

- 1 Legend: (Proposed Amendment(s))
2 Single Underline = Proposed new language
3 **[Bold, Print, and Brackets]** = Current language proposed for deletion
4 Regular Print = Current language
5 (No change.) = No changes are being considered for the designated subdivision
6

7 §157.125. Requirements for Trauma Facility Designation.
8

9 (a) General Provisions. The goal of the trauma system is to reduce the morbidity and
10 mortality of the trauma patient. The objective of the trauma system is to get the right patient, to
11 the right place, at the right time, to receive the right care. The purpose of this section is to set
12 forth the requirements for a health care facility to become a designated trauma facility.
13

14 (1) The Department of State Health Services (department) shall determine the
15 designation level for each location, based on, but not limited to, the location's own resources and
16 levels of care capabilities; Trauma Service Area (TSA) capabilities; and compliance with the
17 essential criteria and standard requirements outlined in this section.
18

19 (2) The Office of Emergency Medical Services (EMS)/Trauma Systems
20 Coordination (office) shall recommend to the Commissioner of the Department of State Health
21 Services (commissioner) the trauma designation of a facility at the level the office deems
22 appropriate.
23

24 (3) Facilities eligible for trauma designation include:
25

26 (A) A General Hospital, licensed or otherwise meeting the description
27 (in accordance with Texas Administrative Code (TAC) Hospital Licensing Section 133.21)
28

29 (i) Each facility operating on a single general hospital license
30 with multiple locations (multi-location license) shall be considered separately for designation.
31 Designation does not include provider based departments of the designated facility, which are
32 not contiguous with the designated facility.
33

34 (ii) Departments or services within a facility shall not be
35 separately designated, or,
36

37 (B) a general hospital owned and operated by the state of Texas, or
38

39 (C) a general hospital owned and operated by the federal government.
40

41 (4) a trauma facility designation is issued for the physical location and to the
42 legal owner of the operations of the facility. If a designated facility has a change of ownership or
43 a change of the physical location of the facility, the designation shall not be transferred or
44 assigned.
45

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

48
49 (A) Comprehensive (Level I) trauma facility designation--The facility,
50 including a free-standing children's facility, shall meet:

51
52 (i) the current American College of Surgeons (ACS) essential
53 criteria for a verified Level I trauma center for adult and/or pediatric criteria and

54
55 (ii) the Level III Program Requirements in subsection (k) of
56 this section that exceed the appropriate ACS level criteria.

57
58 (B) Major (Level II) trauma facility designation--The facility,
59 including a free-standing children's facility, shall meet:

60
61 (i) the current ACS essential criteria for a verified Level II
62 trauma center for adult and/or pediatric criteria and

63
64 (ii) the " Level III Program Requirements" in subsection (k)
65 of this section that exceed the appropriate ACS level criteria.

66
67 (C) Advanced (Level III) trauma facility designation--The facility,
68 including a free standing children's facility, shall meet the " Level III Program Requirements"
69 in subsection (k) of this section and, if the facility chooses to be verified by the ACS the facility
70 must meet the current ACS essential criteria for a verified Level III trauma center for adult
71 and/or pediatric criteria.

72
73 (D) Basic (Level IV) trauma facility designation--The facility meets
74 the Level IV Program Requirements in subsection (k) of this section.

75
76 (6) In Active Pursuit of Designation (IAP) -- subsection applies only to an
77 undesignated facility in accordance with Texas Administrative Code (TAC) Designated Trauma
78 Facility and Emergency Medical Services Account Section 157.131(a)(10).

79
80 (b) Designation Process.

81 (1) Application. A facility seeking designation, shall submit a completed
82 application to include:

83
84 (A) an accurate and complete designation application form for the
85 appropriate level of requested designation, including full payment of the non-refundable, non-
86 transferrable, designation fee as follows;

87
88 (i) Level I and Level II trauma facility applicants, the fee will
89 be no more than \$10 per licensed bed with an upper limit of \$5,000 and a lower limit of \$4,000;

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91 (ii) Level III trauma facility applicants, the fee will be no more
92 than \$10 per licensed bed with an upper limit of \$2,500 and a lower limit of \$1,500; and
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94 (iii) Level IV trauma facility applicants, the fee will be no more
95 than \$10 per licensed bed with an upper limit of \$1000 and a lower limit of \$500.
96

97 (B) Initial designation of Level III or Level IV facility: the applicant or
98 the applicant's representative shall attend a presurvey conference at the office designated by the
99 department. The purpose of the presurvey conference, which is conducted by department staff, is
100 to review facility staff qualifications, survey documents and licensure rules, and to provide
101 consultation prior to the on-site licensure survey. The department staff conducting the presurvey
102 conference is responsible for making a recommendation regarding the issuance of the initial
103 license. The department may waive the presurvey conference requirement.
104

105 (C) any subsequent documents submitted by the date requested by the
106 office;
107

108 (D) a completed trauma designation survey report, including patient
109 care reviews, if required by the department, completed not later than 180 days of the date of the
110 application;
111

112 (E) a plan of correction (POC), detailing how the facility will correct
113 any deficiencies cited in the survey report, to include: the corrective action, the title of the person
114 responsible for ensuring the correction(s) is implemented, how the corrective action will be
115 monitored, the date by which the POC will be completed; and
116

117 (F) evidence of participation in the applicable Regional Advisory
118 Council (RAC).
119

120 (G) evidence of submission of data to the department trauma registry
121

122 (H) Renewal of designation. The applicant shall submit the documents
123 described in subsection (c)(1) – (5) above, to the office not more than 180 days prior to the
124 designation expiration date and at least 90 days prior to the designation expiration date.
125

126 (I) If a facility seeking designation fails to meet the requirements in
127 subsection (c)(1) – (5) above, the application shall be considered withdrawn by the facility.
128

129 (c) Survey A facility seeking designation shall undergo an onsite survey as outlined
130 in this section.
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132 (1) The facility shall be responsible for scheduling a verification or trauma
133 designation survey as follows:
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135 (A) Level I and II facilities shall request a trauma verification survey
136 through the American College of Surgeons (ACS) trauma verification program;

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(B) Level III facilities shall request a trauma verification survey through the ACS trauma verification program, or request a trauma designation survey through Texas EMS Trauma & Acute Care Foundation (TETAF), or an organization approved by the department; and

(C) Level IV facilities shall request a trauma designation survey through Texas EMS Trauma & Acute Care Foundation (TETAF), or an organization approved by the department.

(2) The surveying organization shall notify the office of the date of the planned survey and shall schedule the members of the survey team.

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

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

(3) The multi-disciplinary survey team shall consist of the follows members:

(A) Level I or Level II facilities shall be surveyed by The American College of Surgeons (ACS) with a multi-disciplinary team and includes at a minimum: 2 general surgeons, an emergency physician, and a trauma nurse all active in the management of trauma patients. Children’s facilities shall be surveyed by the ACS with a multi-disciplinary team and includes at a minimum: a pediatric emergency physician; a general surgeon; and a pediatric trauma nurse all active in the management of pediatric trauma patients.

(B) Level III facilities shall be surveyed by the ACS, Texas EMS Trauma & Acute Care Foundation (TETAF), or other department-approved equivalent organization, with a multi-disciplinary team that includes at a minimum: a trauma surgeon and a trauma nurse, both currently active in the management of trauma patients. Children’s facilities shall be surveyed by the ACS, TETAF, or other department-approved equivalent organization with a multi-disciplinary team that includes at a minimum: a pediatric trauma surgeon, a pediatric trauma nurse or a trauma nurse coordinator with pediatric experience. An additional surveyor may be requested by the facility, or required by the DSHS.

(C) Level IV facilities shall be surveyed by TETAF or other department-approved equivalent organization by a surveyor that is either at a minimum: a registered nurse or licensed physician surveyor, who is active in the management of trauma patients. Children’s facilities shall be surveyed by the TETAF or other department-approved equivalent organization, whose surveyor is a pediatric trauma surgeon, or a pediatric trauma nurse, or a trauma nurse coordinator with pediatric experience. A second surveyor may be requested by the facility, or required by the DSHS.

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

183
184 (i) be currently employed at a designated trauma facility that is
185 greater than 100 miles from the requesting facility;
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187 (ii) not be employed in the same TSA as the designating
188 facility;
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190 (iii) not be a current or former employee of the facility that is
191 the subject of the survey or of an affiliated facility;
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193 (iv) not be employed at a facility that is a primary transfer
194 facility with the facility being surveyed, with the exception of a burn facility;
195
196 (v) not survey the facility program and physical location on
197 consecutive designation cycles; and
198
199 (vi) not have been requested by the facility;
200
201 (vii) not possess other potential conflict of interest between the
202 surveyor or the surveyor's place of employment and the facility being surveyed.
203
204 (6) Each member of the survey team shall:
205
206 (A) have at least 5 years experience in the care of trauma patients;
207
208 (B) be currently employed in the management of or providing direct
209 care services to trauma patients;
210
211 (C) have direct experience in the preparation for and successful
212 completion of trauma facility designation for no fewer than 2 successful designation cycles;
213
214 (D) have successfully completed a DSHS-approved trauma facility site
215 surveyor course and be successfully re-credentialed every 4 years; and
216
217 (E) have current credentials as follows:
218
219 (i) for registered nurses: Trauma Nurses Core Course (TNCC)
220 or Advanced Trauma Course for Nurses (ATCN); and Pediatric Advanced Life Support (PALS)
221 or Emergency Nurses Pediatric Course (ENPC);
222
223 (ii) for physicians: Advanced Trauma Life Support (ATLS);
224 and
225
226 (iii) have successfully completed a trauma designation surveyor
227 internship.
228

229 (7) The survey team shall evaluate the facility's compliance and document the
230 noncompliance with this section 157.125 by:

231 (A) reviewing documents, including a minimum of 10 closed medical
232 records per surveyor;

233 (B) tour of the physical plant; and staff interviews to include:

234

235 (i) the current trauma medical director

236 (ii) the current Executive Sponsor of the trauma program

237 (iii) the Chief Nursing Officer

238

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

244

245 (9) The trauma designation survey report in its entirety shall be part of a
246 facility's quality assessment and performance improvement (QAPI) program and subject to
247 confidentiality as articulated in the Health and Safety Code, §773.095.

248

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

252

253 (11) office will review the findings of the survey report and POC. A
254 recommendation for designation will be made to the commissioner if the facility meets the
255 requirements for designation found in this section.

256

257 (12) If deficiencies, findings of not met, are identified on the survey report, the
258 facility shall develop and implement a plan of correction (POC). The POC shall be submitted
259 along with the trauma designation survey report and chart review tools. The POC shall include:

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261 (A) a statement of the cited deficiency;

262

263 (B) a statement describing the corrective action by the facility to ensure
264 compliance with the requirement;

265

266 (C) the identity, by title, of the individual(s), responsible for ensuring the
267 corrective action is completed;

268

269 (D) the date by which the corrective action will be accomplished, not to
270 exceed 60 days from the survey conference exit date.

271

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

274

275 (14) If the commissioner concurs with the recommendation to designate, the
276 facility shall receive a letter of designation valid for 3 years and a certificate of designation.
277

278 (A) Display: The hospital shall prominently and conspicuously display
279 the trauma designation certificate and the current letter awarding designation from the
280 Commissioner, in a public area of the licensed premises that is readily visible to patients,
281 employees, and visitors.
282

283 (B) The trauma designation certificate shall be valid only when
284 displayed with the current letter awarding designation.
285

286 (15) Alteration: the trauma designation certificate and the award letter shall not
287 be altered. Any alteration to either document voids trauma designation for the remainder of that
288 cycle.
289

290 (16) It shall be necessary to repeat the designation process as described in this
291 section prior to expiration of a facility's designation or the designation expires.
292

293 (d) Exceptions and Notifications
294

295 (1) The office will determine the level it deems appropriate for pursuit of
296 designation or re-designation for each of the facility's locations based on, but not limited to: the
297 facility's resources and levels of care capabilities at each location, TSA resources, and the
298 designation requirements for Levels I, II, III, and IV trauma facilities.
299

300 (2) If a facility disagrees with the level(s) determined by the office to be
301 appropriate for pursuit of designation or re-designation, it shall make an appeal in writing within
302 60 days to the director of the office. The written appeal must include a signed letter from the
303 facility's governing board with an explanation as to why designation at the level determined by
304 the office would not be in the best interest of the citizens of the affected TSA or the citizens of
305 the State of Texas.
306

307 (3) The written appeal shall include a signed letter (s) from the executive
308 board of its RAC or individual healthcare facilities and/or EMS providers within the affected
309 TSA with an explanation as to why designation at the level determined by the office would not
310 be in the best interest of the citizens of the affected TSA or the citizens of the State of Texas.
311

312 (4) If the office upholds its original determination, the director of the office
313 will give written notice of such to the facility within 30 days of its receipt of the applicant's
314 complete written appeal.
315

316 (5) The facility shall, within 30 days of the office's sending written
317 notification of its denial, submit a written request for further review. Such written appeal shall
318 then go to the Assistant Commissioner, Division for Regulatory Services.
319

320 (6) If a facility is unable to comply with any of the requirements, the facility
321 shall notify the applicable RAC(s), the emergency medical services providers, and the healthcare
322 facilities to which it customarily transfers-out and/or transfers-in trauma patients.
323

324 (7) If the healthcare facility is unable to comply with the criterion to maintain
325 the current designation status for a period exceeding 30 days, it shall submit to the office a POC
326 as described in (b) (17) (A) (i – iii) of this section, and a request for a temporary exception to
327 criteria. Any request for an exception shall be submitted in writing from an executive officer of
328 the facility. The office shall review the request and the POC and either grant or deny the
329 exception. If the healthcare facility has not come into compliance at the end of the exception
330 period, the office may at its discretion elect one of the following:

331 (A) allow the facility to request designation at the level appropriate to
332 its revised capabilities;
333

334 (B) re-designate the facility at the level appropriate to its revised
335 capabilities;
336

337 (C) suspend the facility's designation status or the facility may
338 relinquish designation status; or
339

340 (D) extend the facility's temporary exception for an additional period
341 not to exceed 90 days as outlined in (c) (2) above.
342

343 (i) If the facility disagrees with a proposal by the office, or is
344 unable or unwilling to meet the office-imposed timelines for completion of a corrective action
345 plans, it may request a secondary review by a designation review committee as defined in
346 subsection (b)(18)(C) of this section.
347

348 (ii) The office may at its discretion choose to activate a
349 designation review committee at any time to solicit technical advice regarding criteria
350 deficiencies.
351

352 (iii) If the designation review committee disagrees with the
353 office's recommendation for corrective actions, the case shall be referred to the assistant
354 commissioner for recommendation to the commissioner.
355

356 (iv) If a facility disagrees with the office's recommendation at
357 the end of the secondary review process, the facility has a right to a hearing, in accordance with
358 the department's rules for contested cases and Government Code, Chapter 2001.
359

360 (v) Designated trauma facilities seeking exceptions to essential
361 criteria shall have the right to withdraw the request at any time prior to resolution of the final
362 appeal process;
363
364

365 (8) Suspensions of a facility's designation status and exceptions to criteria for
366 facilities will be documented on the office website.

367
368 (e) Downgrade of designation levels or relinquishment of designation

369
370 (1) A designated trauma facility that is unable to maintain compliance with
371 the level of the current designation may choose to apply for a lower level of trauma designation
372 at any time. It shall be necessary to repeat the designation process for the lower level. There shall
373 be a paper review by the office to determine if and when a full survey shall be required. The
374 facility shall notify the applicable RAC(s), the emergency medical services providers, and
375 healthcare facilities to which it customarily transfers-out and/or transfers-in trauma patients if it
376 no longer provides trauma services commensurate with its designation level.

377
378 (2) If the facility chooses to relinquish its trauma designation, it shall provide
379 at least 30 day notice to the department, the applicable RAC(s), the emergency medical services
380 providers, and healthcare facilities to which it customarily transfers-out and/or transfers-in
381 trauma patients if it no longer provides trauma services.

382
383 (f) A healthcare facility may not use the terms "trauma facility", "trauma hospital",
384 "trauma center", or similar terminology in its signs or advertisements or in the printed materials
385 and information it provides to the public unless the healthcare facility is currently designated as a
386 trauma facility according to the process described in this section.

387
388 (g) The office shall have the right to review, inspect, evaluate, and audit all trauma
389 patient records, trauma performance improvement committee minutes, and other documents
390 relevant to trauma care in any designated trauma facility or applicant/healthcare facility at any
391 time to verify compliance with the statute and this rule, including the designation criteria. The
392 office shall maintain confidentiality of such records to the extent authorized by the Texas Public
393 Information Act, Government Code, Chapter 552, and consistent with current laws and
394 regulations related to the Health Insurance Portability and Accountability Act of 1996. Such
395 inspections shall be scheduled by the office when deemed appropriate. The office shall provide a
396 copy of the survey report, for surveys conducted by or contracted for the department and the
397 results to the healthcare facility.

398
399 (h) The office may grant an exception to this section if it finds that compliance with
400 this section would not be in the best interests of the persons served in the affected local system.

401
402 (i) Program Requirements.

403
404 (1) Written Plan of Trauma Service Basis and Scope; Levels I-IV. The facility
405 shall develop a written plan of the organized trauma service that includes the scope of services
406 available to all trauma patients, defines the trauma patient population evaluated or treated by the
407 facility, is consistent with accepted professional standards of practice for trauma care, and
408 ensures the health and safety of patients.

409

410 (A) The written plan shall be reviewed and approved by the governing
411 body. The governing body shall ensure that the requirements of this chapter are implemented and
412 enforced.

413
414 (B) The written trauma service plan shall include, at a minimum:

415
416 (i) policies and procedures developed based on national
417 evidence based practices of trauma care, that are adopted, implemented, and monitored for
418 compliance by the facility that govern the trauma services through all phases of care for all
419 patient populations. The plan shall address for the major and severe trauma patient entering into
420 the trauma center and those patients having ISS of 9 or greater at discharge, telemedicine
421 utilization in the Emergency Department (ED), trauma team activations, staff qualifications, and
422 the role of the hospitalists in the care of the trauma patient. A periodic review and revision
423 schedule for all trauma care policies and procedures shall be established;

424
425 (ii) provisions for ongoing interdisciplinary trauma care
426 meetings;

427
428 (iii) a quality assurance and performance improvement (QAPI)
429 program to evaluate performance of all trauma services that is hospital wide, ongoing, and data
430 driven;

431
432 (iv) provisions for staff education; and

433
434 (v) provisions for consistent participation in the applicable
435 trauma service area (TSA) regional advisory council (RAC);

436
437 (vi) requirements for minimal credentials for staff participating
438 in the care of trauma patients.

439 (vii) contingency plans to ensure the continuation of an active
440 trauma program in the event that the Trauma Medical Director or the Trauma Program Manager
441 positions become vacant.

442 (vii) identify a program sponsor who is a member of the
443 executive leadership at the facility.

444
445 (2) Medical Records Content. The medical record must contain information to
446 justify and support the diagnosis, treatment, and describe the patient's progress and response to
447 medications and services. Maintain medical records that document evidence of the following as
448 appropriate:

449 (A) Trauma team response times, mechanism of injury, assessments,
450 interventions, and response to interventions;

451
452 (B) Vital signs and other information necessary to monitor the
453 patient's condition;

454
455 (C) Daily physician notes

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

(A) Trauma Medical Director. There shall be an identified Trauma Medical Director (TMD) responsible for the provision of trauma care services and credentialed by the facility for the treatment of trauma patients. The TMD shall not have medical director responsibilities at more than one designated facility.

(i) The trauma medical director shall be a member of the medical executive committee;

(ii) The trauma medical director shall have responsibility for the overall clinical direction and oversight of the trauma service;

(iii) The responsibilities and authority of the Trauma Medical Director shall include but are not limited to:

(I) reviewing credentials of medical staff requesting privileges on the trauma team and making recommendations to the medical executive committee for either approval or denial of such privileges;

(II) ensuring that a published, on-call schedule and a backup on-call schedule is readily available to all staff in the emergency department, for obtaining surgical care for all surgical specialties;

(III) regularly and actively participating in or on the trauma call panel;

(IV) has the authority to exclude those trauma team members from trauma call who do not maintain trauma program requirements;

(V) ensuring the use of medical staff peer review outcomes, including deviations from trauma standards of care trending, when considering re-credentialing members of the trauma team. All follow-up and feedback from peer review activity must be made available to the reviewers at the time of the onsite survey;

(VI) developing and providing ongoing maintenance of treatment protocols based on current standards of trauma care;

(VII) participating in the ongoing education of the nursing staff in the care of the trauma patient;

501 (VIII) ensuring that the quality assessment and
502 performance improvement (QAPI) is specific to trauma care [trauma performance improvement
503 (PI) program], is ongoing, is data driven and effective; TMD serves as chair of trauma QAPI
504 meetings;

505
506 (VIX) maintaining participation in the applicable trauma
507 service area regional advisory council; and

508
509 (X) actively participates in the hospital, community, and
510 regional disaster preparedness activities.

511
512 (XI) evidence that the TMD is aware of the
513 interdisciplinary team findings on all trauma patients;

514
515 (XII) averaging 16 hours of continuing trauma medical
516 education (CME) annually;

517
518 (XIII) maintains active staff privileges as defined in the
519 facility's medical staff bylaws;

520
521 (iv) The medical director for Level I, II or III shall be a physician who
522 is:

523
524 (I) a board certified general surgeon (or a general surgeon
525 eligible for certification by the American Board of Surgery according to current requirements or
526 an equivalent course approved by the Department of State Health Services

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528
529 (II) a general surgeon who has continuously served as the
530 trauma medical director at the designated facility for the last consecutive five years **and** is
531 currently credentialed in Advanced Trauma Life Support (ATLS).

532
533 (v) The medical director for Level IV shall be a physician who is:

534
535 (I) board certified in emergency medicine by the American
536 Board of Emergency Medicine (ABMS or AOBEM), or eligible for board certification in
537 emergency medicine; and currently credentialed in Advanced Trauma Life Support (ATLS) or an
538 equivalent course approved by the Department of State Health Services; or

539
540 (II) board certified or board eligible in their applicable medical
541 or surgical specialty and currently credentialed in Advanced Trauma Life Support (ATLS) or an
542 equivalent course approved by the Department of State Health Services; or

543
544 (III) has continuously served as the trauma medical director at
545 the designated facility for the last consecutive five years and is currently credentialed in
546 Advanced Trauma Life Support (ATLS).

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(4) Standard: General Surgery.

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

- (i) be board certified in general surgery; or
- (ii) be board eligible in general surgery and currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the Department of State Health Services; or
- (iii) prior to (the effective date of this rule) have continuously provided trauma coverage and participated in trauma call at the designated facility for the last consecutive five years and be currently credentialed in Advanced Trauma Life Support (ATLS);
- (iv) be appropriately credentialed through the trauma program;
- (v) average at least 9 hours of trauma-related continuing medical education annually;
- (vi) maintain compliance with trauma protocols;
- (vii) participate in the trauma QAPI program and attend at least 50% of the trauma interdisciplinary and peer review trauma committee meetings;
- (viii) be present in the ED at the time of arrival of the major or severe trauma patient; maximum response time 30 minutes from trauma team activation;
- (ix) respond within 60 minutes or less when called for an urgent surgical consult; and
- (x) be the admitting physician on all multi-system trauma patients;

(B) If a facility has a surgical residency program, and a team of surgical residents start the evaluation and treatment of the trauma patient, the team shall have, at a minimum, a postgraduate year 4 (PGY-4) or more senior surgical resident who is a member of the facility's residency program.

(C) If the facility has a surgical residency program and a team of surgical residents start the evaluation and treatment of the trauma patient, the attending surgeon shall participate in all major therapeutic decisions, be present in the emergency department for major resuscitations, and be present during all phases of operative procedures.

592 (5) In addition to continuous general surgery coverage the facility shall have
593 continuous orthopedic surgical coverage.

594
595 (6) Additional Trauma Surgical Specialty Services include: Orthopedic and
596 Neurosurgery surgeons shall:

597 (A) be board certified in the applicable surgical specialty; or be board
598 eligible in the applicable surgical specialty; or

599
600 (B) prior to (the effective date of this rule) have continuously provided
601 trauma coverage and participated in trauma call at the designated facility for the last consecutive
602 five years and completes an average of 16 hours of trauma related CME annually.

603
604 (D) be appropriately credentialed through the trauma service;

605
606 (E) average at least 9 hours of trauma-related continuing medical
607 education annually;

608
609 (F) maintain compliance with trauma protocols;

610
611 (G) participate in the trauma QAPI program and a designated liaison
612 shall attend at least 50% of the trauma interdisciplinary and peer review trauma committee
613 meetings; and

614
615 (H) at a minimum, orthopedic surgeons and neurosurgeons, participate
616 in the published, on-call schedule and backup on-call schedule or plan readily available to all
617 staff to obtain specialty surgical care.

618
619 (7) Emergency Medicine. Any emergency medicine physician who is providing
620 trauma coverage shall be in-house 24 hours a day and shall:

621
622 (A) be board certified in emergency medicine and have successfully
623 completed ATLS; or

624
625 (B) be board eligible in emergency medicine and currently credentialed
626 in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the Department
627 of State Health Services; or

628
629 (C) prior to (the effective date of this rule) have continuously provided
630 trauma coverage in the emergency department at the designated facility for the last consecutive
631 five years and be currently credentialed in Advanced Trauma Life Support (ATLS);

632
633 (D) be board eligible in their applicable specialty and currently
634 credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the
635 Department of State Health Services; or

636
637 (E) be appropriately credentialed through the trauma program;

638
639 (F) average at least 9 hours of trauma-related continuing medical
640 education annually;
641
642 (G) maintain compliance with trauma protocols; and
643
644 (H) participate in the trauma QAPI program and a designated liaison
645 shall attend at least 50% of the trauma interdisciplinary and peer review trauma committee
646 meetings.
647
648 (8) Anesthesia Services. If the facility furnishes anesthesia services, it shall do
649 so in compliance with 25 TAC 133.41 Hospital Functions and Services.
650
651 (A) The anesthesiologist providing trauma coverage shall:
652
653 (i) be a board certified anesthesiologist; or
654
655 (ii) be a candidate in the American Board of Anesthesiology
656 examination system; or
657
658 (iii) prior to (the effective date of this rule) have continuously
659 provided anesthesia coverage at the designated facility for the last consecutive five years;
660 average at least 16 hours of trauma-related continuing medical education annually;
661
662 (iv) be appropriately credentialed through the trauma program;
663
664 (vi) maintain compliance with trauma protocols;
665
666 (vii) participate in the trauma QAPI program and a designated
667 liaison shall attend at least 50% of the trauma interdisciplinary and peer review trauma
668 committee meetings.
669
670 (B) Advanced Practice clinician (advanced practice registered nurses
671 or physician assistants) are utilized in the care of major and or severe trauma patients, their
672 presence shall not substitute for the required physician response, in patient care planning nor in
673 QAPI activities. Any Advanced Practice clinician who provides care to trauma patients shall be
674 current in ATLS and be appropriately credentialed by the Texas Board of Nursing (TBON) or
675 the Texas Medical Board (TMB) respectively.
676
677 (9) Radiology Services. Radiology for a Level III shall have on-call radiology
678 services promptly available within 30 minutes of request from inside or outside the hospital.
679
680 (A) The rate of change in interpretation of radiologic studies must be
681 routinely monitored and reviewed with the radiology department identified cases should be
682 reviewed to determine the reason for misinterpretation, adverse outcomes, and opportunities for
683 improvement.

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728

(B) The Radiologist

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

(11) Trauma Program Manager (TPM).

(A) There shall be an identified Trauma Program Manager responsible for monitoring trauma patient care throughout the continuum of care and until discharge. The TPM:

- (i) shall be a registered nurse who;
- (ii) is current in the Trauma Nurse Core Course (TNCC) or Advanced Trauma Course for Nurses (ATCN) or a DSHS-approved equivalent; or
- (iii) is current in a nationally recognized pediatric advanced life support course ((e.g. Pediatric Advanced Life Support (PALS) or the Emergency Nurse Pediatric Course (ENPC));
- (iv) shall be a standing member of the hospital nurse staffing committee as established in accordance with Health and Safety Code (HSC), §§161.031 - 161.033; and
- (v) shall have responsibility for the monitoring the clinical outcomes, direction and oversight of the trauma program.

(B) Each facility shall identify a registered nurse as the trauma program manager who is responsible for the integration of trauma nursing standards of care. The responsibilities and authority of the Trauma Program Manager shall include:

- (i) the authority and responsibility to monitor trauma patient care from ED admission through operative intervention(s), ICU care, stabilization, rehabilitation care, and discharge, including the trauma performance improvement (PI) program;
- (ii) participation in a leadership role in the hospital, community, and regional emergency management (disaster) response committee;
- (iii) being full-time with a minimum of 80% of the time dedicated to the Trauma program; and

729 (iv) completion of a course designed for his/her role which
730 provides essential information on the structure, process, organization and administrative
731 responsibilities of a PI program to include a trauma outcomes and performance improvement
732 course (e.g. Trauma Outcomes Performance Improvement Course (TOPIC) or Trauma
733 Coordinators Core Course (TCCC)).

734
735 (12) Nursing Services for all critical care and patient care areas shall provide
736 evidence of the following:

737
738 (A) all nurses caring for trauma patients throughout the continuum of
739 care have ongoing documented knowledge and skill in trauma nursing for patients of all ages to
740 include trauma specific orientation, annual clinical competencies, and continuing education;

741
742 (B) written standards on nursing care for trauma patients for all units
743 (i.e. ED, ICU, OR, PACU, general inpatient) in the trauma facility shall be implemented;

744
745 (C) a validated acuity-based patient classification system is utilized to
746 define workload and number of nursing staff to provide safe patient care for all trauma patients
747 throughout their hospitalization;

748
749 (D) a written plan, developed by the hospital, for acquisition of
750 additional staff on a 24 hour basis to support units with increased patient acuity, multiple
751 emergency procedures and admissions (i.e. written surge plan.);

752
753 (E) a minimum of two registered nurses shall participate in initial
754 resuscitations for Level I or Level II trauma activations have successfully completed and holds
755 current credentials in an advanced cardiac life support course* (e.g. ACLS or hospital
756 equivalent), a nationally recognized pediatric advanced life support course (e.g. PALS or ENPC)
757 and TNCC or ATCN or a DSHS-approved equivalent. A free-standing children's facility is
758 exempt from the ACLS requirement;

759
760 (F) nursing documentation for trauma patients is systematic and meets
761 the trauma registry guidelines; nursing documentation for trauma activation patients is on a
762 trauma flow sheet, may be electronic or paper, defines the sequence of care, primary and
763 secondary survey with interventions, outcomes, serial vital signs, GCS and components of the
764 RTS, consulting services assessment and plan of care with disposition meets the trauma registry
765 guidelines and documents the response time of all trauma team members.

766
767 (G) documentation that 100% of nursing staff working in the
768 Emergency Department (ED) and responding to trauma activations or caring for trauma patients
769 have successfully completed and hold current credentials in an advanced cardiac life support
770 course (e.g. ACLS or hospital equivalent), a nationally recognized pediatric advanced life
771 support course (e.g. PALS or ENPC) and TNCC or ATCN or a DSHS-approved equivalent,
772 within 18 months of date of employment in the ED or the date of designation.

773
774 (H) requirements specific to a free-standing children's facility:

775
776 (i) 100% of nursing staff who care for trauma patients have
777 successfully completed; and
778
779 (ii) hold current credentials in ENPC or in a nationally recognized
780 pediatric advanced life support course and TNCC or ATCN or a DSHS-approved equivalent,
781 within 18 months of date of employment in the ED or date of designation.
782

783 (13) Texas EMS/Trauma Registry Requirements. Any designated trauma facility
784 shall participate in the Texas EMS/Trauma Registry. Participation shall include:
785

786 (A) Data submission for designation purposes.
787

788 (i) Initial designation. Six months of data prior to the initial
789 designation survey must be uploaded to the Texas EMS/Trauma System Registry. Subsequent to
790 initial designation, data shall be uploaded to the Texas EMS/Trauma Registry as indicated in
791 Chapter 103, Injury Prevention and Control of this title within 45 days of discharge with a 90%
792 acceptance or accuracy rate.
793

794 (ii) Re-designation. Data shall be uploaded to the Texas
795 EMS/Trauma Registry as indicated in Chapter 103, Injury Prevention and Control of this title
796 within 45 days of patient discharge with a 90% acceptance rate.
797

798 (B) Identifying a trauma registrar who has appropriate education and
799 training in injury severity scaling, and four hours of continuing education annually specific to
800 trauma data quality.
801

802 (C) Data validation. The registrar must participate in ongoing data
803 validation through the RAC PI committee.
804

805 (14) Trauma Registrar (Level III only). There shall be an identified Trauma
806 Registrar, who is separate from but supervised by the TPM, who has had appropriate training and
807 includes within 24 months of hire into the position of trauma registrar:
808

809 (A) the Association for the Advancement of Automotive Medicine
810 (AAAM) course, and
811

812 (B) American Trauma Society (ATS) Trauma Registrar Course in injury
813 severity scaling; or
814

815 (C) other course approved by the department. ~~Typically, one full-time~~
816 ~~equivalent (FTE) employee dedicated to the registry shall be required to process approximately~~
817 ~~500 patients annually.~~
818

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

821
822 (16) Emergency Department Equipment and Services. Equipment and services for
823 the evaluation and resuscitation of, and to provide life support for, critically or seriously injured
824 patients of all ages shall be available for resuscitation, temperature warming and cooling
825 management, hemorrhage control, hemodynamic monitoring and orthopedic splinting.

826
827 (A) Equipment.

828
829 (i) Standard: Emergency Department Equipment.

830
831 (I) Airway control and ventilation equipment including
832 laryngoscope and endotracheal tubes of all sizes, bag-valve-mask devices (BVMs), pocket
833 masks, oxygen;

834
835 (II) Mechanical ventilator;

836
837 (III) Pulse oximetry;

838
839 (IV) Suction devices;

840
841 (V) Electrocardiograph-oscilloscope-defibrillator;

842
843 (VI) Internal age-specific paddles;

844
845 (VII) Supraglottic airway management device (e.g.
846 LMA);

847
848 (VIII) Central venous pressure monitoring equipment;

849
850 (IX) All standard intravenous fluids and administration
851 devices, including large-bore intravenous and a rapid infuser system;

852
853 (X) Sterile surgical sets for procedures standard for
854 emergency room such as thoracostomy, venous cutdown, central line insertion, thoracotomy,
855 diagnostic peritoneal lavage, airway control/cricothyrotomy, etc.;

856
857 (XI) Drugs and supplies necessary for emergency care;

858
859 (XII) Cervical spine stabilization device;

860
861 (XIII) Length-based body weight & tracheal tube size
862 evaluation system (such as Broselow tape) and resuscitation medications and equipment that are
863 dose-appropriate for all ages;

864
865 (XIX) Long bone stabilization device;

866

867 (XX) Pelvic stabilization device;
868
869 (XXI) Thermal control equipment for patients and a rapid
870 warming device for blood and fluids;
871
872 (XXII) Non-invasive continuous blood pressure monitoring
873 devices;

874
875 (XXIII) Qualitative end tidal CO₂ monitor;

876
877 (ii) Surgery Department Equipment and Services. Equipment and
878 services for the care of the trauma patient operative interventions as defined by the center's
879 trauma plan to include resuscitation, temperature warming and management, hemorrhage
880 control, hemodynamic monitoring and orthopedic splinting to ensure that trauma standards of
881 care are met.

882
883 ~~Operating Suite Equipment. Special requirements shall include but~~
884 ~~not be limited to:~~

885
886 (I) ~~Thermal control equipment for patient and for blood~~
887 ~~and fluids;~~

888
889 (II) ~~X ray capability including c-arm image intensifier~~
890 ~~with technologist available 24 hours a day;~~

891
892 (III) ~~Endoscopes, all varieties, and bronchoscope;~~

893
894 (IV) ~~Equipment for long bone and pelvic fixation;~~

895
896 (V) ~~Rapid infuser system;~~

897
898 (VI) ~~Appropriate monitoring and resuscitation~~

899 ~~equipment;~~

900
901 (VII) ~~The capability to measure pulmonary capillary~~
902 ~~wedge pressure;~~

903
904 (VIII) ~~The capability to measure invasive systemic arterial~~
905 ~~pressure.~~

906
907 (B) Services.

908
909 (i) Standard: X-ray Capability/Services. An in-house
910 technician shall be available 24-hours a day or be on-call and promptly available within 30
911 minutes of request.

912

913 (ii) Operating Suite. For a Level I, II, and III, operating room
914 services shall be available 24 hours a day. With advanced notice, the Operating Room shall be
915 opened and ready to accept a patient within 30 minutes.

916
917 (iii) Post-Anesthesia Care Unit. For a Level III, a post-
918 anesthesia care unit or surgical intensive care unit shall have available:

919
920 (I) Registered nurses and other essential personnel
921 available 24 hours a day;

922
923 (II) Appropriate equipment to ensure that trauma
924 standards of care are met. ~~monitoring and resuscitation equipment;~~

925
926 ~~(III) Pulse oximetry;~~

927
928 ~~(IV) Thermal control equipment for patients and a rapid~~
929 ~~warming device for blood and fluids.~~

930
931 (iv) Intensive Care Capability
932 For a Level I, II and III, intensive care capability shall be available for the trauma critical care
933 patient and interventions as defined by the center's trauma plan to include resuscitation,
934 temperature warming and cooling management, hemorrhage control, hemodynamic monitoring
935 and orthopedic splinting to ensure that national trauma standards of care are met.

936
937 (I) Designated surgical director or surgical co-director
938 who is responsible for setting policies, developing protocols and management guidelines related
939 to trauma ICU patients. A physician who is providing this coverage must be a surgeon who is
940 credentialed by the TMD to participate in the resuscitation and treatment of trauma patients who
941 is ~~to include requirements such as board certified or board-eligible surgeon trauma continuing~~
942 ~~medical education, compliance with trauma protocols, and participation in the trauma PI~~
943 ~~program;~~ who meets the credentialing requirements as defined in the facility trauma plan.

944
945 (II) Physician, credentialed in critical care by the trauma
946 director, who is on duty in the ICU 24 hours a day or immediately available from in-hospital.
947 Arrangements for 24-hour surgical coverage of all trauma patients shall be provided for
948 emergencies and routine care. This system shall be continuously monitored by the trauma PI
949 program;

950
951 (III) Registered Nurse-patient minimum ratio of 1:2 on
952 each shift for patients identified as critical acuity;

953
954 ~~(IV) Appropriate monitoring and resuscitation~~
955 ~~equipment;~~

956
957 ~~(V) Pulse oximetry;~~

958

959 ~~(VI) Thermal control equipment for patients and a rapid~~
 960 ~~warming device for blood and fluids;~~
 961
 962 ~~(VII) The capability to measure pulmonary capillary~~
 963 ~~wedge pressure;~~
 964
 965 ~~(VIII) The capability to measure invasive systemic arterial~~
 966 ~~pressure.~~
 967
 968 (v) Clinical Support Services.
 969
 970 (vi) Respiratory Services. Respiratory services shall be in-
 971 house and available 24 hours per day.
 972
 973 (vii) Clinical Laboratory Service
 974
 975 (I) Services available 24 hours per day;
 976
 977
 978 ~~(II) Standard analyses of blood, urine, and other body~~
 979 ~~fluids, including microsampling;~~
 980
 981 ~~(III) Blood typing and cross matching, to include~~
 982 ~~massive transfusion and emergency release of blood policies;~~
 983
 984 ~~(IV) Comprehensive blood bank or access to a~~
 985 ~~community central blood bank and adequate hospital storage facilities;~~
 986
 987 ~~(V) Coagulation studies;~~
 988
 989 ~~(VI) Blood gases and pH determinations;~~
 990
 991 ~~(VII) Microbiology;~~
 992
 993 ~~(VIII) Drug and alcohol screening; results should be~~
 994 ~~included in all trauma PI reviews;~~
 995
 996 ~~(IX) Infectious disease Standard Operating Procedures;~~
 997 ~~and~~
 998
 999 ~~(X) Serum and urine osmolality.~~
 1000 (viii) Special Radiological Capabilities Level III.
 1001
 1002 (I) Sonography;
 1003

1004 (II) Computerized tomography. In-house CT technician
1005 24-hours per day or on-call and promptly available within 30 minutes of request. This system
1006 shall be continuously monitored by the trauma PI program;
1007
1008 (III) Angiography of all types;
1009
1010 (IV) Nuclear scanning.
1011
1012 (ix) Specialized Capabilities/Services/Units for Level III.
1013
1014 (x) Acute hemodialysis capability. Transfer agreements shall
1015 be implemented if there is no capability for this standard.
1016
1017 (xi) Organized burn care. Established criteria for care of major
1018 or severe burn patients and/or a process to expedite the transfer of burn patients to a burn center
1019 or higher level of care to include written protocols, written transfer agreements, and a regional
1020 trauma system transfer plan for patients needing a higher level of care or specialty services.
1021
1022 (xii) Spinal cord/head injury rehabilitation management
1023 capability.
1024 (I) In circumstances where a designated spinal cord
1025 injury rehabilitation center exists in the region, transfer agreements must be in effect.
1026
1027 (II) In circumstances where a moderate to severe head
1028 injury center exists in the region, transfer agreements must be in effect.
1029
1030 (xiii) Rehabilitation Medicine.
1031
1032 (I) Physician-directed rehabilitation service, staffed by
1033 personnel trained in rehabilitation care and equipped properly for care of the critically injured
1034 patient, or transfer agreement when medically feasible to a rehabilitation facility and a process to
1035 expedite the transfer of rehabilitation patients to include such things as written protocols, written
1036 transfer agreements, and a regional trauma
1037
1038 (II) Physical therapy;
1039
1040 (III) Occupational therapy;
1041
1042 (IV) Speech therapy;
1043
1044 (IV) Social services.
1045
1046 (xix) Outreach program.
1047
1048 (I) Provide education to and consultations with
1049 physicians of the community and outlying areas

1050
1051 (II) A defined individual to coordinate the facility's
1052 community outreach programs for the public and professionals is evident.
1053
1054 (xx) Public education/injury prevention.
1055
1056 (I) A public education program to address the major
1057 injury problems within the hospital's service area. Documented participation in a RAC injury
1058 prevention program is acceptable.
1059
1060 (II) Coordination and/or participation in
1061 community/RAC injury prevention activities.
1062
1063 (xxi) Training programs. Formal programs in trauma continuing
1064 education provided by hospital for staff based on needs identified from the performance
1065 improvement program for:
1066 (I) staff physicians;
1067
1068 (II) nurses;
1069
1070 (III) allied health personnel, including mid-level
1071 providers such as physician assistants and nurse practitioners;
1072
1073 (IV) community physicians;
1074
1075 (V) prehospital personnel.
1076
1077 (xxii) Research. Trauma registry performance improvement
1078 activities.
1079
1080 (xxiii) Quality assessment and performance improvement.
1081
1082 (I) A facility shall develop, implement, maintain, and
1083 evaluate an effective, ongoing, facility-wide, data-driven, interdisciplinary quality assessment
1084 and performance improvement (QAPI) program. The program shall be individualized to the
1085 facility and meet the criteria and standards described in this section.
1086
1087 (II) The program shall reflect the complexity of the
1088 facility's trauma service plan and the services involved. All facility services (including those
1089 services furnished under contract or arrangement) shall focus on decreasing the deviations from
1090 the trauma standards of care to ensure optimal trauma outcomes, patient safety standards and
1091 cost effective care.
1092
1093 (III) The trauma center shall demonstrate that the facility
1094 staff evaluate the provision of trauma care and patient services, identify opportunities for
1095 improvement, develop and implement improvement plans, and evaluate the implementation of
those plans until resolution is achieved. Evidence shall support that aggregate patient data,

1096 including identification and tracking of trauma patient complications or variances from standards
1097 of care, is continuously reviewed for trends by the trauma interdisciplinary team TIT. [Trauma
1098 Interdisciplinary team (TIDT)--A group composed of the trauma medical director (TMD), the
1099 trauma program manager, an executive officer of the facility, a trauma nurse active in the
1100 management of trauma patients, a trauma nurse active in the management of pediatric trauma
1101 patients, as applicable, and physicians and surgeons that provide coverage or care to trauma
1102 patients, and other healthcare professionals participating in the care of major or severe trauma
1103 patients.]

1104
1105 (V) The trauma interdisciplinary team (TIDT) shall lead
1106 the QAPI meetings and activities; the QAPI meetings shall be documented and include the
1107 attendance, activities, actions, and follow-up.

1108
1109 (VI) The trauma center's QAPI program shall include,
1110 ongoing monthly review of system key elements of trauma care using comparative and trend data
1111 to include, the following aggregate patient data.

1112
1113 (VII) All events and decisions of a trauma center
1114 impacting the ability of the trauma center to comply with any essential criterion, as defined in (c)
1115 (1-2) of this section or changes in the trauma centers resources that affect the region shall require
1116 that the trauma center notify the office, the local RAC plus other affected RACs, including all
1117 changes that affect air medical access to designated landing sites.

1118
1119 (j) Appeals Process. If a facility disagrees with the office's decision regarding its
1120 designation application or status, it may request a secondary review by a designation review
1121 committee.

1122
1123 ~~(1) Membership on a designation review committee will:~~

1124
1125 ~~(A) be voluntary;~~

1126
1127 ~~(B) be appointed by the office director;~~

1128
1129 ~~(C) be representative of trauma care providers and appropriate levels~~
1130 ~~of designated trauma facilities; and~~

1131
1132 ~~(D) include representation from the department and the Trauma~~
1133 ~~Systems Committee of the Governor's EMS and Trauma Advisory Council (GETAC).~~

1134
1135 ~~(2) If a designation review committee disagrees with the office's~~
1136 ~~recommendation for corrective action, the records shall be referred to the assistant commissioner~~
1137 ~~for recommendation to the commissioner.~~

1138
1139 (3) If a facility disagrees with the office's recommendation at the end of the
1140 secondary review, the facility has a right to a hearing, in accordance with the department's rules
1141 for contested cases, and Government Code, Chapter 2001.

June 18, 2015