require a practice period, and that complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after successful completion of residency, that individual is ordinarily unacceptable for inclusion on the trauma team.

¹⁴ Recommended credentials for this person include: Trauma Nurse Core Course (TNCC) (or equivalent education), Certified Emergency Nurse (CEN), demonstrated expertise in trauma care, five (5) or more years clinical nursing experience, experience with hospital quality assurance programs including a trauma registry, experience in education program development, and membership in professional organizations.

(vi) Multi Disciplinary Trauma Committee. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The major focus shall be quality improvement activities, policy development, communication among all team members, development of standards of care, education and outreach programs and work with appropriate groups for injury prevention. The clinical managers (or designees) of the organizational areas involved with trauma care shall play an active role with the committee. The committee shall include representatives from each of the following areas, unless the hospital has no such organizational area defined:

- (A) Administration;
- (B) Anesthesia;
- (C) Emergency Department;
- (D) General Surgery;
- (E) Intensive Care;
- (F) Laboratory;
- (G) Medical Records;
- (H) Nursing;
- (I) Operating Room;
- (J) Orthopedics;
- (K) Pediatrics;
- (L) Prehospital care providers;
- (M) Radiology;
- (N) Rehabilitation;
- (O) Respiratory Therapy; and
- (P) Trauma Nurse Coordinator.

(b) Clinical Components.

(i) An ATH shall have the following medical specialists available to the injured patient:

- day;
- (A) Emergency Medicine in house twenty-four (24) hours per
 - (B) Trauma/General Surgery.
 - (C) Anesthesia.
 - (D) Orthopedic Surgery;

(ii) The following specialists shall be on call and promptly available:

- (A) Internal Medicine; and
- (B) Radiology.

ATH: (iii) It is desirable to have the following specialists available to an

- (A) Obstetrics/Gynecological Surgery;
- (B) Pediatrics; and
- (C) Urologic Surgery.

(iv) The staff specialist on call shall be notified at the discretion of the trauma surgeon or the emergency physician and shall be promptly available. This availability shall be monitored continuously by the quality improvement program. The specialist involved for consultation to the trauma patient shall be appropriately board certified and have an awareness of the unique problems of trauma patients.

(v) A general/trauma surgeon shall be qualified and have privileges to provide thoracic surgical care to patients with thoracic injuries. In instances where this is not feasible, the hospital shall apply for a waiver from the OEMS, who at its sole discretion can grant such a waiver.

(vi) Policies and procedures shall be in place to notify the patient's primary physician of the patient's condition.

(c) Facility Standards.

(i) Emergency Department.

(A) The hospital shall have an emergency department, division, service or section staffed so that trauma patients are assured immediate and appropriate initial care. ATHs shall have a physician in the emergency department twenty-four (24)

hours per day capable of evaluating trauma patients and providing initial resuscitation and performing necessary surgical procedures not requiring general anesthesia.

(B) The emergency department shall have a designated medical director who is board certified in a specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association.¹⁵ This requirement may be satisfied by a physician not currently board certified but meeting the requirements of the hospital for appointment as an emergency department medical director. This exception is only valid for those non-qualifying medical directors at the time these requirements become effective.

(C) All physicians covering the emergency department shall show commitment to trauma care by maintaining competency in resuscitation, airway management, central venous access, cervical immobilization and long bone fracture stabilization of the adult and pediatric trauma patient. This includes all residents.¹⁶

(D) The emergency medicine physician shall activate the trauma team based on predetermined criteria.¹⁷ The emergency department shall have established policies and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The physicians participating on the trauma team shall participate in CME activities related to trauma care, the multi disciplinary trauma committee and the trauma quality improvement process.

(E) General/Trauma Surgeon.

(I) A general/trauma surgeon shall be available on call twenty-four (24) hours per day to respond to the emergency department as requested. The trauma surgeon on call shall be promptly available to respond to the trauma patient. Local criteria shall be established to define conditions requiring the trauma surgeon's immediate hospital presence. The trauma surgeon's participation in major therapeutic decisions and presence in the emergency department for major resuscitation is highly recommended. The trauma surgeon's presence at operative procedures is mandatory. A system shall be developed to assure early notification of the on call surgeon and compliance with this criteria and their appropriateness must be monitored by the hospital's trauma quality improvement process. The surgeon should maintain current certification in ATLS.

(II) The surgeon shall, in conjunction with the

¹⁵ It is understood that many boards require a practice period, and the complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after residency, that individual is ordinarily unacceptable as the medical director of the emergency department.

¹⁶ Current certification in ATLS is highly recommended or maintenance of certification of attendance to an ACEP accredited trauma conference every two (2) years.

¹⁷ Each facility may develop local written protocol for the activation of the trauma team.

emergency physician, make key decisions about management of the trauma patient's care and determine if the patient needs transport to a higher level of care. If transfer is required, either the surgeon or emergency physician shall be accountable to coordinate the process with the receiving physician at the receiving facility. Generally, if an injured patient requiring surgery is to be admitted to the ATH, the surgeon shall be the admitting physician and will coordinate the patient care while hospitalized. Guidelines shall be written at the local level to determine which types of patients should be admitted to the ATH and which patients should be considered for transfer to a higher level of care.

(F) Nursing Personnel.

(I) Emergency nurses shall have special expertise in trauma care.¹⁸

(II) Adequate numbers of registered nurses shall be available in house twenty-four (24) hours per day to staff the emergency department to meet the needs of the trauma patient.

(ii) Surgical Suites. The surgical team is not required to be in house twenty-four (24) hours per day. A team shall be on call with a well-defined mechanism for notification to expedite admission to the operating room if the patient's condition warrants. The process shall be monitored continuously by the trauma quality improvement program. Surgical nurses shall be trained in principles of resuscitation, mechanism of injury theory, multi systems trauma, and knowledge of surgical instrumentation. The surgical nurses are integral members of the trauma team and shall participate in the ongoing quality improvement process of the trauma program and shall be represented on the multi disciplinary trauma committee.

(A) Policies and Procedures. Policies and procedures shall be in place for the following:

(I) Prioritized operating room availability for the emergency trauma patient during a busy operative schedule;

(II) Notification of on call surgical teams;

(III) Managing death in the operating room and facilitating the organ procurement process;

(IV) Preservation of evidence;

(V) Patient monitoring by a registered nurse while the patient is in transport to the radiology suite or ICU from the operating room; and

¹⁸ It is highly recommended that emergency nurses demonstrate successful completion of TNCC (or equivalent education), evidence of continuing education in trauma nursing, and participation in the ongoing quality improvement process of the trauma program.

(VI) Immediate access of blood and blood products to the operating room.

(B) Anesthesia. Anesthesia shall be promptly available with a mechanism established to ensure early notification of the on call anesthesiologist. Local criteria shall be established to determine when the anesthesiologist shall be immediately available for airway emergencies and operative management of the trauma patient. Anesthesia coverage may be provided by a CRNA who is supervised by an anesthesiologist as required for the CRNA's licensure. Local conditions shall be established to determine when the CRNA must be immediately available for airway emergencies and operative management. The availability of the anesthesiologist or the CRNA and the absence of delays in airway control or operative anesthesia shall be documented and monitored by the quality improvement process. The anesthesiologist/CRNA shall have the necessary education background in the care of the trauma patient, and participate in the multi disciplinary trauma committee and the trauma quality improvement process.

(iii) Intensive Care Unit. The ATH shall have an ICU which meets the requirements for licensure in the state of Wyoming. Additionally, the ICU shall have:

(A) Medical Director. The medical director for the ICU is responsible for the quality of care and administration of the ICU. The trauma program director or his designee shall work collaboratively with the ICU medical director to set policy and establish standards of care to meet the unique needs of the trauma patient.

(B) Physician Coverage. Trauma patients admitted to the ICU shall be admitted under the care of a general surgeon or a qualified board certified physician who is knowledgeable about the care of ICU patients. Guidelines may be written for the rare exception to this rule. In addition to overall responsibility for patient care by the primary surgeon or ICU physician, there shall be in house physician coverage for the ICU at all times. This coverage may be provided by a physician who is approved by the director of the ICU. This coverage is for emergencies only (e.g., an unexpected extubation of an ICU patient) and is to ensure the patient's immediate needs are met while the identified surgeon or physician is contacted.

(C) Nursing Personnel. ATHs shall provide staffing in sufficient numbers to meet the needs of the trauma patient. Critical care nurses should show evidence of completion of a structured ICU in-service program which includes didactic and clinical content related to the care of the trauma patient. ICU nurses are an integral part of the trauma team and shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(iv) Post Anesthesia Recovery Room (PAR room). An ATH shall have a PAR room with staff on call twenty-four (24) hours per day and available to the postoperative trauma patient. PAR room staffing shall be in sufficient numbers to meet

the critical needs of the trauma patient. Frequently, it is advantageous to bypass the PAR room and directly admit to the ICU. In this instance, these requirements may be met by the ICU. PAR room nurses shall show evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient. PAR room nurses are an integral part of the trauma team and, as such, shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(d) Clinical Support Services.

(i) An ATH shall have the following service capabilities:

(A) Radiological Service. A board certified radiologist or his designated mid-level practitioner shall be available to the facility for emergency procedures and on a routine basis to assure quality of services rendered. The radiologist is a key member of the trauma team and shall be represented on the multi disciplinary trauma committee. A licensed radiological technician shall be on call twenty-four (24) hours per day and readily available to meet the immediate needs of the trauma patient. The CT (specialty) technician may be on call from home with a mechanism in place to assure the technician is available. The quality improvement process shall verify all procedures are promptly available to the patient; and

(B) Clinical Laboratory Services. Sufficient numbers of clinical laboratory technologists shall be on call twenty-four (24) hours per day and promptly available at all times. The clinical laboratory service shall have the following services available twenty-four (24) hours per day:

(I) Comprehensive blood bank or access to a community central blood bank and adequate storage facilities;

(II) Standard analysis of blood, urine and other body fluids. Toxicology studies may be performed off site if necessary; and

(III) Blood gas and pH determinations. (This function may be performed by providers other than the clinical laboratory service, when applicable.)

(C) Alcohol screening is required and drug screening is highly recommended.

(D) Social Service/Pastoral Care Support. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout recovery. An ATH may utilize community resources as appropriate to meet the needs of the trauma patient and their families.

(E) Rehabilitation. At the earliest stage possible after admission to the trauma center, each ATH shall address a plan for integration of rehabilitation into the acute and primary care of the trauma patient. Designated facilities shall identify a mechanism to initiate rehabilitation services and/or consultation upon admission as well as policies regarding coordination of a multi disciplinary rehabilitation team. Policies shall be in place to address the coordination of transfer between acute care facilities and rehabilitation facilities. Transfer agreements shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry.

(F) Outreach. The ATH shall work collaboratively to plan, facilitate and teach professional education programs for the prehospital care providers, nurses and physicians in their own facility and in the Community Trauma Hospital (CTH) and Trauma Receiving Facilities (TRF) in their region.

(G) Prevention/Public Education. The ATH is responsible for collaborating with RTCs, CTHs, and TRFs to develop education and prevention programs for their professional staff and the public. The education and prevention programs shall include implementation strategies to assure information dissemination to all residents in the region.

(H) Transfer Protocols. The facilities shall have transfer protocols in place with receiving trauma facilities, as well as all specialty referral centers (e.g., burn, pediatrics and rehabilitation). All facilities shall work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to assure the most expedient, safe transfer of the patient. All trauma facilities shall agree to provide services to the trauma patients regardless of their ability to pay. The transfer guidelines need to assure feedback as provided to the facilities and assure this information eventually becomes part of the trauma registry. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations.

(I) Quality Improvement/Evaluation.

(I) All designated facilities will be required to participate in the trauma registry and submit data to OEMS as requested. The ATHs shall assist the CTHs and the TRFs in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records.

(II) Each ATH shall develop an internal quality improvement plan that, at a minimum, addresses the following key components:¹⁹

(1) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

¹⁹ It is highly recommended that the plan incorporate autopsy information on all trauma patients. Complete anatomical diagnosis of injury is essential to the quality of trauma care.

quality improvement plan;

(2) Clearly stated goals and objectives of the

(3) The development of standards of care;

(4) A process to delineate privileges for all physicians participating in trauma care;

(5) Participation in the statewide trauma registry;

(6) Established quality indicators (audit filters). The plan must include, at a minimum, the recommended audit filters by the American College of Surgeons and the JCAHO. The plan should define adverse outcomes by using an explicit list of well-defined complications;

(7) A systematic, informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

(8) A method for computing survival probability and comparing patient outcomes.

(III) The ATH shall participate in the statewide WTC and the RAC of their TSA.

Section 3. Community Trauma Hospitals. Community Trauma Hospitals (CTH) are generally small, rural facilities with a commitment to the resuscitation of the trauma patient and with written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred for definitive care. The hospital is predominantly staffed with family physicians experienced and/or trained across a broad composite field of medicine including appropriate areas of acute trauma management. Frequently, these physicians are the obstetric and intensive care providers of the TSA. They commonly work in consultation with a board certified general surgeon who is committed to trauma management. A system for early notification of the physician on call shall be developed so that he can consistently be present at the time of arrival of the major trauma patient in the emergency department. This level of designation requires a general/trauma surgeon on call and promptly available to respond to the trauma patient. However, this level contemplates that there may be only one surgeon in the community and he may not be available at all times. During periods when the surgeon is not available, the hospital must notify other facilities that routinely transfer/refer patients to the CTH for emergency surgical services.²⁰ Since this level contemplates a surgeon in the community who is committed to trauma care, it is anticipated that the CTH shall provide initial resuscitation and immediate operative intervention to control hemorrhage to assure maximum stabilization prior to transfer to a

²⁰ Each facility shall develop written notification protocols.

higher level of care. In many instances, patients will be maintained in the CTH unless the medical needs of the patient require secondary transfer. The decision to transfer a patient rests with the physician attending the trauma patient. An institution intending to provide prolonged ventilatory care must assure that a physician qualified to provide ventilatory care is available at all times. If physician support is not available twenty-four (24) hours per day, transfer to a higher level of care is recommended.

(a) Hospital Organization.

(i) Trauma Program. The trauma program shall be established and recognized by the medical staff and hospital administration. The trauma program shall come under the overall organization and direction of a general surgeon or emergency physician who is trained, experienced, and committed to the care of the injured patient.

(ii) Trauma Program Director. The director must be a board certified general surgeon, a board certified emergency physician, or a board certified physician with demonstrated competency in trauma care. The director shall develop a quality improvement process and, through this process, shall be responsible for all trauma patients and administrative authority for the hospital's trauma program. The director must be given administrative support to implement the requirements specified by the Wyoming Trauma Plan.²¹

(iii) Trauma Team. The hospital shall have a policy describing the respective roles of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of development, communication among all team members, development of standards of care, education and outreach programs, and interaction with appropriate groups for injury prevention. Suggested membership for the committee include representatives (if available in the community) from:

- (A) Surgeons;
- (B) Emergency physicians;
- (C) Anesthesia;
- (D) Laboratory technician;
- (E) Physician with emergency department privileges;
- (F) Prehospital care providers;

²¹ It is strongly recommended that the director be an instructor in the American College of Surgeons Advanced Trauma Life Support (ATLS) course, and maintain current ATLS certification or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years, and maintain personal involvement in care of the injured, education in trauma care, and involvement in professional organizations.

- (G) Respiratory therapist;
- (H) Family physician(s) skilled in trauma care;
- (I) Registered nurses;
- (J) Physician specialists as dictated by clinical needs;
- (K) Radiology technician; and
- (L) Social services/pastoral care.

(iv) Trauma Nurse Coordinator. A CTH shall have at least a part-time registered nurse working in the role of a trauma nurse coordinator. Working in conjunction with the trauma program director, the trauma nurse coordinator shall organize the program and all systems necessary for the multi disciplinary approach throughout the continuum of trauma care. The trauma nurse coordinator shall coordinate optimal patient care for all injured patients.²²

(v) Multi Disciplinary Trauma Committee. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The committee shall focus on quality improvement activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and interaction with appropriate groups for injury prevention. The clinical managers (or designees) of the organizational areas involved in trauma care shall play an active role with the committee. The committee shall include representatives from each of the following areas, unless the hospital has no such organizational area defined:

- (A) Administration;
- (B) Anesthesia;
- (C) Emergency department;
- (D) Family physicians;
- (E) General surgery;
- (F) Intensive Care;
- (G) Medical Records;

²² Recommended credentials for this position include: Trauma Nurse Core Curriculum (TNCC) (or equivalent education), demonstrated expertise in trauma care and five (5) or more years clinical nursing experience.

- (H) Pediatrics;
- (I) Nursing;
- (J) Prehospital care providers;
- (K) Radiology;
- (L) Rehabilitation;
- (M) Respiratory therapy; and
- (N) Trauma Nurse Coordinator.

(b) Facility Standards.

(i) Emergency Department.

(A) The hospital shall have an emergency department staffed so that trauma patients are assured immediate and appropriate initial care. CTHs may not have a physician in the emergency department twenty-four (24) hours per day. Therefore, adequately trained registered nurses shall be available to initiate basic trauma life support care. Local policy shall be written to assure early notification of the on call physician and/or surgeon to meet the trauma patient in the emergency department.

(B) The emergency department shall have a designated medical director who is board certified in a specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association.²³ This requirement may be satisfied by a physician not currently board certified but meeting the requirements of the hospital for appointment as an emergency department medical director. This exception is only valid for those non-qualifying medical directors at the time these requirements become effective.²⁴ The physicians participating on the trauma team shall participate in continuing education activities related to trauma care, the multi disciplinary trauma committee and the trauma quality improvement process.

(C) Nursing Personnel.

²³ It is understood that many boards require a practice period, and the complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five years after residency, that individual is ordinarily unacceptable as the medical director of the emergency department.

²⁴ All physicians covering the emergency department shall be currently certified in ATLS, or maintain certification of attendance to an ACEP accredited trauma conference every two years, and shall show commitment to trauma care by maintaining competency in resuscitation, airway management, central venous access, cervical immobilization and long bone fracture stabilization of the adult and pediatric trauma patient. This includes all residents assigned to the emergency department and responsible for the resuscitation of the trauma patient.

trauma care.²⁵ (I) Emergency nurses shall have special expertise in

(II) Adequate numbers of registered nurses must be available in house twenty-four (24) hours per day to staff the emergency department to meet the needs of the trauma patient.

(D) General/Trauma Surgeon.

(I) A general/trauma surgeon shall be available on call twenty-four (24) hours per day to respond to the emergency department as requested. This level contemplates a community where only one surgeon may reside. During those periods when the surgeon is not available, the hospital shall notify other facilities who routinely transfer/refer patients to the CTH for emergency surgical care. The trauma surgeon on call shall be promptly available to respond to the trauma patient. The surgeons should have current certification in ATLS.

(II) Local criteria shall be established to define conditions requiring the trauma surgeon's immediate hospital presence. The trauma surgeon's participation in major therapeutic decisions and consultations and presence in the emergency department for major resuscitation is highly recommended. The trauma surgeon's presence at major operative procedures is mandatory. A system shall be developed to assure early notification of the on call surgeon and compliance with this criteria and their appropriateness shall be monitored by the hospital's trauma quality improvement process.

(III) The emergency physician is expected to make key decisions about management for the trauma patient's care and determine if the patient needs transport to a higher level of care in association with the surgeon. The emergency department physician or surgeon shall coordinate the process with the receiving surgeon at the receiving facility when transfer is necessary. If the patient is admitted to the CTH, the admitting physician shall provide care and utilize surgical consultation according to the CTH guidelines for trauma patient care. Guidelines shall be written at the local level to determine which types of patients should be admitted to the CTH and which patients should be considered for transfer to a higher level of care. Telephone, teleradiology and telemedicine consultation capabilities are highly desirable for internal medicine, orthopedic surgery, obstetric/gynecological surgery and radiology. If practical, local coverage of these services is desirable. The CTH's protocol and the skill levels of the surgeon and physician staff of the CTH will determine the transfer protocols to facilitate the movement of the patient to a higher level of care.

(ii) Surgical Suites. The surgical team is not required to be in house

²⁵ It is highly recommended that emergency nurses successfully complete TNCC (or equivalent education), show evidence of continuing education in trauma nursing, and participate in the ongoing quality improvement process of the trauma program.

twenty-four (24) hours per day. A team shall be on call with a well-defined mechanism for notification to expedite admission to the operating room if the patient's condition warrants. This process shall be monitored continuously by the trauma quality improvement program. Surgical nurses shall be trained in principles of resuscitation, mechanism of injury theory, multi system trauma, and knowledge of surgical instrumentation. The surgical nurses are integral members of the trauma team and shall participate in the ongoing quality improvement process of the trauma program and shall be represented on the multi disciplinary trauma committee.

(A) Policies and Procedures. Policies and procedures shall be in place for the following:

(I) Prioritized hospital room availability for the emergency trauma patient;

(II) Notification of on call surgical teams;

(III) Managing death in the OR and facilitating the organ procurement process;

(IV) Preservation of evidence;

(V) Patient monitoring by a registered nurse while the patient is in transport to the radiology suite or ICU from the operating room; and

(VI) Immediate access of blood and blood products to the operating room.

(B) Anesthesia. Anesthesia shall be promptly available with a mechanism established to ensure early notification of the on call anesthesiologist/CRNA. Anesthesia coverage may be provided by a CRNA who is supervised by an anesthesiologist as required for the CRNA's licensure. The CTH shall document conditions when the anesthesiologist/ CRNA must be immediately available for airway emergencies and operative management of the trauma patient. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia shall be documented and monitored by the quality improvement process.

(iii) Intensive Care Unit/Monitored Bed Unit (MBU).

(A) An institution intending to provide prolonged ventilatory care shall assure that a physician qualified to provide ventilatory care is available at all times. If physician support is not available twenty-four (24) hours per day, transfer to a higher level of care is recommended.

(B) The CTH shall have an ICU or MBU which meets the requirements of licensure in the state of Wyoming or the JCAHO. Additionally, the

ICU/MBU shall have:

(I) Medical Director. The medical director for the ICU/MBU is responsible for the quality of care and administration of the ICU/MBU. The trauma program director or his designee shall work collaboratively with the ICU/MBU medical director to set policy and establish standards of care to meet the unique needs of the trauma patient.

(II) Physician Coverage. Trauma patients admitted to the ICU/MBU shall be admitted under the care of the patient's physician or an attending physician with ICU/MBU admission privileges. Consultation with the general surgeon is expected. In addition to the primary physician and general surgeon, there shall be physician coverage for the ICU/MBU as specified by local criteria. The coverage shall be provided by a physician experienced and trained to recognize and manage conditions of the trauma patient as determined by the multi disciplinary trauma committee; and

(III) Nursing Personnel. CTHs shall provide staffing in sufficient numbers to meet the needs of the trauma patient. Critical care nurses shall show evidence of completion of a structured ICU in-service program which includes didactic and clinical content related to the care of the trauma patient. ICU nurses are an integral part of the trauma team and shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(iv) Post Anesthesia Recovery Room (PAR room).

(A) A CTH shall have a PAR room staff on call twenty-four (24) hours per day and available to the postoperative trauma patient. PAR room staffing shall be in sufficient numbers to meet the critical needs of the trauma patient. Frequently, it is advantageous to bypass the PAR room and directly admit to the ICU/MBU. In this instance, these requirements may be met by the ICU/MBU.

(B) PAR room nurses shall show evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient. PAR room nurses are an integral part of the trauma team and shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(c) Clinical Support Services. In addition to licensure requirements, a CTH shall have the following service capabilities:

(i) Radiology Services. It is highly desirable for a CTH to have a board certified radiologist or his designated mid-level practitioner available to the facility for emergency procedures, and on a routine basis, to assure quality of services rendered. The radiologist is a key member of the trauma team and shall be represented on the multi disciplinary trauma committee. A licensed radiological technician shall be on call twenty-four (24) hours per day and readily available to meet the immediate needs of the

trauma patient. Twenty-four (24) hour teleradiology service is necessary if a radiologist is not available. A formal plan for emergency reading of films is necessary as backup, e.g., administrative commitment to twenty-four (24) hour available on call road transport of films to a radiologist. The CT technician may be on call from home with a mechanism in place to assure the technician is available. The quality improvement process shall verify the procedure is promptly available to the patient.

(ii) Clinical Laboratory Services.

(A) The standards for clinical laboratory services in CTHs differ very little from other designated facilities. Blood banking capability or access to community facilities shall be available. Toxicology studies may be performed off site if necessary.

(B) The clinical laboratory service shall have the following services available twenty-four (24) hours per day:

(I) Access to a community central blood bank and adequate storage facilities;

(II) Standard analysis of blood, urine and other body fluids; and

(III) Blood gas and pH determinations (this function may be performed by providers other than the clinical laboratory service, when applicable).

(C) Alcohol screening is required and drug screening is highly recommended.

(D) Sufficient numbers of clinical laboratory technologists shall be promptly available twenty-four (24) hours per day. If this requirement is fulfilled by technicians not in house, quality improvement must document and monitor the availability of testing, blood access, and the prompt recording of accurate results.

(iii) Social Service/Pastoral Care. A CTH may utilize community resources as appropriate to meet the needs of trauma patients and their families.

(iv) Rehabilitation. Each CTH shall address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible, after admission to the trauma center. Designated facilities shall identify a mechanism to initiate rehabilitation services and/or consultation upon admission as well as policies regarding coordination of a multi disciplinary rehabilitation team. Policies shall be in place to address the coordination of transfers between acute care facilities and rehabilitation facilities. Transfer agreements shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry.

(v) Outreach. The CTH shall work collaboratively to plan, facilitate and teach professional education programs for the prehospital care providers, nurses, and physicians in the CTHs and TRFs in their region.

(vi) Prevention/Public Education. The CTH shall collaborate with all other designated facilities to develop education and prevention programs for their professional staff and the public. The plan shall include implementation strategies to assure information dissemination to all residents in the region.

(vii) Transfer Protocols. CTHs shall have transfer protocols in place with receiving trauma facilities as well as all specialty referral centers (i.e., burn, pediatrics and rehabilitation). All facilities shall work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to assure the most expedient, safe transfer of the patient. All designated facilities shall agree to provide services to the trauma patient regardless of their ability to pay. The transfer guidelines need to assure feedback is provided to the facilities and assure this information eventually becomes part of the trauma registry. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations.

(viii) Quality Improvement/Evaluation.

(A) All designated facilities shall participate in the trauma registry and submit data to the OEMS as requested. The CTHs shall assist the TRFs in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records.

(B) Each trauma center shall develop an internal quality improvement plan that, at a minimum, addresses the following key components:²⁶

(I) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

(II) Clearly stated goals and objectives of the quality improvement plan;

(III) The development of standards of care;

(IV) A process to delineate privileges for all physicians participating in trauma care;

(V) Participation in the statewide trauma registry;

(VI) Established quality indicators (audit filters). The

²⁶ Autopsy information on all trauma patients is highly recommended. Complete anatomical diagnosis of injury is essential to the quality improvement process.

plan must include, at a minimum, the recommended audit filters by the ACS and the JCAHO. The plan should define adverse outcomes by using an explicit list of well-defined complications;

(VII) A systematic, informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

(VIII) A method for computing survival probability and comparing patient outcomes.

(C) The CTH shall participate in the statewide WTC and the RAC of their TSA.

Section 4. Trauma Receiving Facilities. Trauma Receiving Facilities (TRF) are generally licensed rural facilities, clinics, or medical assistance facilities with a commitment to the resuscitation and stabilization of the trauma patient and written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred for definitive care. These facilities may not be staffed by a physician, but may be staffed by a licensed mid-level practitioner (e.g., nurse practitioner or licensed/certified physician's assistant). The major trauma patient shall be resuscitated and transferred to a higher level of care from the emergency department as appropriate. This categorization does not contemplate the availability of surgeons, operating rooms or intensive care services.

(a) Facility Organization.

(i) Trauma Program. There must be a commitment on behalf of the entire facility to the organization of trauma care. A trauma program shall be established and recognized by the institution. The trauma program shall come under the overall organization of a physician who is committed and willing to provide off-line administration of the program. In a facility staffed by physician's assistants or nurse practitioners, it most likely will be their supervising physician.

(ii) Trauma Program Director. There shall be a qualified physician director of the trauma program. In this instance, the physician shall work with all members of the trauma team to develop a quality improvement process for the facility. Through this process, he shall have overall responsibility for the quality of trauma care rendered at the facility. The director shall be given administrative support to implement the requirements specified by the Wyoming Trauma Plan. The director shall assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director should be currently certified in ATLS and participate in CME related to trauma care.

(iii) Trauma Team. The facility shall have a policy describing the role of all personnel on the trauma team. The composition of the trauma team in any facility will depend on the characteristics of the facility and its staff. The team leader shall be a

qualified physician or a qualified mid-level practitioner.²⁷ Suggested composition of the trauma team may include:

- (A) Laboratory technician;
- (B) Nurses;
- (C) Physician assistants;
- (D) Physicians;
- (E) Prehospital care providers;
- (F) Radiology technicians;
- (G) Respiratory therapists; and
- (H) Social services/pastoral care.

(iv) Trauma Nurse Coordinator. A TRF shall have a person to conduct many of the administrative functions required by the trauma program. Specifically, this person, with the physician director, shall coordinate optimal patient care for all injured patients. Many requirements for data collection and coordination, quality improvement, education and prevention activities are incumbent upon this position.

(v) Multi Disciplinary Trauma Committee.

(A) The purpose of the committee is to provide oversight and leadership to the entire trauma program. The major focus shall be quality improvement activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and work with appropriate groups for injury prevention. In a TRF, this does not need to be a separate distinct body; however, the functions of this committee may be performed in conjunction with other ongoing committees in the facility.

(B) Suggested membership for the Committee includes representatives (if available in the community) from:

- (I) Administration;
- (II) Emergency Department;

²⁷ Qualified physicians or mid-level practitioners directing the resuscitation of trauma patients shall have current ATLS certification or proof of audit of an ATLS course or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years, and must show commitment to trauma care by maintaining competence in airway management, central venous access, cervical immobilization, and long bone fracture stabilization.

- (III) Medical Records;
- (IV) Pediatrics;
- (V) Prehospital care providers;
- (VI) Radiology/Laboratory;
- (VII) Rehabilitation;
- (VIII) Respiratory therapy; and
- (IX) Trauma Nurse Coordinator.

(C) The clinical managers or designees of the organizational areas involved with trauma care shall play an active role with the committee.

(b) Facility Standards.

(i) Emergency Department.

(A) The facility shall have an emergency department staffed so that trauma patients are assured immediate and appropriate initial care. It is not anticipated that a physician will be available on call to the emergency department in a TRF. This requirement may be met by a qualified mid-level practitioner on call from outside the facility.²⁸ A system shall be developed to assure early notification of the on call practitioner. Compliance with this criteria shall be documented and monitored by the quality improvement process.

(B) The TRF shall have a written policy for notification and mobilization of an organized trauma team. Additionally, written policy shall be in place for pre-activation of the transfer team from the field based on prehospital triage criteria. There shall be written transfer protocols with other trauma facilities in the region. A policy shall be in place to facilitate and expedite the transfer sequence to assure the most appropriate care is rendered. Protocols shall be in place for specialty referral for pediatrics, burn, spinal cord injuries and rehabilitation.

(C) Emergency nurses shall have special expertise in trauma care.²⁹

²⁸ Qualified physicians or mid-level practitioners directing the resuscitation of trauma patients should have current ATLS certification, or proof of audit of an ATLS course, or maintain certification of attendance of an ACEP accredited trauma conference every two (2) years, and must show commitment to trauma care by maintaining competence in airway management, central venous access, cervical immobilization, and long bone fracture stabilization.

²⁹ It is highly recommended that emergency nurses demonstrate successful completion

(D) Adequate numbers of registered nurses shall be available to meet the needs of the trauma patient.

(c) Clinical Support Services. In addition to licensure requirements, a TRF shall have the following service capabilities:

(i) Radiology Services. X-ray capabilities shall be immediately available twenty-four (24) hours per day to meet the resuscitative needs of the trauma patient. A licensed radiological technician shall be available to meet the immediate needs of the trauma patient. The technician may be on call from home with a mechanism in place to assure the technician is available. The quality improvement process shall document and monitor the process.

(ii) Clinical Laboratory Services.

(A) Clinical laboratory services shall be immediately available to the trauma patient. It is not anticipated that blood banking facilities be available; rather, access and blood storage capacities. Toxicology studies may be performed off site if necessary. The clinical laboratory shall have standard analysis of blood, urine and other body fluids services available twenty-four (24) hours per day.

(B) If this requirement is fulfilled by technicians not in house, quality improvement shall document and monitor the availability of testing, blood access and the prompt recording of accurate results.

(iii) Social Service/Pastoral Care. A TRF may utilize community resources as appropriate to meet the needs of trauma patients and their families.

(iv) Prevention/Public Education. A TRF shall work collaboratively with RTCs and ATHs to develop education and prevention programs for their professional staff and the public. The plan shall include implementation strategies to assure information dissemination to all residents in the region.

(v) Transfer Protocols. Transfer protocols shall be written with all trauma receiving facilities and appropriate specialty centers (e.g., burn, pediatrics and rehabilitation). All facilities shall work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to assure the most expedient, safe transfer of the patient. All designated facilities shall agree to provide services to trauma patients regardless of their ability to pay. The transfer guidelines need to assure feedback is provided to the facilities and assure this information eventually becomes part of the trauma registry. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations.

of TNCC (or equivalent education), evidence of continuing education in trauma nursing and participation in the ongoing quality improvement process of the trauma program.

(vi) **Quality Improvement/Evaluation.** All designated facilities shall participate in the trauma registry and submit data to OEMS. The RTCs, ATHs and CTHs shall be responsible to assist the TRFs in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records. Each TRF shall develop an internal quality improvement plan that addresses, at a minimum, the following key components:³⁰

(A) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

(B) Clearly stated goals and objectives of the quality improvement plan;

(C) The development of standards of care;

(D) A process to delineate privileges for all physicians participating in trauma care;

(E) Participation in the statewide trauma registry;

(F) Established quality indicators (audit filters). The plan must include, at a minimum, the recommended audit filters by the ACS and the JCAHO. The plan should define adverse outcomes by using an explicit list of well-defined complications;

(G) A systematic, informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

(H) A method for computing survival probability and comparing patient outcomes.

(I) The TRFs shall participate in the statewide WTC and the RAC of their TSA.

Section 5: Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department including manuals, bulletins, and policy statements, which are inconsistent with this Chapter.

³⁰ Autopsy information on all trauma patients is highly recommended. Complete anatomical diagnosis of injury is essential to the quality improvement process.