

Texas Administrative Code **Requirements for Trauma Facility Designation**
 Title 25, **General Trauma Facility Criteria**
 Part 1, Chapter 157,
 Subchapter G,
 RULE §157.125(s)

Legend: (Proposed Amendments)
Single Underline = Proposed new language
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1 **Figure 1: 25 TAC §157.125(s)**

2 **[General] ADVANCED TRAUMA FACILITY CRITERIA**

3 **[General] Advanced Trauma Facility (Level III)** - provides resuscitation, stabilization, and assessment of
 4 injury victims and either provides treatment or arranges for appropriate transfer to a higher level
 5 designated trauma facility; provides ongoing educational opportunities in trauma related topics for health
 6 care professionals and the public; and implements targeted injury prevention programs (see attached
 7 standards).). The administrative commitment of a Level III trauma facility includes developing processes
 8 that define the trauma patient population evaluated by the facility and track them throughout the course of
 9 their stay in order to maximize funding opportunities.

A. HOSPITAL ORGANIZATION	
1. TRAUMA PROGRAM AND TRAUMA SERVICE [*This requirement is an essential criterion for "lead" trauma facilities]	[D*] E
2. TRAUMA SERVICE COMPONENTS [(for hospitals with no trauma service)]	
<p>a. An identified Trauma Medical Director (TMD) who is a general surgeon and is charged with overall management of trauma services provided by the hospital.</p> <p>The TMD shall be credentialed by the hospital to participate in the resuscitation and treatment of trauma patients <u>using criteria</u> to include <u>such things as board-certification/board-eligibility</u>, trauma continuing medical education, compliance with trauma protocols, and participation in the trauma performance improvement program.</p> <p>The TMD shall be currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the [Texas Department of Health (TDH)] Department of State Health Services (DSHS).</p> <p>The TMD should participate in the development of the regional trauma system plan.</p> <p>The TMD or designee should participate on the hospital emergency management (disaster) response committee.</p> <p>There [be] shall <u>be</u> a defined job description and organization chart delineating the TMD's role and responsibilities.</p>	E
<p>b. An identified Trauma Nurse Coordinator\Trauma Program Manager (<u>TNC\TPM</u>), who is a registered nurse <u>and who has successfully completed TNCC or ATCN and a nationally recognized pediatric advanced life support course (e.g., ENPC or PALS); and has the authority and responsibility to monitor trauma patient care from ED admission through operative intervention(s), ICU care, stabilization, rehabilitation care, and discharge.</u></p>	E

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<p>The TNC\TPM should complete a course designed for his\her role which provides essential information on the structure, process, organization and administrative responsibilities of a PI program to include a trauma outcomes and performance improvement course.</p> <p>The TNC\TPM should participate in the hospital, community, and regional emergency management (disaster) response committee.</p> <p>There shall be a defined job description and organizational chart delineating the Trauma Nurse Coordinator's role and responsibilities.</p> <p>This [should] <u>shall</u> be a full-time position [in "lead" trauma facilities].</p>	
<p>c. An identified Trauma Registrar who has appropriate training ((such as the Association for the Advancement of Automotive Medicine (AAAM) course)) in injury severity scaling. <u>Typically, one full-time equivalent (FTE) employee dedicated to the registry will be required to process approximately 500 to 1,000 patients annually.</u></p>	E
<p>d. Written protocols, developed with approval of the hospital's medical staff, for:</p> <ol style="list-style-type: none"> 1) Trauma team activation 2) Identification of trauma team responsibilities during a resuscitation 3) Resuscitation and Treatment 4) Admission and transfer 	E
<p>e. All major and severe trauma patients should be admitted to an appropriate surgeon and all multi-system trauma patients should be admitted to a general surgeon.</p>	E
<p>[f. Written standards on nursing care for trauma patients for all units (i.e. ED, ICU, OR, PACU, general wards) in the trauma facility are to be implemented]</p>	E
<p>3. SURGERY DEPARTMENTS/DIVISIONS/SERVICES/SECTIONS</p>	
<p>a. General Surgery</p>	E
<p>b. Orthopedic Surgery [*This requirement is an essential criterion for "lead" trauma facilities]</p>	[D*] E
<p>c. Neurosurgery</p>	D
<p>4. EMERGENCY DEPARTMENT/DIVISION/SERVICE/SECTION/ROOM/Center</p>	E
<p>5. SURGICAL SPECIALTIES AVAILABILITY</p> <p>[a.] On-call and promptly available (<u>physically present</u>) at the patient's bedside within 30 minutes of request from inside or outside hospital. The <u>surgeon</u> staff specialists on-call will be immediately advised and will be promptly available within 30 minutes of request. This</p>	E

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<p>capability will be continuously monitored by the performance improvement program.</p>	
<p>General Surgery</p> <p>A [physician] <u>general surgeon</u> who is providing [this] <u>trauma</u> coverage shall be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients to include requirements such as <u>current</u> board certification/eligibility, <u>an average of 9 hours of trauma-related continuing medical education per year</u>, compliance with trauma protocols, and participation in the trauma performance improvement program</p> <p><u>A non-board-certified general surgeon desiring inclusion in a hospital's trauma program shall meet ACS guidelines as specified in its "Resources For Optimal Care Of the Injured Patient: 1999", Chapter 6 "Clinical Functions: General Surgery", Alternate Criteria section, or the most current version of this document.</u></p> <p>In hospitals with surgical residency programs, evaluation and treatment may be started by a team of surgeons that will include a PGY4 or more senior surgical resident who is a member of that hospital's residency program. The attending surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitations, and presence at operative procedures are mandatory. Compliance with these criteria and their appropriateness must be monitored by the trauma performance improvement program.</p> <p>A [physician] <u>general surgeon</u> who is providing [this] trauma coverage shall be currently credentialed in ATLS or an equivalent course approved by [TDH] <u>DSHS</u>.</p> <p>Communication should be such that the <u>attending</u> general surgeon will be present in the ED at the time of arrival of the severe or major trauma patient; maximum response time of the <u>attending</u> surgeon should be 30 minutes from trauma team activation. This system will be continuously monitored by the performance improvement program.</p> <p>When the <u>attending</u> surgeon is not activated initially and it has been determined by the emergency physician that a surgical consult is necessary, maximum response time of the <u>attending</u> surgeon should be 60 minutes from notification. This system will be continuously monitored by the performance improvement program.</p> <p>There shall be a [documented system] <u>published on-call schedule</u> for obtaining general surgery care for situations when the <u>attending</u> general surgeon on call is unavailable. This system will be continuously monitored by the performance improvement program. <u>Ideally, the surgeon is on call only at one institution; otherwise, a published back-up call schedule shall be in place in the Emergency Department.</u></p> <p><u>The attending surgeons that are providing coverage will attend greater than 50% or greater of multidisciplinary and peer review trauma committee meetings.</u></p>	<p>E</p>
<p>Neurosurgerv</p>	<p>D*</p>

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<p><u>A neurosurgeon providing trauma coverage shall be promptly available (physically present) at the patient’s bedside within 30 minutes of request by the attending trauma surgeon or emergency physician from inside or outside hospital.</u></p> <p><u>When the neurosurgeon providing this coverage is not activated initially and it has been determined by the emergency physician or trauma surgeon that an urgent neurosurgical consult is necessary, maximum response time of the neurosurgeon should be 60 minutes from notification. This system will be continuously monitored by the performance improvement program.</u></p> <p><u>A neurosurgeon who is providing trauma coverage shall be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients to include requirements such as current board certification/eligibility, an average of 9 hours of neurotrauma-related continuing medical education per year, compliance with trauma protocols, and participation in the trauma performance improvement program.</u></p> <p><u>A non-board–certified neurosurgeon desiring inclusion in a hospital’s trauma program shall meet ACS guidelines as specified in its “Resources For Optimal Care Of the Injured Patient: 1999”, Chapter 8 “Clinical Functions: Neurosurgery”, Alternate Criteria section., or the most current version of this document.</u></p> <p>A [physician] <u>neurosurgeon</u> who is providing [this] <u>trauma</u> coverage should be currently credentialed in ATLS or an equivalent course approved by [TDH] <u>DSHS</u>.</p> <p><u>There shall be a published on-call schedule for obtaining neurosurgical care. This system will be continuously monitored by the performance improvement program.</u></p> <p><u>An neurosurgeon representative that provides trauma coverage to the facility will attend greater than 50% of multidisciplinary and peer review trauma committee meetings.</u></p> <p><u>*these criteria are “essential” when a Level III has either full-time or routinely-provided limited neurosurgical coverage</u></p>	
<p>Ophthalmic Surgery</p>	<p>D</p>
<p>Orthopedic Surgery</p> <p>An orthopedic surgeon providing trauma coverage shall be promptly available (physically present) at the patient’s bedside within 30 minutes of request by the attending trauma surgeon or emergency physician from inside or outside hospital. This system will be continuously monitored by the performance improvement program.</p> <p>When the orthopedic surgeon is not activated initially and it has been determined by the emergency physician that an urgent surgical consult is necessary, maximum response time of the orthopedic surgeon should be 60 minutes from notification. This system will be</p>	<p>[D*] E</p>

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<p>continuously monitored by the performance improvement program.</p> <p>An orthopedic surgeon who is providing trauma coverage shall be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients to include requirements such as current board certification/eligibility, an average of 9 hours of skeletal trauma-related continuing medical education per year, compliance with trauma protocols, and participation in the trauma performance improvement program.</p> <p>A non-board-certified orthopedic surgeon desiring inclusion in a hospital's trauma program shall meet ACS guidelines as currently specified in its "Resources For Optimal Care Of the Injured Patient: 1999", Chapter 9 "Clinical Functions: Orthopaedic Surgery", Alternate Criteria section.</p> <p>A [physician] orthopedic surgeon who is providing [this] trauma coverage should be currently credentialed in ATLS or an equivalent course approved by [TDH] DSHS.</p> <p>There shall be a published on-call schedule for obtaining orthopedic surgery care. This system will be continuously monitored by the performance improvement program. There shall be a published on-call schedule for obtaining orthopedic surgery care for situations when the orthopedic surgeon on call is unavailable. This system will be continuously monitored by the performance improvement program. Ideally, the orthopedic surgeon is on call only at one institution; otherwise, a published back-up call schedule shall be in place in the Emergency Department.</p> <p>An orthopedic surgeon representative that provides trauma coverage to the facility will attend greater than 50% of multidisciplinary and peer review trauma committee meetings.</p>	
Otorhinolaryngologic Surgery	D
Thoracic Surgery	D
Urologic Surgery	D
6. NON-SURGICAL SPECIALTIES AVAILABILITY	
a. In-house 24 hours a day	
<p>Emergency Medicine</p> <p>An <u>Emergency Medicine board-certified physician</u> who is providing [this] <u>trauma coverage</u> shall [be currently credentialed in ATLS or an equivalent course approved by the Texas Department of Health (TDH). A board-certified emergency physician is exempt from this requirement if the physician participates in the care of at least 10 major or severe trauma patients in the previous 12 month period.] <u>have successfully completed an ATLS Student Course or a DSHS-approved ATLS equivalent course.</u></p> <p>Current ATLS verification is required for all physicians who work in the emergency</p>	E

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<p>department and are not board certified in Emergency Medicine.</p> <p>Any emergency physician who is providing [this] trauma coverage shall be credentialed by [the hospital] the TMD to participate in the resuscitation and treatment of trauma patients of all ages to include requirements such as current board certification/eligibility, an average of 9 hours of trauma-related continuing medical education per year, compliance with trauma protocols, and participation in the trauma performance improvement program.</p> <p>An emergency physician representative that provides trauma coverage to the facility will attend greater than 50% of multidisciplinary and peer review trauma committee meetings.</p>	
<p>b. On-call and promptly available within 30 minutes of request from inside or outside the hospital:</p>	
<p>Anesthesiology</p> <p>Requirements may be fulfilled by a member of the anesthesia care team credentialed by [the hospital] the TMD to participate in the resuscitation and treatment of trauma patients that may include requirements such as board certification, trauma continuing education, compliance with trauma protocols, and participation in the trauma performance improvement program. <u>This system will be continuously monitored by the performance improvement program.</u></p> <p>An anesthesiology physician representative that provides trauma coverage to the facility will attend greater than 50% of multidisciplinary and peer review trauma committee meetings.</p>	E
<p>Cardiology</p>	D
<p>Family Medicine</p> <p>The patient's primary care physician should be notified at an appropriate time.</p>	D
<p>Hematology</p>	D
<p>Internal Medicine</p> <p>The patient's primary care physician should be notified at an appropriate time.</p>	E
<p>Nephrology</p>	D
<p>Pathology</p>	D
<p>Pediatrics</p> <p>The patient's primary care physician should be notified at an appropriate time.</p>	D
<p>Radiology</p>	[D]E

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B. SPECIAL FACILITIES/RESOURCES/CAPABILITIES	
1. EMERGENCY DEPARTMENT	
a. Designated physician director	E
b. Physician with special competence in care of critically injured who is designated member of the trauma team and physically present in the ED 24 hours a day <u>An Emergency Medicine board-certified physician who is providing [this] trauma coverage shall [be credentialed in ATLS or an equivalent course approved by TDH] have successfully completed an ATLS Student Course or a DSHS-approved ATLS equivalent course.</u> Current ATLS verification is required for all physicians who work in the emergency department and are not board-certified in Emergency Medicine.	E
c. Nurse staffing in initial resuscitation area is based on patient acuity and trauma team composition based on historical census and acuity data	E
A minimum of two registered nurses who have trauma nursing training will participate in initial major trauma resuscitation	D
Nursing documentation for trauma patients is systematic and meets the trauma registry guidelines	E
100% of nursing staff has successfully completed ACLS (or hospital equivalent) and a nationally recognized pediatric advanced life support course (i.e. [PALS,] ENPC, PALS) within six months of the date of employment in the ED or date of designation	D
100% of registered nursing staff has successfully completed TNCC, or <u>DSHS [TDH]</u> approved equivalent, within 18 months of date of employment in the ED or date of designation	E
d. Two-way communication with vehicles of pre-hospital emergency medical services	E
e. Equipment and services for <u>the evaluation and resuscitation of</u> , and to provide life support for, [the] critically or seriously injured <u>patients of all ages</u> shall include but not be limited to:	
Airway control and ventilation equipment including laryngoscope and endotracheal tubes of all sizes, bag-valve-mask [resuscitator] <u>devices (BVMs)</u> , pocket masks, oxygen, and mechanical ventilator	E
<u>Pulse oximetry</u>	<u>E</u>
Suction devices	E
Electrocardiograph-oscilloscope-defibrillator	E
<u>Internal age-specific paddles</u>	<u>E</u>
[Apparatus to establish] Central venous pressure monitoring <u>equipment</u>	E

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All standard intravenous fluids and administration devices, including <u>large-bore</u> intravenous catheters and <u>a rapid [infusion devices] infuser system</u>	E
Sterile surgical sets for procedures standard for ED, such as thoracostomy, [venesection] venous cutdown, central line insertion, <u>thoracotomy</u> , diagnostic peritoneal lavage, <u>airway control</u> <u>cricothyrotomy</u> , etc.	E
Gastric lavage equipment	E
Drugs and supplies necessary for emergency care	E
Cervical spine stabilization device	E
<u>Length-based body weight & tracheal tube size evaluation system (such as Broselow tape)</u> and resuscitation medications that are dose-appropriate for all ages	<u>E</u>
Long bone/ <u>pelvic</u> stabilization device	E
Thermal control equipment for patients and a rapid warming device for blood and fluids	E
Non-invasive continuous blood pressure monitoring devices	E
Transcutaneous oximeter	E
<u>Qualitative</u> end tidal CO ₂ monitor	E
X-ray capability The technician will be on-call and promptly available within 30 minutes of request.	E
Support Services These services will be promptly available within 30 minutes of request.	D
2. OPERATING SUITE	E
a. Operating room services - will be available 24 hours a day. With advanced notice, the Operating Room should be opened and ready to accept a patient within 30 minutes. This system will be continuously monitored by the performance improvement program.	
b. Equipment - special requirements shall include but not be limited to:	
Thermal control equipment for patient and for blood and fluids	E
X-ray capability including c-arm image intensifier with technologist available 24 hours a day	[D] <u>E</u>
Endoscopes, all varieties, <u>and bronchoscope</u>	E
<u>Equipment for long bone and pelvic fixation</u>	<u>E</u>

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<u>Rapid infuser system</u>	<u>E</u>
Monitoring equipment	[D] <u>E</u>
1) the capability to measure pulmonary capillary wedge pressure	[D] <u>E</u>
2) the capability to measure invasive systemic arterial pressure	[D] <u>E</u>
3. POSTANESTHETIC RECOVERY ROOM (surgical intensive care unit is acceptable)	
a. Registered nurses and other essential personnel 24 hours a day. <u>All nurses caring for trauma patients throughout the continuum of care have ongoing documented knowledge and skill in trauma nursing to include pediatric and burn patients (i.e., trauma specific orientation, clinical competencies, annual competencies, continuing education). Written standards on nursing care for trauma patients shall be implemented.</u>	<u>E</u>
b. Appropriate monitoring and resuscitation equipment	<u>E</u>
c. <u>Pulse oximetry</u>	<u>E</u>
d. <u>Thermal control</u>	<u>E</u>
4. INTENSIVE CARE CAPABILITY	<u>E</u>
a. Designated surgical director <u>or surgical co-director who is responsible for setting policies and administration related to trauma ICU patients</u> A physician who is providing this coverage [should be] <u>must be a surgeon who is credentialed by the TMD to participate in the resuscitation and treatment of trauma patients to include requirements such as board certification\board-eligibility, trauma continuing medical education, compliance with trauma protocols, and participation in the trauma performance improvement program.</u>	<u>E</u>
b. Physician, credentialed in critical care by the trauma director, on duty in ICU 24 hours a day or immediately available from in-hospital. <u>Arrangements for 24-hour surgical coverage of all trauma patients shall be provided for emergencies and routine care. This system will be continuously monitored by the performance improvement program</u>	<u>E</u>
c. <u>Registered Nurse-patient minimum ratio of 1:2 on each shift for patients identified as critical acuity</u>	<u>E</u>
d. Equipment Appropriate monitoring and resuscitation equipment 1) the capability to measure pulmonary capillary wedge pressure	<u>E</u> [D] <u>E</u> [D] <u>E</u>

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2) the capability to measure invasive systemic arterial pressure	
5. Support Services – [Immediate access to clinical diagnostic services Toxicology screens need not be immediately available but are desirable. If available, results should be included in all performance improvement reviews.] a. <u>Respiratory Therapy Services</u> <u>On-call 24 hours\day</u>	<u>E</u>
5. NURSING SERVICE	
a. All nurses caring for trauma patients throughout the continuum of care have ongoing documented knowledge and skill in trauma nursing to include pediatric and burn patients (i.e., trauma specific orientation, [skills checklist] <u>clinical competencies</u> , annual competencies, continuing education).	E
b. <u>Written standards on nursing care for trauma patients for all units (i.e. ED, ICU, OR, PACU, general wards) in the trauma facility shall be implemented</u>	
c. [b]. 50% of nurses caring for trauma patients certified in their area of specialty (e.g. CEN, CCRN, CNRN, CNOR, etc.)	D
d. [c]. A validated acuity-based patient classification is utilized to define workload and number of nursing staff to provide safe patient care for all trauma patients throughout their hospitalization	E
e. [d]. A written plan, developed by the hospital, for acquisition of additional staff on a 24-hr. basis to support units with increased patient acuity, multiple emergency procedures and admissions	E
6. CLINICAL LABORATORY SERVICE (available 24 hours a day)	
a. Standard analyses of blood, urine, and other body fluids, <u>including microsampling</u>	E
b. Blood typing and cross-matching, to include massive transfusion and emergency release of blood policies	E
c. Coagulation studies	E
d. Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities	E
e. Blood gases and pH determinations	E
f. Serum and urine osmolality	D
g. Microbiology	E
h. Drug and alcohol screening [Toxicology screens need not be immediately available but are desirable. If available, r] <u>Results should be included in all performance improvement reviews.</u>	[D] <u>E</u>
i. Infectious disease Standard Operating Procedures	E

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7. SPECIAL RADIOLOGICAL CAPABILITIES (available 24 hours\day)	
a. Angiography of all types	D
b. Sonography	[D] <u>E</u>
c. Nuclear scanning	D
d. Computerized tomography	E
e. <u>In-house CT technician 24-hours a day or call-back process for trauma activations. The performance improvement program will continuously monitor this system.</u>	[D] <u>E</u>
8. ACUTE HEMODIALYSIS CAPABILITY <u>Transfer agreement if no capability</u>	[D] <u>E</u>
9. ORGANIZED BURN CARE 1. <u>Physician-directed burn center staffed by nursing personnel trained in burn care and equipped properly for care of the extensively burned patient;</u>	E
10. SPINAL CORD/HEAD INJURY REHABILITATION MANAGEMENT CAPABILITY or appropriate services made available. In circumstances where a designated spinal cord injury rehabilitation center exists in the region, early transfer should be considered; transfer agreements should be in effect. In circumstances where a head injury center exists in the region, transfer should be considered in selected patients; transfer agreements should be in effect.	E
11. REHABILITATION MEDICINE Physician-directed rehabilitation service, staffed by personnel trained in rehabilitation care and equipped properly for care of the critically injured patient, or transfer agreement when medically feasible to a rehabilitation facility[.] <u>and a system/process to expedite the transfer rehabilitation patients to include such things as written protocols, written transfer agreements, and a regional trauma system transfer plan for patients needing a higher level of care or specialty services.</u>	E
<u>Physical therapy</u>	<u>E</u>
<u>Occupational therapy</u>	<u>E</u>
<u>Speech therapy</u>	<u>D</u>
12. Social Service	<u>E</u>

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C. PERFORMANCE IMPROVEMENT	
1. Organized Performance Improvement Program <u>with a pediatric-specific component established by the hospital, to include trauma audit filters (see attached standard list).</u>	E
2. <u>Special audit for all trauma deaths and other specified cases[.], including complications, utilizing age-specific criteria.</u>	E
3. Morbidity and mortality review.	E
4. Multidisciplinary trauma conference for performance improvement activities, continuing education and problem solving to include documented nurse and pre-hospital participation. Regular and periodic multidisciplinary trauma conferences that include all members of the trauma team should be held. This conference will be for the purpose of performance improvement through critiques of individual cases. [*This requirement is an essential criterion for "lead" trauma facilities]	[D*] <u>E</u>
5. Medical and nursing care audit, utilization review, and tissue review for compliance with trauma protocols and appropriate and quality patient care throughout the continuum.	E
6. <u>Feedback regarding trauma patient transfers-in from EDs and in-patient units will be provided to all transferring facilities[.], and include such things as >2-hour ED stays in referring facility and rationale for denial of transfer from a referring facility.</u>	E
7. Trauma registry Documentation of severity of injury (by revised trauma score, age, injury severity score) and outcome (survival, length of stay, ICU length of stay) with monthly review of statistics. Data will be forwarded to the state trauma registry on at least a quarterly basis.	E
8. [Coordination] <u>Participation with the regional [trauma system] advisory council's Performance Improvement program , including adherence to regional protocols, review of pre-hospital trauma care, submitting data to the RAC as requested including such things as summaries of transfer denials and transfers to hospitals outside of the RAC.</u>	E
9. <u>Published on-call schedule must be maintained for general surgeons and neurosurgeons, orthopedic surgeons, anesthesia, radiology, and other major specialists if available</u>	E
10. <u>Times of and reasons for diversion must be documented and reviewed by the performance improvement program</u>	E
11. Performance improvement personnel - dedicated to and specific for the trauma program	D
[12. Nursing performance improvement plan and ongoing activities documented which address the trauma patient population in all phases of trauma care]	[D]
[13. Written transfer agreements for patients needing a higher level of, or specialty, care if unavailable]	[E]
[14. A system for establishing an appropriate landing zone in close proximity to the	[E]

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hospital (if rotor wing services are available).]	
D. REGIONAL TRAUMA SYSTEM	
1. Must participate in the regional trauma system per RAC requirements	<u>E</u>
E. TRANSFERS	
[Written transfer agreements] A system/process to expedite the transfer of major and severe trauma patients to include such things as written protocols, written transfer agreements, and a regional trauma system transfer plan for patients needing higher level of <u>care</u> [,] or specialty[, care] services.	<u>E</u>
2. A system for establishing an appropriate landing zone in close proximity to the hospital (if rotor wing services are available) .	<u>E</u>
[D.] <u>E. OUTREACH PROGRAM</u>	
1. [Telephone and on-site] Provide education to and consultations with physicians of the community and outlying areas. [*This requirement is an essential criterion for "lead" trauma facilities]	[D*] <u>E</u>
2. [Nurse Participation in] A defined individual to coordinate the facility's community outreach programs for the public and professionals is evident [*This requirement is an essential criterion for "lead" trauma facilities]	[D*] <u>E</u>
[E.] <u>G. PUBLIC EDUCATION/INJURY PREVENTION</u>	
1. A program to address the major injury problems within the hospital's service area. Documented participation in a RAC public education program is acceptable.	<u>E</u>
2. Coordination and/or participation in community injury prevention activities	<u>E</u>
[G.]<u>H. TRAINING PROGRAM</u>	
1. Formal programs in trauma continuing education provided by hospital for:	
a. Staff physicians	[D] <u>E</u>
b. Nurses	<u>E</u>
c. Allied health personnel, including <u>mid-level providers such as</u> physician[s] assistants and <u>nurse practitioners</u>	<u>E</u>
d. Community physicians	[D] <u>E</u>
e. Pre-hospital personnel [*This requirement is an essential criterion for "lead" trauma facilities]	[D*] <u>E</u>
I. RESEARCH	
Trauma registry performance improvement activities	<u>E</u>