1 §157.125. Requirements for Trauma Facility Designation.
2
3 (a) General Provisions. The goal of the trauma system is to reduce
4 the morbidity and mortality of the trauma patient. The objective of the
5 trauma system is to get the right patient, to the right place, at the right
6 time, to receive the right care. The purpose of this section is to set forth the
7 requirements for a health care facility to become a designated trauma
8 facility.
9
10 (1) The Department of State Health Services (department)
11 shall determine the designation level for each health care facility by physical
12 location, based on, but not limited to, the location's own resources and
13 levels of care capabilities; Trauma Service Area (TSA) capabilities; and
14 compliance with the essential criteria and standard requirements outlined in
15 this section.
16
17 (2) The Office of Emergency Medical Services (EMS)/Trauma
18 Systems Coordination (office) shall recommend to the Commissioner of the
19 Department of State Health Services (commissioner) the trauma designation
20 of a facility at the level the office deems appropriate.
21
22 (3) Facilities eligible for trauma designation include:
23
24 (A) A hospital in the state of Texas, licensed or otherwise
25 meeting the description (in accordance with Texas Administrative Code
26 (TAC) Chapter 133 Hospital Licensing); a hospital owned and operated by
27 the state of Texas, or a hospital owned and operated by the federal
28 government; with the capability to provide stabilization and transfer or
29 treatment for the major and severe trauma patient.
30
31
32 (4) Each facility operating on a single hospital license with
33 multiple locations (multi-location license) shall be considered
34 separately by physical location for designation.
35
36 (5) Designation does not include provider based departments
37 of the designated facility, which are not contiguous with the
38 designated facility. If patients that meet trauma activation criteria are
39 received by the facility, these patients must be included in the trauma
40 registry and trauma performance improvement process.
41
42 (6) Departments or services within a facility shall not be
43 separately designated.
44

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(7) A trauma facility designation is issued for the physical location and to the legal owner of the operations of the facility. If a designated facility has a change of ownership or a change of the physical location of the facility, the designation shall not be transferred or assigned.

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

(A) Comprehensive (Level I). The facility shall meet the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center and TAC 157.125 (j) in this section and the Texas trauma facility requirements for a Level III trauma facility.

(B) Major (Level II). The facility shall meet the current ACS essential criteria for a verified Level II trauma center and TAC 157.125 (j) in this section and the Texas trauma facility requirements for a Level III trauma facility.

(C) Advanced (Level III). The facility shall meet TAC 157.125 (j) and (m) requirements in this section.

(D) Basic (Level IV). The facility shall meet TAC 157.125 (j) and (n) requirements in this section.

(9) In Active Pursuit of Designation (IAP) applies only to an undesignated facility that applies for trauma designation and is in active pursuit of designation in accordance with Texas Health and Safety Code, Chapter 780 Trauma Facilities and Emergency Medical Services, Section 780.004 (2)(i). In Active Pursuit is defined by the State for funding purposes and not by other entities.

(b) Designation Process.

(1) Facility Conferences.

(A) Application for an initial designation by a facility will require a pre-survey conference. The CEO, TMD and TPM of the facility shall attend a pre-survey conference at the department designated by the office. The purpose of the pre-survey conference, conducted by office staff, is to review and discuss the designation requirements for the applicable level prior to the initial onsite designation survey. The office may waive the pre-survey conference requirement.

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(B) Application for redesignation determined to be a designation with contingencies or denial of designation will necessitate a conference. The CEO, TMD and TPM shall attend a conference at the department designated by the office. The purpose of the conference, conducted by office staff, is to review and discuss the corrective action plan (CAP) to achieve compliance with the rule. The office may waive the conference requirement.

(2) Application Packet. A facility seeking designation, shall submit a completed application packet to include:

(A) an accurate and complete designation application form for the appropriate level of requested designation;

(B) full payment of the non-refundable, non-transferrable, designation fee as follows;

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

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

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

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

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

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(E) evidence of participation in the applicable Regional Advisory Council (RAC);

(F) evidence of submission of data to the department trauma registry; and

(G) any subsequent documents requested by the office.

(3) If a facility seeking initial designation fails to meet the requirements in subsections (b)(1) – (2) above, the application shall be considered withdrawn by the facility.

(4) Renewal of designation. The applicant shall submit the documents described in subsection (b)(2)(A) – (G) above, to the office at least 90 days prior to the designation expiration date.

(5) If a facility seeking redesignation fails to meet the requirements in subsection (b)(2)(A) – (G) above, the application shall be denied and the original designation will expire on its expiration date.

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

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

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

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

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

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

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

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(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 survey team shall evaluate the facility's compliance and document the noncompliance with §157.125 by:

(A) reviewing documents;

(B) performing a minimum of ten patient care reviews on closed medical records;

(C) tour of the physical plant; and

(D) staff interviews to include:

(i) the Chief Executive Officer;
(ii) the Chief Nursing Officer;
(iii) the current Trauma Medical Director;
(iv) the current Trauma Program Manager;
(v) the current Executive Sponsor of the trauma program; and
(vi) general staff.

(4) The surveyor(s) shall provide the facility with a written, signed survey report regarding their evaluation of the facility's compliance/noncompliance with §157.125. This survey report shall be forwarded to the facility no later than 30 calendar days of the completion date of the survey. The facility is responsible for forwarding a copy of this report, including patient care reviews, to the office in the application packet if it intends to continue the designation process.

(5) The trauma designation application packet, survey report and patient care reviews in its entirety shall be part of a facility's performance improvement (PI)/Multidisciplinary Trauma PI and peer case review program and subject to confidentiality as articulated in the Health and Safety Code, §773.095.

(6) The office shall review the findings of the survey report, patient care reviews and any POC submitted by the facility to determine compliance with the requirements.

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218 (7) A recommendation for designation will be made to the
219 commissioner if the facility meets the requirements for
220 designation found in this section.
221
222 (8) If the commissioner concurs with the recommendation to
223 designate, the facility shall receive a letter of designation valid for 3 years
224 and a certificate of designation.
225
226 (A) Display: The hospital shall display the trauma
227 designation certificate and the current letter awarding designation from the
228 Commissioner, in a public area of the licensed premises that is readily visible
229 to patients, employees, and visitors.
230
231 (B) The trauma designation certificate shall be valid only
232 when displayed with the current letter awarding designation.
233
234 (C) If the facility closes or loses trauma designation, the
235 certificate shall be returned to the office.
236
237 (D) Alteration: the trauma designation certificate and the
238 award letter shall not be altered. Any alteration to either document
239 voids trauma designation for the remainder of that cycle.
240
241 (9) The facility shall have the right to withdraw its application
242 at any time prior to being recommended for trauma facility
243 designation by the office.
244
245 (10) It shall be necessary to repeat the designation process as
246 described in this section prior to expiration of a facility's designation or
247 the designation expires.
248
249 (11) The office shall post the current designation status of each
250 facility on the office website.
251
252 (12) If a facility disagrees with the office's decision regarding its
253 designation status, the facility has a right to a hearing, in accordance with
254 the department's rules for contested cases, and Government Code, Chapter
255 2001.
256
257 (d) Exceptions and Notifications
258
259 (1) Written notification of an event or decision impacting the
260 ability of a trauma facility to comply with designation
261 criteria to maintain the current designation status, or to

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262 increase the trauma facility's capabilities that affect the
263 region, shall be provided to the following:
264
265 (A) the emergency medical services providers within 24
266 hours;
267
268 (B) the healthcare facilities to which it customarily
269 transfers-out and/or transfers-in trauma patients
270 within 24 hours;
271
272 (C) applicable RAC(s) within 24 hours; and
273
274 (D) the office within 5 days.
275
276 (2) If the healthcare facility is unable to comply with program
277 requirements to maintain the current designation status, it shall submit to
278 the office a POC as described in (b)(2)(D) of this section, and a request for a
279 temporary exception to criteria. Any request for an exception shall be
280 submitted in writing from an executive officer of the facility. The office shall
281 review the request and the POC and either grant or deny the exception. If
282 the healthcare facility has not come into compliance at the end of the
283 exception period, the office may at its discretion elect one of the following:
284
285 (A) allow the facility to request designation at the level
286 appropriate to its revised capabilities;
287
288 (B) redesignate the facility at the level appropriate to its
289 revised capabilities; or
290
291 (C) the facility may relinquish designation status.
292
293 (e) Upgrade or Downgrade of designation levels.
294
295 (1) An application for a higher or lower level designation may
296 be submitted to the office at any time.
297
298 (2) A designated trauma facility that is increasing its trauma
299 capabilities may choose to apply for a higher level of trauma designation at
300 any time. It shall be necessary to repeat the designation process for the
301 higher level.
302
303 (3) A designated trauma facility that is unable to maintain
304 compliance with the level of the current designation may choose
305 to apply for a lower level of trauma designation at any time. It

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shall be necessary to repeat the designation process for the lower level. There shall be a desk review by the office to determine if and when a full survey shall be required.

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

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

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

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

(j) Program Requirements.

(1) Program Plan. The facility shall develop a written plan of the trauma program that includes a detailed description of the scope of services available to all trauma patients, defines the trauma patient population evaluated and/or treated by the facility, transferred, or transported by the facility, that is consistent with accepted professional standards of practice for trauma care, and ensures the health and safety of patients.

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(A) The written plan and the program policies and procedures shall be reviewed and approved by the facility's governing body. The governing body shall ensure that the requirements of this chapter are implemented and enforced.

(B) The written program plan shall include, at a minimum:

(i) policies and procedures based on national evidence-based standards of practice of trauma care, that are adopted, implemented, and enforced for compliance by the facility, that governs the trauma program through all phases of care for all patient populations;

(ii) A periodic review and revision schedule for all trauma care policies and procedures;

(iii) written triage, stabilization and transfer guidelines for the trauma patient that include consultation and transport services;

(iv) the availability of all necessary equipment and services to provide the appropriate level of care and support of the patient population served;

(v) requirements for minimal credentials for all medical and healthcare staff participating in the care of trauma patients;

(vi) provisions for medical and healthcare staff education; including annual competency and skills assessment that is appropriate for the patient population served;

(vii) telemedicine utilization in the Emergency Department (ED);

(ix) the role of the hospitalist/intensivist physicians in the care of the trauma patient;

(x) provisions for consistent participation by the TMD, TPM, TR, or other members of the trauma program in the regional advisory council (RAC);

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394
395 (xi) a trauma staff registered nurse as a
396 representative on the nurse staffing committee as
397 established in accordance with TAC §§133.41(o)(2)(F);
398
399 (xii) identify a program sponsor who is a member of
400 the executive leadership at the facility;
401
402 (xiii) contingency plans to ensure the immediate
403 continuation of an active trauma program in the event that
404 the Trauma Medical Director or the Trauma Program
405 Manager position becomes vacant;
406
407 (2) Medical Records. Maintain medical records that contain
408 information to justify and support the immediate evaluation, activation,
409 resuscitation, diagnosis, treatment, and describe the patient's progress and
410 response to medication and interventions from arrival in the Emergency
411 Department through hospital discharge.
412
413 (3) Performance Improvement Plan. The facility shall develop,
414 implement, maintain, and evaluate an effective, ongoing, facility-wide,
415 data-driven, outcomes based multidisciplinary performance
416 improvement (PI) plan. The plan shall be individualized to the facility
417 and meet the requirements described in this section.
418
419 (A) The Trauma PI plan shall be reviewed and approved
420 by the facility's governing body. The governing body
421 shall ensure that the requirements of this section are
422 implemented and enforced.
423
424 (B) The trauma PI plan shall include, at a minimum:
425
426 (i) A description of the facility's trauma program
427 and the services provided. All facility services
428 (including those services furnished under
429 contract or arrangement) shall focus on
430 decreasing deviations from the trauma
431 standards of care to ensure achievement of
432 optimal trauma outcomes, patient safety
433 standards and cost effective care.
434
435 (ii) Demonstrate how the staff evaluate the
436 standards of practice, provision of trauma care
437 and patient services, identify opportunities for

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improvement, develop and implement improvement plans, and evaluate the plan’s outcomes 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, and levels of review is continuously reviewed for opportunities by the trauma multidisciplinary PI committee.

(iii) Composition of the trauma multidisciplinary PI committee to include the trauma medical director (TMD), the trauma program manager (TPM), an executive officer of the facility, a trauma nurse active in the management of trauma patients, a trauma nurse active in the management of pediatric trauma patients as applicable, and physicians and surgeons that provide coverage or care to trauma patients, and other healthcare professionals participating in the care of major or severe trauma patients.

(iv) Provisions for documentation of the attendance, activities, actions, and follow-up of outcomes, with ongoing monthly review of trauma center regulatory compliance, trauma patient outcomes, and trauma system performance from committee meetings.

(v) A twelve-month summary of the Trauma PI process shall be provided to the governing body for review.

(4) Texas EMS/Trauma Registry Requirements. Any designated trauma facility must submit accurate, timely, and complete trauma registry data to the Texas EMS/Trauma Registry.

A. Initial designation. Six months of data prior to the initial designation survey must be uploaded to the Texas EMS/Trauma System Registry. Subsequent to initial designation, data shall be uploaded to the Texas EMS/Trauma Registry as indicated in Chapter 103,

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481 Injury Prevention and Control of this title within 60 days
482 of discharge with an 80% acceptance or accuracy rate.
483
484 (ii) Re-designation. Data shall be uploaded to the
485 Texas EMS/Trauma Registry as indicated in Chapter 103,
486 Injury Prevention and Control of this title within 60 days of
487 patient discharge with an 80% acceptance rate.
488
489 (B) Data validation. The Trauma Registrar must
490 participate in ongoing data validation through the initial hospital submission
491 and/or the RAC.
492
493 (5) Outreach and Education.
494
495 (A) A defined individual to coordinate the facility's
496 community outreach and education programs for the
497 public and professionals is evident;
498
499 (B) Provide education to and consultations with
500 physicians of the community and outlying areas; and
501
502 (C) Training programs in trauma continuing education
503 provided by facility for staff and community members
504 involved in trauma care based on needs identified from
505 the PI program for:
506
507 (i) staff physicians;
508 (ii) nurses;
509 (iii) Advanced Practice clinicians including Physician
510 Assistants, Advanced Nurse Practitioners and
511 Certified Registered Nurse Anesthetists;
512 (iv) allied health personnel
513 (v) specialty and community physicians;
514 (vi) prehospital personnel; and
515 (vii) other appropriate personnel involved in trauma
516 care
517
518 (6) Injury Prevention and Public Education.
519
520 (A) A public education program to address the major
521 injury problems identified within the facility's service
522 area; and
523

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

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

(8) Medical Staff. The facility 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.

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

(i) The TMD shall be a member of the Medical Executive Committee (MEC);

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

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

(I) reviewing credentials of medical staff requesting privileges on the trauma team and making recommendations to the MEC 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) 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 case review outcomes, including deviations from trauma standards of care trending, when considering re-credentialing members of the trauma team.

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568 All follow-up and feedback from peer case review activity must be made
569 available to the reviewers at the time of the onsite survey;
570
571 (VI) developing and providing ongoing
572 management of treatment protocols based on current standards of trauma
573 care;
574
575 (VII) participating in the ongoing education of
576 the medical and nursing staff in the care of the trauma patient;
577
578 (VIII) ensuring that the trauma
579 multidisciplinary PI and peer case review meeting is specific to trauma care,
580 is ongoing, is data driven and effective; TMD serves as chair of the trauma
581 peer case review and the multidisciplinary PI committee meetings;
582
583 (VIX) participation in the applicable RAC(s) and
584 reviewing the RAC(s) trauma system plan;
585
586 (XI) participates in the facility, community,
587 and regional disaster preparedness activities and has evidence of disaster
588 response education
589
590 (XII) evidence that the TMD is aware of the
591 multidisciplinary team findings on all trauma patients;
592
593 (XIII) averaging 9 hours of continuing trauma
594 medical education (CME) annually;
595
596 (XIV) maintains active staff privileges as
597 defined in the facility's medical staff bylaws;
598
599 (10) Trauma Program Manager (TPM). There shall be an
600 identified Trauma Program Manager responsible for monitoring trauma
601 patient care throughout the continuum of care and through discharge.
602
603 (A) The TPM:
604 (i) shall be a registered nurse;
605
606 (ii) is current in the Trauma Nurse Core Course
607 (TNCC) or Advanced Trauma Course for Nurses
608 (ATCN) or a DSHS-approved equivalent
609 course;
610

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

(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 (e.g. Trauma Outcomes Performance Improvement Course (TOPIC)) or an office approved equivalent course;

(vi) has completed the Association for the Advancement of Automotive Medicine (AAAM) course or an office approved equivalent course within 24 months of becoming the trauma program manager;

(vii) is responsible for the integration and monitoring of compliance of the trauma nursing standards of care;

(viii) has evidence of disaster response education

(ix) has the authority and oversight in collaboration with the TMD to:

(I) monitor the clinical outcomes and system performance of the trauma program.

(II) monitor trauma patient care from prehospital and arrival, through operative intervention(s), ICU care, stabilization, rehabilitation care, and discharge, through the

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trauma performance improvement (PI) program;

(x) participates in a leadership role in the facility through committee participation, facility-wide PI initiatives and emergency management (disaster) response committee.

(xi) Participates in RAC activities through committee membership and regional emergency preparedness.

(k) Trauma Designation Level I (Comprehensive). The facility shall meet the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center and TAC 157.125 (j) and (m) in this section **and the Texas Trauma Designation Level III (Advanced) requirements.**

(l) Trauma Designation Level II (Major). The facility shall meet the current ACS essential criteria for a verified Level II trauma center and TAC 157.125 (j) and (m) in this section **and the Texas Trauma Designation Level III (Advanced) requirements.** .

(m) Trauma Designation Level III (Advanced). The facility shall meet the current ACS essential criteria for a Level III trauma center if verified by ACS; and TAC 157.125 (j) in this section; and the following requirements:

(1) The Trauma Medical Director shall be a physician who is:

(A) a board certified general surgeon or a general surgeon eligible for certification by the American Board of Surgery according to current requirements and currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office, or

(B) a general surgeon who has continuously served as the Trauma Medical Director at the designated facility for the last consecutive 36 months and is currently credentialed in Advanced Trauma Life Support (ATLS).

(2) General Surgery.

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697 (A) All surgeons who provide trauma coverage or
698 participates in trauma call coverage shall:
699
700 (i) be board certified and currently credentialed
701 in Advanced Trauma Life Support (ATLS); or
702
703 (ii) prior to (the effective date of this rule) have
704 continuously provided trauma coverage and participated in trauma call
705 at the designated facility for the last consecutive 36 months and
706 currently credentialed in Advanced Trauma Life Support (ATLS); and
707
708 (iii) be appropriately credentialed through the
709 trauma program;
710
711 (iv) average at least 9 hours of trauma-related
712 continuing medical education annually;
713
714 (v) maintain compliance with trauma protocols as
715 evidence through the PI process;
716
717 (vi) participate in the trauma PI program and
718 attend at least 50% of the trauma multidisciplinary PI and
719 peer case review trauma committee meetings;
720
721 (vii) be present in the ED at the time of arrival for a
722 full trauma team activation of a trauma patient; maximum
723 response time 30 minutes from trauma team activation;
724
725 (viii) be present in the ED within 60 minutes or less
726 from a limited trauma team activation of a trauma patient;
727 and
728
729 (ix) be the admitting physician on all multi-system
730 trauma patients requiring the consultation of one or more
731 specialty services;
732
733 (B) If a facility has a surgical residency program, and a
734 team of surgical residents start the evaluation and treatment of
735 the trauma patient, the team shall have, at a minimum, a
736 postgraduate year 4 (PGY-4) or more senior surgical resident
737 who is a member of the facility's residency program. The
738 presence of a surgical resident does not take the place of the
739 attending physician. The attending physician must be compliant
740 with all response times.

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(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.

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

(4) Trauma Surgical Specialties.

(A) Orthopedic and Neurosurgery surgeons shall:

(i) be board certified or in the applicable surgical specialty; or

(ii) 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

(iii) be appropriately credentialed for trauma care by the TMD;

(iv) average at least 9 hours of trauma-related continuing medical education annually;

(v) maintain compliance with trauma protocols;

(vi) participate in the trauma multidisciplinary PI program and a designated liaison shall attend at least 50% of the trauma multidisciplinary and peer case review trauma committee meetings; and

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

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

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

(C) prior to (the effective date of this rule) have continuously provided trauma coverage in the emergency department at the designated facility for the last consecutive five years and be currently credentialed in Advanced Trauma Life Support (ATLS); or an equivalent course approved by the office.

(D) be board eligible in their applicable specialty and currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office; and

(E) be appropriately credentialed through the trauma program;

(F) average at least 9 hours of trauma-related continuing medical education annually;

(G) maintain compliance with trauma protocols as evidenced through the PI process; and

(H) participate in the trauma multidisciplinary PI program and a designated liaison shall attend at least 50% of the trauma multidisciplinary PI and peer case review committee meetings.

(6) Anesthesia Services. If the facility furnishes anesthesia services, it shall do so in compliance with 25 TAC 133.41 Hospital Functions and Services. The anesthesiologist providing trauma coverage shall:

(A) be a board certified anesthesiologist; or

(B) be a candidate in the American Board of Anesthesiology examination system; or

(C) prior to (the effective date of this rule) have continuously provided anesthesia coverage at the designated facility for the last consecutive five years; average at least 9 hours of continuing medical education(CME) annually; and

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828
829 (D) be appropriately credentialed by the Trauma Medical
830 Director for trauma care;
831
832 (E) maintain compliance with trauma protocols;
833
834
835 (F) a designated liaison shall attend at least 50% of the
836 trauma multidisciplinary PI and peer case review committee
837 meetings.
838
839 (7) Radiology Services.
840
841 (A) A radiologist shall be on-call and promptly available
842 within 30 minutes of request from inside or outside the
843 hospital. The response times shall be continuously
844 monitored by the trauma PI program.
845
846 (B) The rate of change in interpretation of radiologic
847 studies must be routinely monitored and reviewed with
848 the radiology department. Identified cases should be
849 reviewed to determine the reason for misinterpretation,
850 adverse outcomes, and opportunities for improvement.
851
852 (8) Advanced Practice providers (advanced practice registered
853 nurses, physician assistants or Certified Registered Nurse
854 Anesthetist) utilized in the care of major and/or severe
855 trauma patients, shall not be a substitute for the required
856 physician response, in patient care planning nor in PI
857 activities. Any Advanced Practice provider who provides care
858 to trauma patients shall be current in ATLS, have defined
859 trauma procedure credentialing, have 9 hours of CME
860 annually, and be appropriately credentialed by the Texas
861 Board of Nursing (TBON) or the Texas Medical Board (TMB)
862 respectively.
863
864 (9) Nursing Staff. As part of the facility's trauma program
865 approved by the governing body, the program will have an
866 identified Trauma Program Manager with equivalent authority
867 and responsibility as granted to other department or nurse
868 managers. There shall be a demonstrated commitment by
869 the facility for furthering the education and understanding of
870 trauma standards of care for all nursing staff caring for the
871 trauma patient.

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872
873 (10) Nursing Services for all critical care and patient care areas
874 shall provide evidence of the following:
875
876 (A) all nurses caring for trauma patients throughout the
877 continuum of care have ongoing documented knowledge and
878 skills in trauma nursing for patients of all ages to include trauma
879 specific orientation, annual clinical competencies, and continuing
880 education;
881
882 (B) written standards on nursing care for trauma
883 patients for all units (i.e. ED, ICU, OR, PACU, general inpatient)
884 in the trauma facility shall be implemented;
885
886 (C) a facility approved acuity-based patient classification
887 system is utilized to define workload and number of nursing staff
888 to provide safe patient care for all trauma patients throughout
889 their hospitalization;
890
891 (D) a written plan, developed by the hospital, for
892 acquisition of additional staff on a 24 hour basis to support units
893 with increased patient acuity, multiple emergency procedures
894 and admissions (i.e. written surge plan.);
895
896 (E) a minimum of two registered nurses shall participate
897 in initial resuscitations for full and limited trauma activations,
898 have successfully completed and hold current credentials in
899 an advanced cardiac life support course (ACLS); a nationally
900 recognized pediatric advanced life support course (PALS or
901 ENPC); and TNCC or ATCN; or an office approved equivalent for
902 each course;
903
904 (F) nursing documentation for trauma patients is
905 systematic, meets the trauma registry guidelines, and includes
906 at a minimum: time of trauma activation, reason for activation,
907 the sequence of care, primary and secondary survey with
908 interventions, outcomes, serial vital signs, Glasgow Coma Score
909 (GCS), consulting services assessment, plan of care with
910 disposition and the response times of all trauma team members.
911
912 (G) documentation that 100% of nursing staff working in
913 the Emergency Department (ED) and responding to trauma
914 activations or caring for trauma patients have successfully
915 completed and hold current credentials in an advanced cardiac

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916 life support course (e.g. ACLS or hospital equivalent), a
917 nationally recognized pediatric advanced life support course (e.g.
918 PALS or ENPC) and TNCC or ATCN or a DSHS-
919 approved equivalent, within 12 months of date of employment.
920
921 (H) A stand-alone children's facility shall have documentation that 100%
922 of nursing staff who care for trauma patients have successfully completed
923 and hold current credentials in a nationally recognized pediatric advanced
924 life support course (e.g. PALS or ENPC) and TNCC or ATCN or a DSHS-
925 approved equivalent, within 12 months of date of employment in the ED.
926 Stand-alone facilities must have provisions for ACLS standards of care.
927
928 (11) Trauma Registrar. There shall be an identified Trauma
929 Registrar, who is separate from but supervised by the TPM,
930 who has:
931
932 (A) appropriate education and training in injury severity
933 scaling within 24 months of hire into the position of trauma
934 registrar which includes:
935
936 (i) the Association for the Advancement of Automotive
937 Medicine (AAAM) course or an office approved
938 equivalent; and
939
940 (ii) the American Trauma Society (ATS) Trauma
941 Registrar Course or an office approved equivalent; and
942
943 (B) four hours of continuing education annually specific
944 to trauma data quality.
945
946 (12) Emergency Department Equipment. Equipment for the
947 evaluation, resuscitation, and life support of the major and severe trauma
948 patient or the complex neurosurgical or orthopedic injured patients of all
949 ages shall be available for resuscitation, temperature warming and cooling
950 management, hemorrhage control, hemodynamic monitoring, splinting and
951 burn care.
952
953 (13) Surgery Department. Equipment and services for the care
954 of the trauma patient of all ages for operative interventions as defined
955 by the center's trauma plan to include resuscitation, temperature
956 warming and management, hemorrhage control, hemodynamic
957 monitoring and splinting to ensure that trauma standards of care are
958 met.
959

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(A) Operating Suite. Operating room services shall be available 24 hours a day. With advanced notice, the Operating Room shall be opened and ready to accept a patient within 30 minutes.

(B) Post-Anesthesia Care Unit. A post-anesthesia care unit or surgical intensive care unit shall have registered nurses and other essential personnel available 24 hours a day.

(14) Intensive Care Capability. Intensive care capability shall be available for the age specific care of 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 splinting to ensure that trauma standards of care are met.

(A) Designated physician 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 surgeon and meets the credentialing requirements as defined in the facility trauma program plan; or

(B) A physician credentialed in surgical critical care on duty credentialed by the TMD 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; or

(C) Arrangements for 24-hour surgical coverage of all trauma patients shall be provided for emergencies and routine care. This coverage and response times shall be monitored through the trauma PI program.

(15) Clinical Support Services.

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

(B) Clinical Laboratory Service.

(i) Laboratory services shall be in-house and available 24 hours per day;

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1004
1005 (ii) a written policy and procedures for emergent
1006 blood release for trauma resuscitations and for
1007 massive transfusion procedures developed
1008 collaboratively between the trauma service and
1009 the blood bank and appropriate resources for
1010 implementation;
1011
1012
1013 (C) Standard Radiological Services. An in-house
1014 technician shall be available 24-hours a day or be on-call
1015 and promptly available on-site within 30 minutes
1016 of request. The radiology technician call back response
1017 shall be continuously monitored for the trauma PI
1018 program;
1019
1020 (D) Special Radiological Capabilities shall be available for
1021 the trauma patient as defined by the facility's trauma plan to
1022 include:
1023
1024 (i) Sonography;
1025
1026 (ii) Computerized Tomography (CT). An in-house
1027 CT technician shall be available 24-hours a day or be on-
1028 call and promptly available on-site within 30 minutes of
1029 request. The CT scan technician response times and CT
1030 availability shall be continuously monitored for the trauma
1031 PI program;
1032
1033 (iii) Angiography of all types; and
1034
1035 (iv) Nuclear scanning.
1036
1037 (16) Specialized Capabilities/Services/Units.
1038
1039 (A) Acute hemodialysis capability. A written transfer
1040 plan which shall be implemented if the facility does not have the
1041 capability for this standard.
1042
1043 (B) Acute burn capability. Established procedures for
1044 acute management of major or severe burn patients, a written
1045 transfer plan, and prearranged transfer agreements to expedite
1046 the transfer of acute burn patients to a higher level of specialized
1047 burn care.

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1048
1049 (C) Spinal cord/head injury and rehabilitation
1050 management capability. Established procedures for
1051 acute management of identified spinal cord injury or
1052 moderate to severe head injury patients, a written
1053 transfer plan, and prearranged transfer agreements to
1054 expedite transfer of patients to a higher level of
1055 specialized care.
1056
1057
1058 (D) Rehabilitation Medicine.
1059
1060 (i) A physician-directed rehabilitation service,
1061 staffed by personnel trained in rehabilitation care and
1062 equipped properly for care of the critically injured patient,
1063 or a written transfer plan when medically feasible to a
1064 rehabilitation facility and prearranged transfer agreements
1065 to expedite the transfer of rehabilitation patients.
1066
1067 (ii) The facility shall have the following services
1068 available for a critically injured patient:
1069
1070 (I) Physical therapy;
1071
1072 (II) Occupational therapy;
1073
1074 (III) Speech therapy; and
1075
1076 (IV) Social services.
1077
1078 (n) Trauma Designation Level IV (Basic). The Level IV trauma
1079 designated facility will meet the following requirements:
1080
1081 (1) The Trauma Medical Director shall be a physician who is:
1082 (A) A Texas licensed physician currently practicing
1083 medicine in the facility;
1084 (B) credentialed in Advanced Trauma Life Support (ATLS)
1085 or an equivalent course approved by the office;
1086 (C) cover a minimum of ten call shifts per month at the
1087 trauma center.
1088
1089 (D) board certified in emergency medicine by the
1090 American Board of Emergency Medicine (ABMS or AOBEM), and

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currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office; or

(E) board certified in their applicable medical or surgical specialty and currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office; or

(F) has continuously served as the Trauma Medical Director at the designated facility for the last consecutive five years and is currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office.

(2) Emergency Medicine. A physician providing trauma coverage shall be on-call (if not in-house 24/7), promptly available onsite within 30 minutes of request from inside or outside the hospital and shall:

(A) be currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office; and

(B) be board certified in emergency medicine; or

(C) be board eligible in emergency medicine; or

(D) prior to (the effective date of this rule) have continuously provided trauma coverage in the emergency department at the designated facility for the last consecutive five years and currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the office; or

(E) be board eligible in their applicable specialty; and

(F) be appropriately credentialed through the trauma program;

(G) average at least 9 hours of trauma-related continuing medical education annually;

(H) maintain compliance with trauma protocols as evidenced through the trauma performance improvement process; and

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(I) participate in the trauma PI/multidisciplinary PI program and a designated liaison shall attend at least 50% of the trauma multidisciplinary PI and peer case review committee meetings.

(3) Radiologist Services.

(A) A radiologist shall be on-call and promptly available within 30 minutes of request from inside or outside the hospital. The radiologist call-back response times shall be continuously monitored through the trauma PI program.

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

(4) Advanced practice clinicians utilized in the care of major and/or severe trauma patients, shall not be a substitute for the required physician response, in patient care planning, nor in PI activities. Any Advanced practice clinician who provides care to trauma patients shall be currently credentialed in ATLS and be appropriately credentialed by the Texas Board of Nursing (TBON) or the Texas Medical Board (TMB) respectively. If advanced practice clinicians' supervision is provided through a physician and telemedicine technology, specific protocols and performance improvement measures must be documented and monitored.

(5) Nursing Staff. As part of the facility'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 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.

(6) 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;

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(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;

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

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

(E) all Registered nurses participating in initial resuscitations for full and limited trauma activations, have successfully completed and hold current credentials in an advanced cardiac life support course (ACLS); a nationally recognized pediatric advanced life support course (PALS or ENPC); and TNCC or ATCN; or an office approved equivalent for each course;

(F) nursing documentation for trauma patients is systematic and meets the trauma registry guidelines, includes at a minimum: trauma activation times, the sequence of care, primary and secondary survey with interventions, diagnostic evaluation, outcomes, serial vital signs, GCS, consulting services assessment, plan of care with disposition and the response times of all trauma team members.

(G) documentation that 100% of nursing staff working in the Emergency Department (ED) and responding to trauma activations or caring for trauma patients have successfully completed and hold current credentials in an advanced cardiac life support course (e.g. ACLS or hospital equivalent), a nationally recognized pediatric advanced life support course (e.g. PALS or ENPC) and TNCC or ATCN or a DSHS-approved equivalent, within 12 months of date of assignment.

(H) A stand-alone children's facility shall have documentation that 100% of nursing staff who care for trauma patients have successfully completed and hold current credentials in a nationally recognized pediatric advanced life support course (e.g. PALS or ENPC) and TNCC or ATCN or a DSHS-approved equivalent, within 12 months of date of employment in the ED.

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(7) Identified Trauma Registrar who has had appropriate education and training within 24 months of hire into the position of trauma registrar which includes:

(A) the Association for the Advancement of Automotive Medicine (AAAM) course, or an office approved equivalent course.

(B) four hours of continuing education annually specific to trauma data quality.

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

(9) Clinical Support Services.

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

(B) Clinical Laboratory Service.

(i) Laboratory services shall be in-house and available 24 hours per day;

(ii) capability for immediate release of blood for a transfusion; and

(iii) protocol to obtain additional blood components.

(C) 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. The on-call response time will be monitored through the trauma performance improvement process.

(D) Special Radiological Capability. A computerized tomography(CT) technician shall be available 24-hours per day on-call and promptly available on-site within 30 minutes of request. The call-back response times shall be monitored through the trauma PI program;

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(10) Specialized Capabilities/Services/Units.

(A) Acute burn capability. Established procedures for acute management of major or severe burn patients, a written transfer plan, and prearranged transfer agreements to expedite the transfer of acute burn patients to a higher level of specialized burn care.

(A) Spinal cord/head injury and rehabilitation management capability. Established procedures for acute management of identified spinal cord injury or moderate to severe head injury patients, a written transfer plan, and prearranged transfer agreements to expedite transfer of patients to a higher level of specialized care.

(o) Survey Team.

(1) The multi-disciplinary survey team shall consist of the following members:

(A) Level I or Level II facilities shall be surveyed by The American College of Surgeons (ACS) with a multi-disciplinary team that includes at a minimum: 2 general surgeons, an emergency physician, and a trauma program manager all currently active in the management of trauma patients. Pediatric facilities shall be surveyed by the ACS with a multi-disciplinary team that includes at a minimum: (2) general surgeons (one must be pediatric), and a pediatric trauma program manager all currently active in the management of pediatric trauma patients.

(B) Level III facilities shall be surveyed by the ACS or other office-approved organization, with a multi-disciplinary team that includes at a minimum: a general surgeon and a trauma program manager both currently active in the management of trauma patients. Pediatric facilities shall be surveyed by the ACS or other office-approved organization, with a multi-disciplinary team that includes at a minimum: a pediatric general surgeon and a pediatric trauma program manager both currently active in the management of pediatric trauma patients. An additional surveyor may be requested by the facility, or required by the department.

(C) Level IV facilities shall be surveyed by an office-approved organization by a surveyor that is either at a minimum: a trauma program manager or a trauma medical director, currently active in the management of trauma patients. Pediatric facilities shall be surveyed by an

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office-approved organization by a surveyor that is either at a minimum: a pediatric general surgeon, or a pediatric trauma program manager with pediatric experience. An additional surveyor may be requested by the facility, or required by the department.

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

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

(B) not be employed in the same TSA as the designating facility;

(C) not be a current or former employee of the facility that is the subject of the survey or of an affiliated facility;

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

(E) not survey the facility program and physical location on consecutive designation cycles; or participate as members of the same Board, and

(F) not have been requested by the facility;

(G) not possess other potential conflict of interest between the surveyor or the surveyor's place of employment and the facility being surveyed.

(3) Each member of the survey team shall:

(A) have at least 5 years experience in the care of trauma patients;

(B) be currently employed managing a trauma program and practicing in the coordination of care for trauma patients;

(C) have direct experience in the preparation for and successful completion of trauma facility designation for no fewer than 2 successful designation cycles;

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1353 (D) have successfully completed an office-approved
1354 trauma facility site surveyor course and be successfully re-credentialed
1355 every 4 years; and
1356
1357 (E) have current credentials as follows:
1358
1359 (i) for registered nurses: Trauma Nurses Core
1360 Course (TNCC) or Advanced Trauma Course for Nurses (ATCN); and
1361 Pediatric Advanced Life Support (PALS) or Emergency Nurses Pediatric
1362 Course (ENPC);
1363
1364 (ii) for physicians: Advanced Trauma Life Support
1365 (ATLS); and
1366
1367 (iii) have successfully completed a trauma designation surveyor internship.
1368
1369

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