

1 Proposed Amendment(s)

2
3 §157.125. Requirements for Trauma Facility Designation.

4
5 (a) General Provisions. The goal of the trauma system is to reduce the morbidity and
6 mortality of the trauma patient. The objective of the trauma system is to get the right patient, to
7 the right place, at the right time, to receive the right care. The purpose of this section is to set
8 forth the requirements for a health care facility to become a designated trauma facility.

9
10 (1) The Department of State Health Services (department) shall determine the
11 designation level for each location, based on, but not limited to, the location's own resources and
12 levels of care capabilities; Trauma Service Area (TSA) capabilities; and compliance with the
13 essential criteria and standard requirements outlined in this section.

14
15 (2) The Office of Emergency Medical Services (EMS)/Trauma Systems
16 Coordination (office) shall recommend to the Commissioner of the Department of State Health
17 Services (commissioner) the trauma designation of a facility at the level the office deems
18 appropriate.

19
20 (3) Facilities eligible for trauma designation include:

21
22 (A) A General Hospital, licensed or otherwise meeting the description
23 (in accordance with Texas Administrative Code (TAC) Hospital Licensing Section 133.21).

24
25
26 (B) a general hospital owned and operated by the state of Texas, or

27
28 (C) a general hospital owned and operated by the federal government.

29
30 (i) Each facility operating on a single general hospital license
31 with multiple locations (multi-location license) shall be
32 considered separately for designation.

33 (ii) Designation does not include provider based departments
34 of the designated facility, which are not contiguous with the
35 designated facility.

36
37 (iii) Departments or services within a facility shall not be
38 separately designated.

39
40 (4) a trauma facility designation is issued for the physical location and to the
41 legal owner of the operations of the facility. If a designated facility has a change of ownership or
42 a change of the physical location of the facility, the designation shall not be transferred or
43 assigned.

44
45 (5) The four levels of trauma designation and the requirements for each are as
46 follows:

47
48 (A) Comprehensive (Level I) trauma facility designation. The facility
49 shall meet the current American College of Surgeons (ACS) essential criteria for a verified Level
50 I trauma center.

51
52 (B) Major (Level II) trauma facility designation. The facility shall
53 meet the current ACS essential criteria for a verified Level II trauma center.

54
55 (C) Advanced (Level III) trauma facility designation. The facility shall
56 meet the Level III Program Requirements in subsection (k) of this section and if the facility
57 chooses to be verified by the ACS the facility must meet the current ACS essential criteria for a
58 verified Level III trauma center.

59
60 (D) Basic (Level IV) trauma facility designation. The facility meets
61 the Level IV Program Requirements in subsection (k) of this section.

62
63 (6) In Active Pursuit of Designation (IAP). Subsection applies only to an
64 undesignated facility in accordance with Texas Administrative Code (TAC) Designated Trauma
65 Facility and Emergency Medical Services Account Section 157.131(a)(10).

66
67 (b) Designation Process.

68
69 (1) Application. A facility seeking designation, shall submit a completed
70 application to include:

71
72 (A) an accurate and complete designation application form for the
73 appropriate level of requested designation, including full payment of the non-refundable, non-
74 transferrable, designation fee as follows;

75
76 (i) Level I and Level II trauma facility applicants, the fee will
77 be no more than \$10 per licensed bed with an upper limit of \$5,000 and a lower limit of \$4,000;

78
79 (ii) Level III trauma facility applicants, the fee will be no more
80 than \$10 per licensed bed with an upper limit of \$2,500 and a lower limit of \$1,500; and

81
82 (iii) Level IV trauma facility applicants, the fee will be no more
83 than \$10 per licensed bed with an upper limit of \$1000 and a lower limit of \$500.

84
85 (B) Initial designation of a trauma facility. The CEO, TMD and TPM
86 of the facility shall attend a presurvey conference at the office designated by the department. The
87 purpose of the presurvey conference, conducted by department staff, is to review and discuss the
88 designation requirements for the applicable level prior to the initial onsite designation survey.
89 The department may waive the presurvey conference requirement. A facility will not be
90 recommended for designation until the presurvey conference is completed.

91

92 (C) any subsequent documents submitted by the date requested by the
93 office;

94
95 (D) a completed trauma designation survey report, including patient
96 care reviews, if required by the department, submitted no later than 180 days from the date of the
97 survey;

98
99 (E) a plan of correction (POC), detailing how the facility will correct
100 any deficiencies cited in the survey report, to include: statement of the cited deficiency, the
101 corrective action to ensure compliance with the requirement, the title of the individual(s)
102 responsible for ensuring the correction action(s) is implemented, the date by which the corrective
103 action will be implemented, not to exceed 90 days from the date the facility received the official
104 survey report, and how the corrective action will be monitored.

105
106 (F) evidence of participation in the applicable Regional Advisory
107 Council (RAC).

108
109 (G) evidence of submission of data to the department trauma registry
110

111 (H) Renewal of designation. The applicant shall submit the documents
112 described in subsection (be)(1) (C) – (G) above, to the office at least 90 days prior to the
113 designation expiration date.

114
115 (I) If a facility seeking designation fails to meet the requirements in
116 subsection (c)(1) – (5) above, the application shall be considered withdrawn by the facility.

117
118 (c) Survey Process. A facility seeking designation shall undergo an onsite survey
119 as outlined in this section.

120
121 (1) The facility shall be responsible for scheduling a verification or trauma
122 designation survey as follows:

123
124 (A) Level I and II facilities shall request a trauma verification survey
125 through the American College of Surgeons (ACS) trauma verification program;

126
127 (B) Level III facilities shall request a trauma verification survey
128 through the ACS trauma verification program, or request a trauma designation survey through an
129 organization approved by the office; and

130
131 (C) Level IV facilities shall request a trauma designation survey
132 through an organization approved by the office.

133
134 (2) The surveying organization shall notify the office of the date of the
135 scheduled survey and shall schedule the members of the survey team.

136

137 (A) The facility shall be responsible for any expenses associated with
138 the survey.

139
140 (B) The office, at its discretion, may appoint an observer to accompany
141 the survey team. In this event, the cost for the observer shall be borne by the office.

142
143 (3) The multi-disciplinary survey team shall consist of the following
144 members:

145
146 (A) Level I or Level II facilities shall be surveyed by The American
147 College of Surgeons (ACS) with a multi-disciplinary team and includes at a minimum: two
148 trauma surgeons, and a trauma nurse all active in the management of trauma patients. Pediatric
149 facilities shall be surveyed by the ACS with a multi-disciplinary team and includes at a
150 minimum: one pediatric trauma surgeon; one adult trauma surgeon, and a pediatric trauma
151 nurse, all active in the management of trauma patients.

152
153 (B) Level III facilities shall be surveyed by the ACS, or other office-
154 approved organization, with a multi-disciplinary team that includes at a minimum: a trauma
155 surgeon and a trauma nurse, active in the management of trauma patients. Pediatric facilities
156 shall be surveyed by the ACS, or an office-approved organization with a multi-disciplinary team
157 that includes at a minimum: a trauma surgeon with pediatric experience, and a pediatric trauma
158 nurse or a Trauma Program Manager with pediatric experience, all active in the management of
159 pediatric trauma patients. An additional surveyor may be requested by the facility, or required by
160 the department.

161
162 (C) Level IV facilities shall be surveyed by an office approved
163 organization by a surveyor that is either at a minimum: a registered nurse or a licensed physician,
164 active in the management of trauma patients. Children's facilities shall be surveyed by an office-
165 approved organization, whose surveyor is a general surgeon with pediatric experience, or a
166 pediatric trauma nurse, or a Trauma Program Manager with pediatric experience, active in the
167 management of pediatric trauma patients. A second surveyor may be requested by the facility, or
168 required by the department.

169
170 (D) Each member of the survey teams described above shall:

171
172 (i) be currently employed at a designated trauma facility that is
173 greater than 100 miles from the requesting facility;

174
175 (ii) not be employed in the same TSA as the designating
176 facility;

177
178 (iii) not be a current or former employee of the facility that is
179 the subject of the survey or of an affiliated facility;

180
181 (iv) not be employed at a facility that is a primary transfer
182 facility with the facility being surveyed, with the exception of a burn facility;

183
184 (v) not survey the facility program and physical location on
185 consecutive designation cycles; and
186
187 (vi) not have been requested by the facility;
188
189 (vii) not possess other potential conflict of interest between the
190 surveyor or the surveyor's place of employment and the facility being surveyed.
191
192 (6) Each member of the survey team shall:
193
194 (A) have at least 5 years experience in the care of trauma patients;
195
196 (B) be currently employed in the management of or providing direct
197 care services to trauma patients;
198
199 (C) have direct experience in the preparation for and successful
200 completion of trauma facility designation for no fewer than 2 successful designation cycles;
201
202 (D) have successfully completed a DSHS-approved trauma facility site
203 surveyor course and be successfully re-credentialed every 4 years; and
204
205 (E) have current credentials as follows:
206
207 (i) for registered nurses: Trauma Nurses Core Course (TNCC)
208 or Advanced Trauma Course for Nurses (ATCN); and Pediatric Advanced Life Support (PALS)
209 or Emergency Nurses Pediatric Course (ENPC);
210
211 (ii) for physicians: Advanced Trauma Life Support (ATLS);
212 and
213
214 (iii) have successfully completed a trauma designation surveyor
215 internship.
216
217 (7) The survey team shall evaluate the facility's compliance and document the
218 noncompliance with this section 157.125 by:
219 (A) reviewing documents, including a minimum of 10 closed medical
220 records per surveyor;
221 (B) tour of the physical plant; and staff interviews to include:
222
223 (i) the Chief Executive Officer
224 (ii) the Chief Nursing Officer
225 (iii) current Trauma Medical Director
226 (iv) the current Executive Sponsor of the trauma program, if not
227 the CEO or CNO.
228

229 (8) The surveyor(s) shall provide the facility with a written, signed survey
230 | report documenting the findings of the facility's compliance / noncompliance with §157.125.
231 The survey report shall be forwarded to the facility within 30 calendar days of the completion
232 date of the survey. The facility is responsible for forwarding a copy of the survey report,
233 including patient record reviews, to the office if it intends to continue the designation process.
234

235 (9) The trauma designation survey report and patient care reviews in its
236 entirety shall be part of the facility's quality assessment and performance improvement
237 (QAPI)/Multidisciplinary Trauma PI and peer review program and subject to confidentiality as
238 articulated in the Health and Safety Code, §773.095.
239

240 (10) If a hospital seeking designation fails to meet the requirements of this
241 section, the application shall be denied and, for facilities seeking re-designation, the original
242 designation will expire on its expiration date.
243

244 (11) The office will review the findings of the survey report and patient care
245 reviews and POC. A recommendation for designation will be made to the commissioner if the
246 facility meets the requirements for designation found in this section.
247

248 (13) The facility shall have the right to withdraw its application at any time
249 prior to being recommended for trauma facility designation by the office.
250

251 (14) If the commissioner concurs with the recommendation to designate, the
252 facility shall receive a letter of designation valid for 3 years and a certificate of designation.
253

254 (A) Display: The hospital shall prominently and conspicuously display
255 the trauma designation certificate and the current letter awarding designation from the
256 Commissioner, in a public area of the licensed premises that is readily visible to patients,
257 employees, and visitors.
258

259 (B) The trauma designation certificate shall be valid only when
260 displayed with the current letter awarding designation.
261 |

262 (C) If the facility closes or the trauma designation is revoked or
263 expires, the certificate shall be returned to the department.
264

265 (15) Alteration: the trauma designation certificate and the award letter shall not
266 be altered. Any alteration to either document voids trauma designation for the remainder of that
267 cycle.
268

269 (16) It shall be necessary to repeat the designation process as described in this
270 | section prior to expiration of a facility's designation or the designation expires.
271 |

272 (17) The office shall post the current designation status of each facility on the
273 office website.
274

275 (d) Exceptions and Notifications

276

277 (1) If a facility is unable to comply with any of the critical elements of the
278 trauma program (TS, NS, Ortho, TMD, TPM, Anesthesiology, EM, Trauma Registrar, Trauma
279 Registry etc.), the facility must notify the office, applicable RAC(s), the emergency medical
280 services providers, and the healthcare facilities to which it customarily transfers-out and/or
281 transfers-in trauma patients.

282

283 (2) If the healthcare facility is unable to comply with program requirements to
284 maintain the current designation status, it shall submit to the office a POC as described in (b)
285 (17) (A) (i – iii) of this section, and a request for a temporary exception to criteria. Any request
286 for an exception shall be submitted in writing from an executive officer of the facility. The office
287 shall review the request and the POC and either grant or deny the exception. If the healthcare
288 facility has not come into compliance at the end of the exception period, the office may at its
289 discretion elect one of the following:

290

291 (A) allow the facility to request designation at the level appropriate to
292 its revised capabilities;

293

294 (B) re-designate the facility at the level appropriate to its revised
295 capabilities; or

296

297 (C) suspend the facility's designation status or the facility may
298 relinquish designation status.

299

300 (e) Downgrade of designation levels or relinquishment of designation

301

302 (1) A designated trauma facility that is unable to maintain compliance with
303 the level of the current designation may choose to apply for a lower level of trauma designation
304 at any time. It shall be necessary to repeat the designation process for the lower level. There shall
305 be a paper review by the office to determine if and when a full survey shall be required.

306

307 (2) The facility must notify the office within 5 days of the date that it no
308 longer provides trauma services commensurate with its designation level.

309

310 (3) If the facility chooses to relinquish its trauma designation, it shall provide
311 at least 30 day notice to the department, the applicable RAC(s), the emergency medical services
312 providers, and healthcare facilities to which it customarily transfers-out and/or transfers-in
313 trauma patients if it no longer provides trauma services.

314

315 (f) A healthcare facility may not use the terms "trauma facility", "trauma hospital",
316 "trauma center", or similar terminology in its signs, advertisements or in printed materials and
317 information it provides to the public unless the healthcare facility is currently designated as a
318 trauma facility according to the process described in this section.

319

320 (g) The office shall have the right to review, inspect, evaluate, and audit all trauma
321 patient records, trauma QAPI/performance improvement and peer review committee minutes and
322 other documents relevant to trauma care in any designated trauma facility or applicant/healthcare
323 facility at any time to verify compliance with the statute and this rule, including the designation
324 criteria. The office shall maintain confidentiality of such records to the extent authorized by the
325 Texas Public Information Act, Government Code, Chapter 552, and consistent with current laws
326 and regulations related to the Health Insurance Portability and Accountability Act of 1996. Such
327 inspections shall be scheduled by the office when deemed appropriate. The office shall provide a
328 copy of the survey report, for surveys conducted by or contracted for the department and the
329 results to the healthcare facility.

330
331 (h) The office may grant an exception to this section if it finds that compliance with
332 this section would not be in the best interests of the persons served in the affected local system.

333
334 (i) Program Requirements.

335
336 (1) Written Plan of Trauma Service Basis and Scope; Levels I-IV. The facility
337 shall develop a written plan of the organized trauma service that includes the scope of services
338 available to all trauma patients, defines the trauma patient population evaluated or treated by the
339 facility, is consistent with accepted professional standards of practice for trauma care, and
340 ensures the health and safety of patients.

341
342 (A) The written trauma service plan shall be reviewed and approved by
343 the governing body. The governing body shall ensure that the requirements of this chapter are
344 implemented and enforced.

345
346 (B) The written trauma service plan shall include, at a minimum:

347
348 (i) policies and procedures based on national evidence based
349 practices of trauma care, that are adopted, implemented, and monitored for compliance by the
350 facility that governs the trauma services through all phases of care for all patient populations.
351 The plan shall address the major and severe trauma patient entering into the trauma center and
352 those patients having an ISS of 9 or greater at discharge, telemedicine utilization in the
353 Emergency Department (ED), trauma team activations, staff qualifications, and the role of the
354 hospitalists in the care of the trauma patient. A periodic review and revision schedule for all
355 trauma care policies and procedures shall be established;

356
357 (ii) provisions for ongoing multidisciplinary trauma care
358 meetings and trauma peer review;

359
360 (iii) a quality assurance and performance improvement
361 (QAPI)/multidisciplinary PI program to evaluate performance of all trauma care that is hospital
362 wide, ongoing, data driven, and outcomes based;

363
364 (iv) provisions for staff education; and
365

366 (v) provisions for participation by the TMD, TPM, TR, or
367 other members of the trauma program in the regional advisory council (RAC);
368

369 (vi) requirements for minimal credentials for staff participating
370 in the care of trauma patients;

371 (vii) shall have a nurse caring for trauma patients as a standing
372 member of the hospital nurse staffing committee as established in accordance with Health and
373 Safety Code (HSC), §§161.031 - 161.033; and
374

375 (viii) contingency plan to ensure the immediate continuation of
376 an active trauma program in the event that the Trauma Medical Director or the Trauma Program
377 Manager position becomes vacant.

378
379 (vix) identify a program sponsor who is a member of the
380 executive leadership at the facility.
381

382 (2) Medical Records Content. Maintain medical records that contain
383 information to justify and support the immediate evaluation, activation, resuscitation, diagnosis,
384 treatment, and describe the patient's progress and response to medication and interventions from
385 arrival in the Emergency Department through discharge. Records include evidence of
386 documentation of the following as appropriate:
387

388 (A) Trauma team response times, mechanism of injury, assessments,
389 interventions, and response to interventions;
390

391 (B) Vital signs and other information necessary for ongoing
392 monitoring of the patient's condition; and
393

394 (C) Daily physician notes by the admitting physician and all sub-
395 speciality physicians participating in the patient's care.
396

397 (3) Medical Staff. The hospital must have an organized, effective trauma
398 program that is recognized in the medical staff bylaws and approved by the governing body.
399 Medical staff credentialing shall include a process for requesting and granting delineation of
400 privileges for trauma care.
401

402 (A) Trauma Medical Director. There shall be an identified Trauma
403 Medical Director (TMD) responsible for the provision of trauma care and credentialed by the
404 facility for the treatment of trauma patients.
405

406 (i) The Trauma Medical Director shall be a member of the
407 Medical Executive Committee (MEC);
408

409 (ii) The Trauma Medical Director shall have responsibility for
410 the overall clinical direction and oversight of the trauma program;
411

412 (iii) The responsibilities and authority of the Trauma Medical
413 | Director shall include but are not limited to:
414
415 (I) reviewing credentials of medical staff requesting
416 privileges on the trauma team and making recommendations to the Medical Executive
417 Committee for either approval or denial of such privileges;
418
419 (II) ensuring that a published, on-call schedule and a
420 backup on-call schedule is readily available to all staff in the emergency department for
421 obtaining surgical care for all surgical specialties;
422
423 (III) regularly and actively participating in or on the
424 trauma call panel;
425
426 (IV) has the authority to exclude those trauma team
427 members from trauma call who do not maintain trauma program requirements;
428
429 (V) ensuring the use of medical staff peer review
430 outcomes, including deviations from trauma standards of care trending, when considering re-
431 credentialing members of the trauma team. All follow-up and feedback from peer review activity
432 must be made available to the reviewers at the time of the onsite survey;
433
434 (VI) developing and providing ongoing maintenance of
435 treatment protocols based on current standards of trauma care;
436
437 (VII) participating in the ongoing education of the
438 medical and nursing staff in the care of the trauma patient;
439
440 (VIII) ensuring that the trauma quality assessment and
441 performance improvement (QAPI)/Multidisciplinary Performance Improvement committee
442 meeting is specific to trauma care, is ongoing, is data driven and effective. TMD serves as chair
443 of trauma QAPI meetings;
444
445 (IX) participation in the applicable RAC(s) and
446 reviewing the RAC trauma system plan.
447 (X) participates in the facility, community, and regional
448 disaster preparedness activities.
449
450 (XI) evidence that the TMD is aware of the
451 multidisciplinary team findings on all trauma patients;
452 |
453
454 (XII) averaging 16 hours of continuing trauma medical
455 education (CME) annually;
456

457 (XIV) maintains active staff privileges as defined in the
458 facility's medical staff bylaws;

459
460 (iv) The Trauma Medical Director for Level III shall be a physician
461 who is:

462
463 (I) a board certified general surgeon or a general surgeon
464 eligible for certification by the American Board of Surgery according to current requirements or
465 an equivalent course approved by the office; or

466
467 (II) a general surgeon who has continuously served as the
468 Trauma Medical Director at the designated facility for the last consecutive five years **and** is
469 currently credentialed in Advanced Trauma Life Support (ATLS).

470
471 (v) The Trauma Medical Director for Level IV shall be a physician
472 who is:

473
474 (I) board certified in emergency medicine by the American
475 Board of Emergency Medicine (ABMS or AOBEM), or eligible for board certification in
476 emergency medicine and currently credentialed in Advanced Trauma Life Support (ATLS) or an
477 equivalent course approved by the office; or

478
479 (II) board certified or board eligible in their applicable medical
480 or surgical specialty and currently credentialed in Advanced Trauma Life Support (ATLS) or an
481 equivalent course approved by the office; or

482
483 (III) has continuously served as the Trauma Medical Director at
484 the designated facility for the last consecutive five years and is currently credentialed in
485 Advanced Trauma Life Support (ATLS).

486
487 (4) Standard: General Surgery.

488
489 (A) All surgeons who provide trauma coverage or participates in
490 trauma call coverage shall:

491
492 (i) be board certified in general surgery; or

493
494 (ii) be board eligible in general surgery and currently
495 credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the
496 office; or

497
498 (iii) prior to (the effective date of this rule) have continuously
499 provided trauma coverage and participated in trauma call at the designated facility for the last
500 consecutive five years and be currently credentialed in Advanced Trauma Life Support (ATLS);
501 and

502

503 (iv) be appropriately credentialed through the trauma program;
504
505 (v) average at least 16 hours of trauma-related continuing
506 medical education annually;
507
508 (vi) maintain compliance with trauma protocols;
509
510 (vii) participate in the trauma QAPI program and attend at least
511 50% of the trauma multidisciplinary and peer review trauma committee meetings;
512
513 (viii) be present in the ED at the time of arrival for a full trauma
514 team activation of a trauma patient; maximum response time 30 minutes from trauma team
515 activation;
516
517 (ix) be present in the ED within 60 minutes or less when called
518 for a limited trauma team activation; and
519
520 (x) be the admitting physician on all multi-system trauma
521 patients requiring the consultation of one or more specialty services;
522
523 (B) If a facility has a surgical residency program, and a team of
524 surgical residents start the evaluation and treatment of the trauma patient, the team shall have, at
525 a minimum, a postgraduate year 4 (PGY-4) or more senior surgical resident who is a member of
526 the facility's residency program. The presence of a surgical resident does not take the place of
527 the attending physician. The attending physician must be compliant with all response times.
528
529 (C) If the facility has a surgical residency program and a team of
530 surgical residents start the evaluation and treatment of the trauma patient, the attending surgeon
531 shall participate in all major therapeutic decisions, be present in the emergency department for
532 major resuscitations, and be present during all phases of operative procedures.
533
534 (5) In addition to continuous general surgery coverage the facility shall have
535 continuous orthopedic surgical coverage.
536
537 (6) Trauma Surgical Specialty Services. Orthopedic and Neurosurgery surgeons
538 shall:
539 (A) be board certified in the applicable surgical specialty; or be board
540 eligible in the applicable surgical specialty; or
541
542 (B) prior to (the effective date of this rule) have continuously provided
543 trauma coverage and participated in trauma call at the designated facility for the last consecutive
544 five years; and
545
546 (C) be appropriately credentialed through the trauma service;
547

548 (D) average at least 16hours of trauma-related continuing medical
549 education annually;
550
551 (E) maintain compliance with trauma protocols;
552
553 (F) participate in the trauma QAPI/Multidisciplinary PI program and a
554 designated liaison shall attend at least 50% of the trauma Multidisciplinary and peer review
555 trauma committee meetings; and
556
557 (G) at a minimum, orthopedic surgeons and neurosurgeons, participate
558 in the published, on-call schedule and backup on-call schedule or plan readily available to all
559 staff to obtain specialty surgical care.
560
561 (7) Emergency Medicine. Any emergency medicine physician who is providing
562 trauma coverage shall be in-house 24 hours a day and shall:
563
564 (A) be board certified in emergency medicine and have successfully
565 completed ATLS; or
566
567 (B) be board eligible in emergency medicine and currently credentialed
568 in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office; or
569
570 (C) prior to (the effective date of this rule) have continuously provided
571 trauma coverage in the emergency department at the designated facility for the last consecutive
572 five years and be currently credentialed in Advanced Trauma Life Support (ATLS); or
573
574 (D) be board eligible in their applicable specialty and currently
575 credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the
576 office; and
577
578 (E) be appropriately credentialed through the trauma program;
579
580 (F) average at least 16 hours of trauma-related continuing medical
581 education annually;
582
583 (G) maintain compliance with trauma protocols; and
584
585 (H) participate in the trauma QAPI/multidisciplinary PI program and a
586 designated liaison shall attend at least 50% of the trauma multidisciplinary PI and peer review
587 committee meetings.
588
589 (8) Anesthesia Services. If the facility furnishes anesthesia services, it shall do
590 so in compliance with 25 TAC 133.41 Hospital Functions and Services.
591
592 (A) The anesthesiologist providing trauma coverage shall:
593

- 594 (i) be a board certified anesthesiologist; or
595
596 (ii) be a candidate in the American Board of Anesthesiology
597 examination system; or
598
599 (iii) prior to (the effective date of this rule) have continuously
600 provided anesthesia coverage at the designated facility for the last consecutive five years;
601 average at least 16 hours of continuing medical education annually; and
602
603 (iv) be appropriately credentialed through the trauma program;
604
605 (vi) maintain compliance with trauma protocols;
606
607 (vii) participate in the trauma QAPI/Multidisciplinary PI
608 | program; and
609 (viii) a designated liaison shall attend at least 50% of the trauma
610 multidisciplinary peer review trauma committee meetings.
611

612 (B) Advanced Practice clinicians (advanced practice registered nurses
613 or physician assistants) utilized in the care of major and/or severe trauma patients, shall not be a
614 substitute for the required physician response, in patient care planning nor in QAPI activities.
615 Any Advanced Practice clinician who provides care to trauma patients shall be current in ATLS
616 and be appropriately credentialed by the Texas Board of Nursing (TBON) or the Texas Medical
617 Board (TMB) respectively.
618

619 | (9) Radiology Services.
620

621 (A) A radiologist shall be on-call and promptly available within 30
622 minutes of request from inside or outside the hospital. This system
623 shall be continuously monitored by the trauma PI program.
624

625 (B) The rate of change in interpretation of radiologic studies must be
626 routinely monitored and reviewed with the radiology department. Identified cases should be
627 reviewed to determine the reason for misinterpretation, adverse outcomes, and opportunities for
628 improvement.
629

630 (10) Nursing Staff. As part of the facility's trauma program approved by the
631 governing body, the program will have an identified Trauma Program Manager with equivalent
632 authority and responsibility as granted to other department or nurse managers. There shall be a
633 demonstrated commitment by the facility for furthering the education and understanding of
634 trauma standards of care for all nursing staff caring for the trauma patient.
635

636 (11) Trauma Program Manager (TPM).
637

638 (A) There shall be an identified Trauma Program Manager responsible
639 for trauma patient care throughout the continuum of care and through discharge.

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(B) The TPM:

(i) shall be a registered nurse;

(ii) is current in the Trauma Nurse Core Course (TNCC) or Advanced Trauma Course for Nurses (ATCN) or an office approved equivalent;

(iii) is current in a nationally recognized pediatric advanced life support course ((Pediatric Advanced Life Support (PALS) or the Emergency Nurse Pediatric Course (ENPC));

(B) The Trauma Program Manager is responsible for the integration of trauma nursing standards of care. The responsibilities and authority of the TPM shall include:

(i) monitoring the clinical outcomes, direction and oversight of the trauma program.

(ii) monitoring trauma patient care from ED arrival through operative intervention(s), ICU care, stabilization, rehabilitation care, and discharge, including the trauma performance improvement (PI) program;

(iii) participation in a leadership role in the facility including the facility-wide QAPI Committee, community, and regional emergency management (disaster) response committee;

(iv) has completed a course designed for his/her role which provides essential information on the structure, process, organization and administrative responsibilities of a trauma program; Trauma Coordinators Core Course (TCCC); or an office approved equivalent course;

(v) has completed a course designed for his/her role which provides essential information of a trauma PI program to include trauma outcomes and performance improvement; Trauma Outcomes Performance Improvement Course (TOPIC); or an office approved equivalent course.

(12) Nursing Services for all critical care and patient care areas shall provide evidence of the following:

(A) all nurses caring for trauma patients throughout the continuum of care have ongoing documented knowledge and skills in trauma nursing for patients of all ages to include trauma specific orientation, annual clinical competencies, and continuing education;

(B) written standards on nursing care for trauma patients for all units (i.e. ED, ICU, OR, PACU, general inpatient) in the trauma facility shall be implemented;

686 (C) a facility approved acuity-based patient classification system is
687 utilized to define workload and number of nursing staff to provide safe patient care for all trauma
688 patients throughout their hospitalization;

689
690 (D) a written plan, developed by the hospital, for acquisition of
691 additional staff on a 24 hour basis to support units with increased patient acuity, multiple
692 emergency procedures and admissions (i.e. written surge plan.);

693
694 (E) a minimum of two registered nurses shall participate in initial
695 resuscitations for full and limited or trauma activations, have successfully completed and hold
696 current credentials in an advanced cardiac life support course (ACLS); a nationally
697 recognized pediatric advanced life support course (PALS or ENPC); and TNCC or ATCN; or an
698 office approved equivalent for each course;

699
700 (F) nursing documentation for trauma patients is systematic and meets
701 the trauma registry guidelines, includes at a minimum:: the sequence of care, primary and
702 secondary survey with interventions, outcomes, serial vital signs, GCS, consulting services
703 assessment, plan of care with disposition and documents the response time of all trauma team
704 members.

705
706 (G) documentation that 100% of nursing staff working in the
707 Emergency Department (ED) and responding to trauma activations or caring for trauma patients
708 have successfully completed and hold current credentials in an advanced cardiac life support
709 course (e.g. ACLS or hospital equivalent), a nationally recognized pediatric advanced life
710 support course (e.g. PALS or ENPC) and TNCC or ATCN or a DSHS-approved equivalent,
711 within 18 months of date of employment in the ED.

712
713 (H) A stand-alone children’s facility shall have documentation that 100% of nursing staff
714 who care for trauma patients have successfully completed and hold current credentials in a
715 nationally recognized pediatric advanced life support course (e.g. PALS or ENPC) and TNCC or
716 ATCN or a DSHS-approved equivalent, within 18 months of date of employment in the ED.

717
718 (13) Texas EMS/Trauma Registry Requirements. Any designated trauma facility
719 must participate in the Texas EMS/Trauma Registry. Participation shall include:

720
721 (A) Data submission for designation purposes.

722
723 (i) Initial designation. Six months of data prior to the initial
724 designation survey must be uploaded to the Texas EMS/Trauma System Registry. Subsequent to
725 initial designation, data shall be uploaded to the Texas EMS/Trauma Registry as indicated in
726 Chapter 103, Injury Prevention and Control of this title within 45 days of discharge with a 90%
727 acceptance or accuracy rate.

728
729 (ii) Re-designation. Data shall be uploaded to the Texas
730 EMS/Trauma Registry as indicated in Chapter 103, Injury Prevention and Control of this title
731 within 45 days of patient discharge with a 90% acceptance rate.

732
733 (B) Identified Trauma Registrar who has appropriate education,
734 training in injury severity scaling, and four hours of continuing education annually specific to
735 trauma data quality.

736
737 (C) Data validation. The Trauma Registrar must participate in ongoing
738 data validation through the department and/or the RAC PI committee.

739
740 (14) Trauma Registrar **Level III only**. There shall be an identified Trauma
741 Registrar, who is separate from but supervised by the TPM, who has had appropriate training
742 within 24 months of hire into the position of trauma registrar which includes:

743
744 (A) the Association for the Advancement of Automotive Medicine
745 (AAAM) course, or

746
747 (C) other office approved equivalent course.

748
749 (15) Pre-hospital EMS Communication. There shall be two-way
750 communication with all pre-hospital emergency medical services vehicles.

751
752 (16) Emergency Department Equipment and Services. Equipment and services
753 for the evaluation, resuscitation, and life support for critically or seriously injured patients of all
754 ages shall be available for resuscitation, temperature warming and cooling management,
755 hemorrhage control, hemodynamic monitoring and orthopedic splinting.

756
757 (A) Equipment.

758
759 (i) Standard: Emergency Department Equipment.

760
761 (I) Airway control and ventilation equipment including
762 laryngoscope and endotracheal tubes of all sizes, bag-valve-mask devices (BVMs), pocket
763 masks, oxygen;

764
765 (II) Mechanical ventilator;

766
767 (III) Pulse oximetry;

768
769 (IV) Suction devices;

770
771 (V) Electrocardiograph-oscilloscope-defibrillator;

772
773 (VI) ~~Internal age-specific paddles;~~

774
775 (VII) Supraglottic airway management device (e.g.
776 LMA);

777

- 778 (VIII) Central venous pressure monitoring equipment;
779
780 (IX) Standard intravenous fluids and administration
781 devices, including large-bore intravenous catheters and a rapid infuser system;
782
783 (X) Sterile surgical sets for procedures standard for
784 emergency care: thoracostomy, ~~venous cutdown~~, central line insertion, ~~thoracotomy~~, ~~diagnostic~~
785 ~~peritoneal lavage~~, airway control/cricothyrotomy, etc. as appropriate;
786
787 (XI) Drugs and supplies necessary for emergency care;
788
789 (XII) Cervical spine stabilization capability;
790
791 (XIII) Current length-based pediatric body weight &
792 tracheal tube size evaluation system, resuscitation medications and equipment that are dose-
793 appropriate for all ages;
794
795 (XIX) Long bone stabilization capability;
796
797 (XX) Pelvic stabilization capability;
798
799 (XXI) Thermal control equipment for patients and a rapid
800 warming device for blood and fluids;
801
802 (XXII) Non-invasive continuous blood pressure monitoring
803 devices;
804
805 (XXIII) Quantitative end tidal CO₂ monitor;
806
807 (17) Surgery Department Equipment and Services. Services for the care of the
808 trauma patient for operative interventions as defined by the center's trauma plan to
809 include resuscitation, temperature warming and management, hemorrhage control,
810 hemodynamic monitoring and orthopedic splinting to ensure that trauma standards of
811 care are met.
812
813 (A) Services.
814
815 (I) Operating Suite. For a Level III. Operating room
816 services shall be available 24 hours a day. With advanced notice, the Operating Room
817 shall be opened and ready to accept a patient within 30 minutes.
818
819 (II) Post-Anesthesia Care Unit. For a Level III, a post-
820 anesthesia care unit or surgical intensive care unit shall have available:
821
822 (III) Registered nurses and other essential personnel
823 available 24 hours a day;

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(IV) Appropriate equipment to ensure that trauma standards of care are met

(18) Intensive Care Capability for a Level III. Intensive care capability shall be available for the trauma critical care patient and interventions as defined by the facility's trauma plan to include resuscitation, temperature warming and cooling management, hemorrhage control, hemodynamic monitoring and orthopedic splinting to ensure that trauma standards of care are met.

(I) Designated surgical director or surgical co-director responsible for setting policies, developing protocols and management guidelines related to trauma ICU patients. A physician providing this coverage must be a board certified or board-eligible surgeon and meets the credentialing requirements as defined in the facility trauma program plan; or

(II) A Physician credentialed in critical care on duty in the ICU 24 hours a day or immediately available from in-hospital and meets the credentialing requirements as defined in the facility trauma program plan. Arrangements for 24-hour surgical coverage of all trauma patients shall be provided for emergencies and routine care. This system shall be continuously monitored by the trauma PI program;

(19) Clinical Support Services. **Level III and IV.**

(I) Respiratory Services. Respiratory services shall be in-house and available 24 hours per day.

(II) Clinical Laboratory Service. Laboratory services shall be in-house and available 24 hours per day;

(III) Standard Radiological Capability/Services. An in-house technician shall be available 24-hours a day or be on-call and promptly available on-site within 30 minutes of request.

(IV) Special Radiological Capabilities shall be available for the trauma patient as defined by the facility's trauma plan to include:

(I) Sonography;

(II) Computerized Tomography. In-house CT technician 24-hours per day or on-call and promptly available on-site within 30 minutes of request. This system shall be continuously monitored by the trauma PI program;

(III) Angiography of all types;

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(IV) Nuclear scanning.

(20) Specialized Capabilities/Services/Units. Level III.

(x) Acute hemodialysis capability. A Transfer plan shall be implemented if there is no capability for this standard.

(xi) Organized Burn Care. Established criteria for care of major or severe burn patients and/or a process to expedite the transfer of burn patients to a burn center or higher level of care to include written protocols, written transfer agreements, and a regional trauma system transfer plan for patients needing a higher level of care or specialty services.

(xii) Spinal cord/head injury rehabilitation management capability.

(I) In circumstances where a designated spinal cord injury rehabilitation center exists in the region, transfer plan must be in effect.

(II) In circumstances where a moderate to severe head injury center exists in the region, transfer plan must be in effect.

(xiii) Rehabilitation Medicine.

(I) Physician-directed rehabilitation service, staffed by personnel trained in rehabilitation care and equipped properly for care of the critically injured patient, or transfer plan when medically feasible to a rehabilitation facility and a process to expedite the transfer of rehabilitation patients to include written protocols, written transfer plan, and a regional trauma system transfer plan for patients needing a higher level of care or specialty services.

(II) Physical therapy;

(III) Occupational therapy;

(IV) Speech therapy;

(IV) Social services.

(21) Outreach and Education.

(A) A defined individual to coordinate the facility's community outreach and education programs for the public and professionals is evident.

(B) Provide education to and consultations with physicians of the community and outlying areas;

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(C) Training programs in trauma continuing education provided by facility for staff and community members involved in trauma care based on needs identified from the QAPI program for:

- (i) staff physicians;
- (ii) nurses;
- (iii) allied health personnel including Physician Assistants and Advanced Nurse Practitioners;
- (iv) specialty and community physicians;
- (v) prehospital personnel; and
- (vi) any other appropriate personnel involved in trauma care.

(21) Injury Prevention and Public Education.

(A) A public education program to address the major injury problems identified within the facility's service area.

(B) Coordination and/or participation in community and/or RAC injury prevention activities.

(22) Research. Trauma registry performance improvement activities.

(23) Quality assessment and performance improvement/Multidisciplinary Performance Improvement.

(I) A facility shall develop, implement, maintain, and evaluate an effective, ongoing, facility-wide, data-driven, outcomes based multidisciplinary quality assessment and performance improvement (QAPI) program. The program shall be individualized to the facility and meet the criteria and standards described in this section.

(II) The program shall reflect the complexity of the facility's trauma plan and the services involved. All facility services (including those services furnished under contract or arrangement) shall focus on decreasing deviations from the trauma standards of care to ensure optimal trauma outcomes, patient safety standards and cost effective care.

(III) The facility shall demonstrate that the staff evaluate the provision of trauma care and patient services, identify opportunities for improvement, develop and implement improvement plans, and evaluate the implementation of those plans until resolution is achieved. Evidence shall support that aggregate patient data, including identification and tracking of trauma patient complications or variances from standards of care, is continuously reviewed for trends by the trauma multidisciplinary team. The Trauma Multidisciplinary committee must be

962 | composed of the trauma medical director (TMD), the trauma program manager
963 (TPM), an executive officer of the facility, a trauma nurse active in the
964 management of trauma patients, a trauma nurse active in the management of
965 pediatric trauma patients as applicable, and physicians and surgeons that provide
966 coverage or care to trauma patients, and other healthcare professionals
967 participating in the care of major or severe trauma patients.
968

969 (V) The trauma multidisciplinary team shall participate
970 in the QAPI meetings and activities; the QAPI meetings shall be documented and include the
971 attendance, activities, actions, and follow-up.
972

973 (VI) The trauma QAPI program shall include, ongoing
974 monthly review of system key elements of trauma care using comparative and trend data to
975 include, the following aggregate patient data: (Needs to be defined.)
976

977 (VII) All events and decisions of a trauma facility
978 impacting the ability of the trauma program to comply with any critical elements, as defined in
979 (c) (1-2) of this section or changes in the trauma facility's resources that affect the region shall
980 require that the facility notify the office, the local RAC plus other affected RACs, including all
981 changes that affect air medical access to designated landing sites.
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