Pediatric Emergency Care Facilities Licensure Survey

County _____

Date of Survey _____

Designated Level _____

Type of Survey _____

Name of Facility _____ Hospital License # _____

Address _____

Telephone (____)_____ Fax (____) _____

Manager / Director _____ License / Certificate # _____

# of Bays _____

Surveyor's Signature _____ Date _____

Pediatric Emergency Care Facilities Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
All	**0720-31-.01**	**100 - 154**	**DEFINITIONS** 1. Abuse. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish 2. ACLS. Advance Cardiac Life Support. 3. ACS. American College of Surgeons. 4. ALARA. As Low As Reasonably Achievable. 5. APLS. Advanced Pediatric Life Support. 6. ATLS. Advanced Trauma life Support. 7. Basic Pediatric Emergency Facility. The facility shall be capable of identifying those pediatric patients who are critically ill or injured, stabilizing pediatric patients, including the management of airway, breathing and circulation, and providing an appropriate transfer to a definitive care facility. 8. Board. Board for Licensing Health Care Facilities. 9. CRPC. Comprehensive Regional Pediatric Center. The facility shall be capable of providing comprehensive specialized pediatric medical and surgical care to all acutely ill and injured children and shall have a pediatric intensive care unit. . The center shall be responsible for serving as a regional referral center for the specialized care of pediatric patients or in special circumstances provide safe and timely transfer of children to other resources for specialized care. 10. CPR. Cardiopulmonary Resuscitation. 11. Do-Not-Resuscitate order (DNR). A written order, other than a POST, not	1) Pediatric patients: up to 18 years of age with special consideration for those over 18 years of age with special health care needs and currently established with pediatric medical home.	Evidence of competency for staff such as listing of all patient care staff, their certifications and competency/skills evaluations with expiration dates.

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			to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices. 12. E. Essential. 13. ECG. Electrocardiogram. 14. ED. Emergency Department. 15. EED. Essential in Emergency Department. 16. EF. Essential in Facility. 17. EFI. Essential in the Facility and Immediately available within 15 minutes. 18. EMS. Emergency Medical Service 19. EMSC. Emergency Medical Services for Children. 20. ENPC. Emergency Nursing Pediatric Course. 21. EP. Promptly available within 30 minutes. 22. EPI. Essential in Pediatric Intensive care unit. 23. ES. Essential if service not provided at facility 24. FAST. Focused Assessment with Sonography for Trauma. 25. General Pediatric Emergency Care Facility. The facility shall have a defined separate pediatric inpatient service and a department of pediatrics within the medical staff structure. The facility may accept appropriate referrals of pediatric patients. 26. General Pediatric Emergency Care Facility with a Pediatric Intensive Care Unit. A facility that meets the requirements of a General Pediatric Emergency Care Facility and has a dedicated Pediatric Intensive Care Unit meeting the requirements defined herein. The facility may accept		

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			appropriate referrals of pediatric patients. 27. ICP. Intracranial Pressure. 28. IM. Intramuscular. 29. Immediately available. Available within 15 minutes. 30. IV. Intravenous. 31. Mid-level practitioner. Either an Advanced Practice Registered Nurse or Physician Assistant. 32. MTP. Massive Transfusion Protocol. 33. OR. Operating Room. 34. PA. Physician's Assistant. 35. Patient and Family Centered Care. Patient and family centered care is a mutually beneficial partnership among health care providers, patients and families working together in the planning, delivery and evaluation of health care. The four core concepts of patient- and family-centered care are Dignity and Respect, Information Sharing, Participation and Collaboration. 36. PALS. Pediatric Advanced Life Support. 37. PECC. Pediatric Emergency Care Coordinator. 38. PECF. Pediatric Emergency Care Facilities. Facilities that provide pediatric emergency and trauma services and are classified according to their abilities to provide such services. The classifications are: 1) Basic Pediatric Emergency Facility, 2) Primary Pediatric Emergency Facility, 3) General Pediatric Emergency Facility, 4) General Pediatric Emergency Care Facility with a Pediatric Intensive Care Unit and 4)		

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			Comprehensive Regional Pediatric Center. 39. Physician. A person currently licensed as such by the Tennessee Board of Medical Examiners or currently licensed by the Tennessee Board of Osteopathic Examination. 40. PICU/PI. Pediatric Intensive Care Unit. A PICU is a separate physical unit specifically designated for the treatment of pediatric patients who, because of shock, trauma, or other life-threatening conditions, require intensive assessment, monitoring and care. A facility with a PICU shall self-designate as either a General Facility with a PICU or a CRPC. 41. PIPS. Performance Improvement and Patient Safety. 42. Primary Pediatric Emergency Facility. The facility shall provide the same services as a Basic Pediatric Emergency Facility in addition to limited capabilities for the management of lower acuity pediatric admissions and observations 43. PTC. Pediatric Trauma Center. 44. QA. Quality Assessment. 45. QI. Quality Improvement. 46. RA. Readily available is defined as within one hour. 47. RN. Registered Nurse. 48. RT. Licensed Respiratory Therapist. 49. SE. Strongly encouraged. 50. TNCC. Trauma Nursing Core Course. 51. Trauma. A physical injury or wound caused by external force. 52. Trauma Program Leader. A trauma program director, manager, or nurse coordinator.		

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			53. Trauma Registry. A central registry compiled of injury incidence information supplied by designated trauma centers and Comprehensive Regional Pediatric Centers (CRPCs). 54. Trauma Team. Trauma Team consists of the necessary personnel commensurate to the level of trauma activation.		
	0720-31-.02		**LICENSING PROCEDURE**		
All	**0720-31-.02 (1)**	**200**	The facility shall designate the classification of Pediatric Emergency Care Facility it will maintain and the level of care it will provide and submit this information to the Department of Health on the joint annual report. If multiple facilities operate under the same provider number, each geographically distinct facility shall designate the level at which it provides service and will be surveyed at that level.	Documentation of designation is included in the joint annual report to the Department of Health.	Copy of facility's joint annual report.
	0720-31-.03		**ADMNISTRATION**		
All	**0720-31-.03 (1)**	**300**	The facility administration shall provide the following:		
All	**0720-31-.03 (1) (a)**	**301**	Adequate and properly trained personnel who can demonstrate competency in pediatric patient care delivery in their assigned area of the facility. This shall include but is not limited to the following required pediatric skills and competencies that are assessed annually:		Staff roster listing staff certifications, orientation outline for each position, and continuing education. Copies of call lists for current & previous 12 months.
All	**0720-31-.03 (1) (a) 1**	**302**	Recognition, interpretation and recording of age-appropriate physiological variables	Family Centered Care (FCC): Family centered care is an approach to health care that focuses on the relationships between families and	See table 1 in PECF document for detailed medications, monitors and equipment. Shall provide documentation of staff
All	**0720-31-.03 (1) (a) 2**	**302**	Capable of managing pediatric shock and respiratory failure including early recognition and stabilization of problems that may lead to shock and respiratory failure,		

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All	**0720-31-.03 (1) (a) 3**	**302**	Medication administration and fluid administration~~,~~	health care providers. Family centered care emphasizes the vital role that families play in ensuring the health and well-being of infants, children, and adolescents.	completion of competency requirements Family Centered Care: examples of how facility incorporates FCC principles into its patient care processes
All	**0720-31-.03 (1) (a) 4**	**302**	Resuscitation (including cardiopulmonary resuscitation certification and PALS or similar certification),		
All	**0720-31-.03 (1) (a) 5**	**302**	Respiratory care techniques,		
All	**0720-31-.03 (1) (a) 6**	**302**	Preparation and maintenance of patient monitors, and		
All	**0720-31-.03 (1) (a) 7**	**302**	Principles of patient- and family centered care and psychosocial skills to meet the needs of both the patient and his/her family,		
All	**0720-31-.03 (1) (b)**	**303**	A policy requiring annual pediatric multidisciplinary mock codes for staff caring for pediatric patients.	This should include all departments in which pediatric care is provided, i.e. OR, Respiratory, ED, In-Patient, etc.	Rosters and documentation of annual mock codes
All	**0720-31-.03 (1) (c)**	**303**	A Physician Pediatric Emergency Care Coordinator and a Nurse Pediatric Emergency Care Coordinator responsible for assuring readiness of staff and facility to provide emergency services to children at the facility's designated level of care.	1. Current physician PECC and nurse PECC information in statewide EMSC database. Updated annually and as personnel changes occur for facility position. 2. Physician and nurse PECC roles may be assigned to persons already fulfilling other roles in the facility	• Documentation reflecting participation of PECC in departmental facility and regional pediatric readiness. • Process by which staff can contact PECC with any pediatric concerns. Job description stating roles and responsibilities as well as documentation reflecting participation in pediatric readiness for each facility represented
All	**0720-31-.03 (1) (c) 1**	**304**	The physician PECC and the nurse PECC shall work collaboratively to facilitate all aspects of pediatric readiness within the facility. Aspects of pediatric readiness shall include but are not limited to multidisciplinary staff education, medication, equipment, supplies, quality and performance improvement, policies and procedures, integration of pediatric needs in facility disaster and/or emergency plans and collaboration with regional pediatric care agencies and committees.		
All	**0720-31-.03 (1) (c) 2**	**305**	The physician and nurse PECCs may be concurrently assigned other roles in the ED		

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			or may oversee more than one program in the ED. The CRPC who has the educational agreement with the facility shall be notified of any changes in the Physician and Nurse PECC personnel.		
All	**0720-31-.03 (1) (c) 3**	**306**	PECC roles may be shared through formal agreements with administrative entities when applied within facility systems.		
All	**0720-31-.03 (1) (d)**	**307**	The financial resources to provide the emergency department or the pediatric emergency department with the equipment necessary to provide the level of services of the designated PECF classification.		
All	**0720-31-.03 (1) (e)**	**308**	Facilities designed for easy access and appropriate for the care of pediatric patients at the designated PECF classification.		
All	**0720-31-.03 (1) (f)**	**309**	Access to emergency care for all urgent and emergent pediatric patients regardless of financial status.		Facility shall have policies that address EMTALA laws
All	**0720-31-.03 (1) (g)**	**310**	Participation in a network of pediatric emergency care within the region where it is located by linking the facility with a regional referral center to:	Documentation outlining the institution's role in a network of regional care and within the EMSC system in TN to address: • capability for caring for ED, ICU, medical and surgical pediatric patients, • plans for types of transport available for selected patients, with the relationship to other facilities in the region specified • scope of professional training • any institutional problems within the	• Meeting minutes showing participation in local & regional pediatric readiness. Including but not limited to your local healthcare coalition, CoPEC, CECATN, etc. • Documentation of identified gaps and follow up interventions as necessary.

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				network along with plans of action to rectify, and • any problems regarding inaccessibility to pediatric courses, transfer/transport issues, and interfacility issues with a summary of steps taken to assure improvement. • How the facility demonstrates a working relationship with the CRPC to assure health care workers in the facility and region have access to continuing education to maintain & update skills for recognizing and stabilizing pediatric emergencies. Demonstrate means of access to 24hrs/day consultation with a CRPC from the ED and other patient care areas treating pediatric patients.	
Basic, Primary, General and General with a PICU	**0720-31-.03 (1) (g) 1**	**311**	Guarantee transfer and transport agreements to include at least one CRPC, and	All Basic, Primary, General, and General with a Pediatric Intensive Care Unit PECFs shall have a transfer agreement in place with	Copy of transport and transfer agreements with CRPC and all others as indicated

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				at least one CRPC. Basic and primary facilities may also have an agreement with a general pediatric emergency care facility with a PICU in the region.	
Basic, Primary, General and General with a PICU	**0720-31-.03 (1) (g) 2**	**312**	Refer seriously and critically ill patients and special needs patients to an appropriate facility.		
Basic, Primary, General and General with a PICU	**0720-31-.03 (1) (h)**	**313**	Basic, Primary, General, and General with a PICU facilities shall have one education agreement with a CRPC.	Assure basic, primary, general, and general with a PICU must have one education agreement with one CRPC	Copy of current education agreement between facility and CRPC
All	**0720-31-.03 (1) (i)**	**314**	A collaborative environment with the EMS and EMSC systems to educate pre-hospital personnel, nurses, and physicians.	**Basic / Primary / General Facilities/General with a PICU:** 1. Demonstration of collaboration with CRPC: • Continuing education • Regional and state research and data collection • Quality indicators **CRPC:** 2. An education summary that includes records of participation by an institution's staff in education and outreach to area pre-hospital personnel, nurses, and physicians should be maintained	

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				• Examples of training: PALS, PBTLS, BTLS, assessment classes, monthly case conferences, and child death reviews (pathology, police dept, MSSW, nursing, physician) which include the following groups: local fire departments, ambulance services, and community college paramedic/EMT programs. 3.Demonstration of how FCC principles are integrated in programs and how family representatives, which are not hospital employees, participate as faculty or advisors for training.	
All	**0720-31-.03 (1) (j)**	**315**	Collaboration with pre-hospital care and transport.	**<u>Basic/Primary/General/ General with PICU</u>** • Summary of local destination guidelines. • Process for escalating variances	Documentation of process for escalating variances from local guidelines or protocols

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				from local guidelines or protocols **CRPC:** • Pediatric pre-hospital protocols and the facility's involvement in development and review of these protocols	
All	**0720-31-.03 (1) (k)**	**316**	Public education regarding access to pediatric emergency care, injury prevention, first aid and cardiopulmonary resuscitation.	• Statement of support for public education and an institutional plan for local and regional involvement. • Records of participation in regional media, school, parent, or medical provider education. • Documentation of public education such as health fairs, PBLS & other public classes, newspaper articles, hospital publications, school visits, community talks, and infant CPR.	Examples of promotion of FCC principles must be present among the documentation of public education, including considerations of age appropriateness, literacy, cultural and language issues for the population served.
All	**0720-31-.03 (1) (l)**	**317**	A QA and QI program in all areas that provide pediatric care that shall include but is not limited to the following indicators:	These items should be specifically included in the written QI plan. The pertinent sections of the plan, along with a summary report of these indicators, should be available with quarterly breakdown by indicator	• Written QI plan that addresses these items specifically. • Summary report of indicators with quarterly breakdown and committee recommendations based on QI or medical

Commented [BD1]: We don't state in the rules that this has to be done quarterly. Are we going to get any pushback from facilities on this? I feel this is fairly standard.

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				and QI or medical executive committee recommendations based on data review.	executive committee data review. • Identified issues and opportunities for improvement should be documented with plan of action
All	**0720-31-.03 (1) (l) 1**	**318**	Deaths;	Hospital should ensure that all pediatric deaths are reviewed, and this review is reported to QI Committee and/or Medical Executive Committee	Copy of committee meeting agenda assuring all pediatric deaths are reviewed & review reported to appropriate committee(s).
All	**0720-31-.03 (1) (l) 2**	**319**	Incident reports;	Review for trends and plan of action.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
All	**0720-31-.03 (1) (l) 3**	**320**	Child abuse cases;	Review for appropriate follow-up.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
All	**0720-31-.03 (1) (l) 4**	**321**	Cardiopulmonary or respiratory arrests;	Outcome of arrests subcategorized as cardiopulmonary or respiratory should be included in QI data.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
All	**0720-31-.03 (1) (l) 5**	**322**	Admissions within forty-eight (48) hours after being discharged from the emergency department.;	Hospital QI reports or QI plan should include documentation that these admissions are reviewed by a medical staff committee and reported to the medical executive committee.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
All	**0720-31-.03 (1) (l) 6**	**323**	Surgery within forty-eight (48) hours after being discharged from an emergency department;	Hospital QI reports or QI plan should include documentation that these	Summary report of indicators with quarterly breakdown and committee

Commented [BD2]: I capitalized the first letter of many of the regulations to match the grammer in the rules

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				admissions are reviewed by a medical staff committee and reported to medical executive committee.	recommendations based on data review
All	**0720-31-.03 (1) (l) 7**	**324**	Pediatric transfers;	Log of pediatric transfers listing: • department of the hospital transferred from (ED vs. patient floor vs. ICU), • mode of transport/transfer • length of stay prior to transport, and • patient outcomes after transport. CRPC: • List of transferred patients (received and transferred). • Demonstrate how outcome data is made available to referring hospitals (transfers received). • Summary Report included	Copy of transfer log that lists: • All pediatric patients referred/transfer include patients transferred from ED, floor, and ICU. Copy of facility's transfer policy
All	**0720-31-.03 (1) (l) 8**	**325**	Pediatric inpatient illness and injury outcome data		Facility to show evidence of review of inpatient illness and injury outcome data
CRPC and General with a PICU	**0720-31-.03 (1) (l) 9**	**326**	Participation in a QI program in both a CRPC and a General Facility with a PICU which compares their PICU performance	Documentation of participation in QI program	Documentation of participation in QI program

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			with PICUs of similar census and capabilities;		
All	**0720-31-.03 (1) (l) 10**	**327**	Program specific objectives for hospital pediatric readiness as defined by the current version of the U.S. Department of Health and Human Services' Health Resources and Services Administration's Maternal and Child Health Bureau's Emergency Medical Services for Children Program's National EMSC Performance Measures; and	A National Pediatric Readiness survey is available through the EMSC Innovation and Improvement Center to assist with pediatric readiness Current EMSC performance measures can be found on the EMSC website for reference	Documentation of National Pediatric Readiness Program score within the last 24 months
All	**0720-31-.03 (1) (l) 11**	**328**	Facilities shall participate in data collection to assure that quality indicators, as established by the Board are monitored; and the data shall be made available to a central data monitoring agency, as approved by the Board.	Identify if the Board has established additional quality indicators and identify facility compliance with these.	
All	**0720-31-.03 (1) (m)**	**329**	Resuscitation equipment and a metric weight-based medication resource are available in any area caring for a pediatric patient.	See Table: requirement for infant and child scale (measure in kg only)	
CRPC	**0720-31-.03 (1) (m) 2**		In a Comprehensive Regional Pediatric Center, facility administration shall also:		
CRPC	**0720-31-.03 (1) (m) 2 (a)**	**330**	Provide assistance to local and state agencies for EMS and EMSC in organizing and implementing a network for providing pediatric emergency care within a defined region that:	Documentation of the institution's representation in local and state EMS and EMSC.	Documentation of attendance at various meetings i.e. CoPEC, regional EMS directors' meetings, healthcare coalition meetings, state committee meetings, etc.
CRPC	**0720-31-.03 (1) (m) 2 (a) 1**	**331**	Provides transfer and transport agreements with other classifications of facilities;	The CRPC shall enter into transfer and transport agreements with Basic, Primary, and General, and General	List of transfer/transport agreements with: • Basic, Primary, General, and General with PICU institutions to

Commented [BD3]: So the National assessment occurs every 5 years with the next being in 2026. A facility can take the NPRP open assessment at any time. This is DIFFERENT from what is stated in the rule which asks for the facility to address the program specific objectives in the EMSC performance measures. Would like to have facilities participate in the NPRP (need to add that to the list of revisions for next time). For now, the SG should state something to the effect of "Current EMSC performance measures are available through the EMSC Innovation and Improvement Center. The TN EMSC Program Manager is available to assist facilities with this information." And in the SD/EoC column state "Facility documentation of achieving the current EMSC performance or planning in place to achieve these measures." "Facilities can assess their level of pediatric readiness by participating in the National Pediatric Readiness Project Assessment available through the EMSC Innovation and Improvement Center."

Again, need to add in the requirement for participating in the NPRP survey in the next set of rules. I think the 24 month timeframe is reasonable, but note that the national assessment is done every 5 years. New EMSC Performance Measures don't come out on a regular basis, unfortunately, and the current ones are under the 2023-2027 cycle.

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				with PICU institutions to facilitate ready transfer and appropriate mode of transport. The CRPC shall also have agreements listed with other facilities providing services not available at the facility. The CRPC shall also share outcome data with referring institutions for patients transferred.	facilitate ready transfer and appropriate mode of transport, and • Facilities providing services not available at CRPC. Demonstrate process for sharing outcome data with referring hospitals for patients transferred.
CRPC	**0720-31-.03 (1) (m) 2 (a) 2**	**332**	Provides transport services when needed for receiving critically ill or injured patients within the regional network;	The CRPCs shall maintain a pediatric critical care transport team capable of 24hrs/day response to provide interfacility transport for ill/injured patients within the area of service. Policies should clearly document the mechanism for activation of transport team as well as identification of medical control and team composition.	Policies that clearly document: • mechanism for activation of pediatric critical care transport team, and • identification of medical control and team composition.
CRPC	**0720-31-.03 (1) (m) 2 (a) 3**	**333**	Provides necessary consultation to participating network hospitals;		Evidence of mechanism to provide 24hrs/day medical consultation to participating network hospitals
CRPC	**0720-31-.03 (1) (m) 2 (a) 4**	**334**	Organizes and implements a network of educational support that:		Regional hospital education plan demonstrating defined annual goals & objectives that may include: • Program outlines

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					• CMEs • Orientation • Course schedules • Attendance Rosters • Involvement of PICU,RT, and ED personnel
CRPC	**0720-31-.03 (1) (m) 2 (a) 4 (i)**	**335**	Trains instructors to teach pediatric pre-hospital, nursing, and physician-level emergency care;	.	• Provide list of faculties for provider courses i.e. ENA, NAEMT, AHA, AAP, etc. • Demonstrate evidence of participation at the pre-hospital provider, nursing and physician level
CRPC	**0720-31-.03 (1) (m) 2 (a) 4 (ii)**	**336**	Assures that training courses are available to all facilities and health care providers utilizing pediatric emergency care facilities within the region;	Evidence provided to document regional availability of training including schedules, locations and attendance at hospital-sponsored courses/training programs by staff and physicians from regional facilities.	• Schedules of classes offered by CRPC in region. • Attendance roster showing program attendees from regional facilities.
CRPC	**0720-31-.03 (1) (m) 2 (a) 4 (iii)**	**337**	Supports EMS agencies and EMS Directors in maintaining a regional network of pre-hospital provider education and training;		Evidence of EMS training and education may include: • Participation in Emergency Medical Technician and/or Paramedic training programs where appropriate. • Joint educational programs to include equipment, supplies and drugs specific to neonatal

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					and pediatric patients. • Opportunity for appropriate clinical experience. • Participation in EMS system quality assessment and quality assurance mechanisms as well as case studies. • Assistance in the development of regional standards, guidelines, policies, and procedures. • Attendance at regional EMS director's meetings as allowed. All involvement should be documented.
CRPC	**0720-31-.03 (1) (m) 2 (a) 4 (iv)**	**338**	Assures dissemination of new information and maintenance of pediatric emergency skills;		
CRPC	**0720-31-.03 (1) (m) 2 (a) 4 (v)**	**339**	Updates standards of care protocols for pediatric emergency care;		As evidenced by policy guidelines outlining the review and/or revision of policies, procedures, standards, guidelines and protocols for the ED, PICU and pediatric critical care transport team.
CRPC	**0720-31-.03 (1) (m) 2 (a) 4 (vi)**	**340**	Assures that emergency departments and pediatric intensive care units within the facility shall participate in regional education for emergency medical service		Documented evidence of ED and PICU personnel involvement in education of EMS providers, Emergency Departments and the

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			providers, emergency departments and the general public;		general public, as evidenced by: • CME offerings • Staff education • Provision of clinical experience for health-related studies
CRPC	**0720-31-.03 (1) (m) 2 (a) 4 (vii)**	**341**	Provides public education and promotes patient and family centered care in relation to policies, programs and environments for children treated in emergency departments.	Family members or organizations representing families should be routinely consulted in an advisory capacity	Family Centered Care Committee/Family involvement documented by: • Committee minutes listing family participants, • or program publications listing family members as planning and development participants.
CRPC	**0720-31-.03 (1) (m) 2 (a) 5**	**342**	Assists in organizing and providing support for regional, state and national data collection efforts for EMSC that:		Evidence of participation in regional, state, and national registries and state annual report summarized
CRPC	**0720-31-.03 (1) (m) 2 (a) 5 (i)**	**343**	Defines the population served;		Population data such as: • States/counties served with approximate number of children residing in areas, • age group breakdown, top diagnoses or common causes of hospitalization,

Commented [BD4]: Consider changing the last part of this to "and the general public. Evidence may include Program outlines, CME's, Course Schedules and Attendance Rosters." This would match what is required at the beginning of this list of rules in tag 334.

Commented [BD5]: I think we should delete the SG here and add in SD/EoC "Documentation of facility participation in Tennessee EMSC program."

Commented [BD6]: In this SG, we are spelling out what needs to be included whereas in tag 344 we say that words "quality indicators such as:" and leave it open ended to the choice of the facility. Think we need to change this SG to take out "Summary including:" and change to "Population data such as:".

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					• fluctuation in pediatric population, and trends in severe illness or injury rates
CRPC	**0720-31-.03 (1) (m) 2 (a) 5 (ii)**	**344**	Maintains and monitors pediatric specific quality indicators;		Evidence of routine quality review of specific quality indicators such as • Death rates, • Readmissions, • ED wait times, • ED patients leaving without being seen, • Family satisfaction surveys, • Drug reactions, • Medication errors, etc.
CRPC	**0720-31-.03 (1) (m) 2 (a) 5 (iii)**	**345**	Includes injury and illness epidemiology.		Documentation of injury and illness epidemiology trends.
CRPC	**0720-31-.03 (1) (m) 2 (a) 5 (iv)**	**346**	Includes trauma/illness registry (this shall include severity, site, mechanism and classification of injury/illness, plus demographic information, outcomes and transport information);		Evidence of participation shall be included Information included in the registry is determined by national and state trauma data dictionaries.
CRPC	**0720-31-.03 (1) (m) 2 (a) 5 (v)**	**347**	Is adaptable to answer questions for clinical research;		
CRPC	**0720-31-.03 (1) (m) 2 (a) 5 (vi)**	**349**	Supports active institutional and collaborative regional and statewide research.		Demonstrates organized research program participation in state and national registries participation in EMSC & CRPC research efforts & data collection

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CRPC	**0720-31-.03 (1) (m) 2 (b)**	**350**	Organize a structured QI program with the assistance and support of local/state EMS and EMSC programs that allows ongoing review and:		Documentation of QA/QI programs with local and state EMS and EMSC agencies with specific indicator evidenced by: • agenda • benchmarking • outcome data reviewed routinely • action plans for identifying problem areas
CRPC	**0720-31-.03 (1) (m) 2 (b) 1**	**351**	Reviews all issues and indicators described under all classifications of Pediatric Emergency Care Facilities emergency departments;		
CRPC	**0720-31-.03 (1) (m) 2 (b) 2**	**352**	Provides feedback, quality review and information to all participating facilities, EMS and transport systems, and appropriate state agencies;	A plan for collaborative participation between the CRPC and other participating regional facilities shall be developed and documented outlining mechanisms for feedback between facilities, prehospital providers and transport systems, and state agencies as well as sharing QI data and information.	Documentation of evidence may Include: • Patient data feedback process summary • Transport system QA process summary • Summary of interfacility / interagency interaction • Current QI issues with indicators • Linkage to planned education efforts
CRPC	**0720-31-.03 (1) (m) 2 (b) 3**	**353**	Develops quality indicators for the review of pediatric care which are linked to periodic continuing education and reviewed at all participating institutions;		
CRPC	**0720-31-.03 (1) (m) 2 (b) 4**	**354**	Reviews all pediatric trauma and medical related morbidity and mortality, including those that are primary admitted patients versus secondary transferred patients; and		Documentation may include the following:

Commented [BD7]: This whole section of the rules, tags 350-355 needs to be looked at more with the next revision as some of this could be included more effectively in other areas of the rules and may also represent some duplication. Add that to the list.

Commented [BD8]: I think we should delete the SG here. This is the introductory rule statement for Tags 351, 352, 353, 354, and 355. Consider changing the SD/EoC to "Documentation of QA/QI program with local/state EMS & EMSC agencies which may include: agenda, benchmarking, outcome data, action plans for identified problem areas.

Took out annual review as not stated in the rule and took out family involvement as it is addressed in tag 355.

Commented [BD9]: Should we delete the current SD/EoC and move the SG to that column?

Commented [BD10R9]: This SD/EoC should be combined to cover Tags 352 and 353.

Commented [DJ11R9]: I think the SD/EoC list is more useful to facilities and the SG is not necessary.

Commented [BD12]: This is review of pediatric trauma and medical related morbidity and mortality with the assistance of EMS and EMSC programs as per the heading in this section of the rules. Consider deleting the SG and changing the SD/EoC to "Documentation of morbidity and mortality review with collaboration with local/state EMS and EMSC programs with evidence that may include meeting agendas, meeting minutes and attendance rosters."

Commented [DJ13R12]: Agreed

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					• Patient data feedback process summary • Transport system QA process summary • Summary of interfacility / interagency interaction • Current QI issues with indicators • Linkage to planned education efforts • meeting dates and agenda
CRPC	**0720-31-.03 (1) (m) 2 (b) 5**	**355**	Evaluates the emergency services provided for children with an emphasis on patient and family centered philosophy of care, family participation in care, family support during emergency visits and transfers and family information and decision-making.		Documentation may include: • Policy addressing family centered care • Process to evaluate principles of family centered care
CRPC	**0720-31-.03 (1) (m) 2 (c)**	**356**	Provide the following pediatric emergency department/trauma personnel:		Evidence of physician credentialing in specialty.
CRPC	**0720-31-.03 (1) (m) 2 (c) 1**	**357**	A physician on duty in the emergency department who is board eligible or board certified and meeting the requirements of maintenance of certification in pediatric emergency medicine; or is a credentialed pediatric emergency medicine provider in Tennessee prior to the promulgation of these rules.		• ED roster showing certification/board eligible status in pediatric emergency medicine. Any variance from 24-hour coverage should be documented with a
CRPC	**0720-31-.03 (1) (m) 2 (c) 2**	**358**	Physicians who are board eligible or board certified and meeting the requirements of maintenance of certification, or who are		

Commented [BD14]: Consider changing the SD/EoC to "Documentation of review of Patient and Family centered care core concepts with action plans for problems identified with evidence which may include meeting agendas, meeting minutes and attendance rosters."

Commented [BD15]: The rule doesn't evaluate the credentialing criteria and those criteria are typically addressed not only by the director but also by the facilities credentialing committee.

For the SD/EoC we should consider changing this to
1. ED Roster showing board certification/board eligibility status in pediatric emergency medicine or credentialing in pediatric emergency medicine prior to the promulgation of these rules.
2. Pediatric Emergency Medicine Physician call schedule documenting 24-hour coverage. Any variance from 24-hour coverage should be documented with a plan of action for compliance.

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
			credentialed providers in Tennessee prior to the promulgation of these rules in the following subspecialties: pediatric surgery, pediatric orthopedic surgery, neurosurgery and pediatric anesthesiology.		plan of action for compliance • Credentialing criteria used by Director to assess pediatric emergency capabilities of covering physicians
CRPC	**0720-31-.03 (1) (m) 2 (c) 2 (i)**	**359**	These physicians shall be readily available to the emergency department twenty-four (24) hours per day, seven (7) days per week and shall also be promptly available during this same time as determined by the patient's acuity.	**See Table 1** for medical and surgical specialty lists.	
CRPC	**0720-31-.03 (1) (m) 2 (c) 2 (ii)**	**360**	For on call physician coverage, if the physician is not a pediatric subspecialty trained provider, then they should have sufficient training and experience in pediatric emergency and trauma care and be knowledgeable about current management of pediatric trauma and emergent medical problems in their specialty.		
CRPC	**0720-31-.03 (1) (m) 2 (c) 3**	**361**	The CRPC shall also have other subspecialty trained surgical and medical providers who are board eligible or board certified and meeting the requirements of maintenance of certification, or who are credentialed providers in Tennessee prior to the promulgation of these rules in their respective subspecialty as listed in Table 1.		
CRPC	**0720-31-.03 (1) (m) 2 (c) 4**	**362**	Registered nurses with pediatric emergency, pediatric critical care or pediatric surgical experience as well as training in trauma care;		Documentation that registered nurses are available within the emergency department at all times with experience in care of the pediatric emergency and trauma patients as evidenced by: • nurse job descriptions

Commented [BD16]: Consider SD/EoC for this to be "Facility physician call schedule with any variance in coverage documented with a plan of action for compliance."

Commented [BD17]: I need to review this a little more as far as the SD/EoC. The right words might be "Documentation in physician core privileges for care of pediatric patients and documentation of pediatric specific CME in their respective subspecialty."

Commented [JP18R17]: Review word "Sufficient" in next review

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					• training records for each department • competency requirements
CRPC	**0720-31-.03 (1) (m) 2 (c) 5**	**363**	Laboratory personnel, radiology technician and respiratory therapist with pediatric experience;		For Respiratory Therapy, Lab Technicians, and Radiology Technicians: • Evidence of 24-hour hospital coverage • Call schedules, • Job descriptions, • Continuing education demonstrating competency in pediatrics
CRPC	**0720-31-.03 (1) (m) 2 (c) 6**	**364**	Available support services to the emergency department as included in Table 1;		
CRPC	**0720-31-.03 (1) (m) 2 (c) 7**	**365**	A CRPC coordinator position whose responsibilities include, but are not limited to:		CRPC Coordinator job description with reporting responsibilities within the organization
CRPC	**0720-31-.03 (1) (m) 2 (c) 7 (i)**	**366**	being a regional liaison and coordinator for the statewide EMSC project, including participation in CRPC Coordinator meetings quarterly;	.	Documentation of working relationships with representatives from regional pediatric emergency care facilities, EMS and EMSC
CRPC	**0720-31-.03 (1) (m) 2 (c) 7 (ii)**	**367**	planning and providing educational activities to meet the needs of the emergency network facilities and pre-hospital providers;		Evidence of participation in educational activities for hospital and pre-hospital providers.

Commented [DJ19]: Move SG to SD/EoC

Commented [DJ20]: Move SG to SD/EoC

Commented [DJ21]: Move SG to SD/EoC

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
CRPC	**0720-31-.03 (1) (m) 2 (c) 7 (iii)**	**368**	support of maintaining and updating the CRPC Pediatric Facility Notebook, which may be in electronic format;		
CRPC	**0720-31-.03 (1) (m) 2 (c) 7 (iv)**	**369**	review and coordination of quality improvement indicators for emergency network facilities and pre-hospital providers;		Data from quality indicators for emergency network facilities and prehospital providers shall be reviewed routinely. Review of all incidents of hospital or emergency department diversions/advisories should be documented. QI/QA indicators should be used for identifying local and regional education opportunities
CRPC	**0720-31-.03 (1) (m) 2 (c) 7 (v)**	**370**	attending a conference on pediatric emergency and/or critical care on a yearly basis;		Evidence of attendance at least one conference with a focus on pediatrics emergency and/or pediatric critical care
CRPC	**0720-31-.03 (1) (m) 2 (c) 7 (vi)**	**371**	serving as a resource person for national, state and regional EMS health professionals, health department officials, community colleges/universities, facilities, physicians, and professional societies to coordinate EMSC project activities and share program expertise in their regions; and		Evidence may include, but is not limited to, documentation of participation in the following: • Healthcare Coalition • State and Local EMS meetings • Local EMS education programs • CoPEC • Regional educational events

Commented [DJ22]: Healthcare Coalition;

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
CRPC	**0720-31-.03 (1) (m) 2 (c) 7 (vii)**	**372**	utilizing data collected by the CRPC from pre-hospital and facility records to provide data for performance improvement, education and research.	Education offerings shall be evidence-based and targeted towards regional educational needs.	
All	**0720-31-.04**		**ADMISSIONS, DISCHARGES AND TRANSFERS**		
All	**0720-31-.04 (1)**		All levels of Pediatric Emergency Care Facilities shall:		
All	**0720-31-.04 (1) (a)**	**373**	be capable of providing appropriate triage, resuscitation, stabilization and, when appropriate, timely transfer of pediatric patients for a higher level of care;		• Documentation of routine review of pediatric transfer logs. • Documentation of education Protocols in place guiding appropriate triage, stabilization, and transfer of pediatric patients
All	**0720-31-.04 (1) (b)**	**374**	be responsible for having appropriate transfer agreements to assure that all pediatric patients receive timely emergency care at the most appropriate pediatric facility available;	All Basic, Primary, General, and General with a PICU pediatric emergency care facility shall have a transfer agreement in place with at least one CRPC and any facility they routinely transfer to for specialized care.	Copy of transfer agreement(s) with CRPC(s) and any other facility that they have an agreement with. Written pediatric interfacility transfer guidelines. These may include: ♣ Criteria for transfers (e.g., specialty services) Criteria for selection of appropriate transport service ♣ Process for initiation of transfer ♣ Plan for transfer of patient information
All	**0720-31-.04 (1) (c)**	**375**	have Transfer Agreements and Transfer Guidelines in accordance with the current Health Resources and Services Administration (HRSA) EMSC performance measures requirements;		

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					• Integration of family-centered care • Integration of telehealth/Telecommunications
All	**0720-31-.04 (1) (d)**	**376**	have the ability to communicate with a Comprehensive Regional Pediatric Center for pediatric consultation; and		Established processes for consulting CRPC's 24/7
All	**0720-31-.04 (1) (e)**	**377**	develop policies that describe sate transport and handoff of patients between all patient care areas of the facility and between other facilities;		Policies outlining interdepartmental patient handoff and transport. Written pediatric interfacility transfer guidelines. These may include: • Criteria for transfers (e.g., specialty services) • Criteria for selection of appropriate transport service • Process for initiation of transfer • Plan for transfer of patient information • Integration of family-centered care • Integration of telehealth/ telecommunications
Primary	**0720-31.04 (2)**		A Primary Pediatric Emergency Facility shall support the Basic Facilities within a region when necessary, by having triage and transfer agreements to receive appropriate patients as a part of a regional pediatric care network		Written transfer agreements for interfacility transfers.
General General with a PICU	**0720-31-.04 (3)**	**389**	A General Pediatric Emergency Facility shall support the Basic and Primary Facilities within a region by having triage	General and General with a PICU facilities shall support Basic and	

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
			and transfer agreements to receive appropriate patients as a part of a regional pediatric care network.	Primary facilities with prearranged transfer agreements in regions without close proximity to a CRPC	
General and General with a PICU	**0720-31-.04 (4)**	**390**	A General Pediatric Emergency Facility shall have a defined separate pediatric inpatient service with a department of pediatrics within the medical staff structure.	The General Pediatric Facility and General Pediatric Facility with a PICU shall provide the same services as the Primary Facility and shall have a defined separate pediatric inpatient service not including NICU and/or Nursery services. The pediatric inpatient unit should be geographically distinct with defined nursing, medical and administrative management structure and be primarily utilized for pediatric patients. The bylaws should reflect a separate pediatric department in the medical staff structure with regular meetings at least quarterly. The Department of Pediatrics shall have formal involvement in development and monitoring of pediatric emergencies and critical care protocols, policies, and QI/QA and management programs.	• Organizational chart demonstrating separate nursing, medical & administration management structures. • Bylaws of Pediatric Medical Staff Department reflecting required meetings. • Demonstration of Department of Pediatrics involvement in development & monitoring of protocols, policies, QI/QA & management programs

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
	0720-31-.04 (5)		A Comprehensive Regional Pediatric Center shall:		
CRPC	**0720-31-.04 (5) (a)**	**378**	Assist with the provision of regional pre-hospital indirect (off-line) and direct (on-line) medical control for pediatric patients.		• Process to provide or participate in regional medical control 24hrs/day and to receive call-ahead ambulance information. • Communication system to link pre-hospital personnel with designated medical personnel at CRPC • Process for alternative means of communication during radio downtime/outage.
CRPC	**0720-31-.04 (5) (b)**	**379**	Promote a regional network of indirect and direct medical control by lower-level non-CRPC facilities hospitals within the region by working closely with the regional Emergency Medical Services EMS medical directors to assure:		Active involvement in regional communications systems may be evidenced by: • Participation in regional EMS communications committees • Participation in regional HCC
CRPC	**0720-31-.04 (5) (b) 1**	**380**	standards for pre-hospital care;	When possible, CRPCs should be utilized as subject matter experts in the creation and review of local prehospital pediatric protocols.	Evidence may include documentation of: • Participation in developing standards for pre-hospital care. • Participation in local and/or state QI/QA programs.
CRPC	**0720-31-.04 (5) (b) 2**	**381**	triage and transfer guidelines; and	CRPC should have a process to provide regional triage	Evidence may include documentation of:

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
				capabilities in the event of a pediatric surge event.	• Participation in development and review of local destination guidelines. • Process for reviewing and following up on inappropriate destinations. • Triage processes during regional pediatric surge events.
CRPC	**0720-31-.04 (5) (b) 3**	**382**	quality indicators for pre-hospital care.		Evidence may include documentation of: • Review of all incidents of diversions/advisories. • Process for prehospital quality care indicators. • Process to review results w/regional and/or key state stakeholders as necessary.
CRPC	**0720-31-.04 (5) (c)**	**383**	Accept all patients who require a higher level of care not available at non-CRPC facilities:		Evidence may include documentation of: • Routine review of transfer denials (i.e. meeting agendas). • Process to provide guidance to regional facilities when transfer requests are denied.
CRPC	**0720-31-.04 (5) (c) 1**	**384**	prearranged transfer agreements to facilitate timely inter-facility triage and transfer of pediatric patients who need a higher level of care not available at the non-CRPC facility; and		Written pediatric interfacility transfer guidelines. These may include: • Criteria for transfers (e.g., specialty services) • Criteria for selection of appropriate transport

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					service • Process for initiation of transfer • Plan for transfer of patient information • Integration of family-centered care • Integration of telehealth/telecommunications • Policies or procedures to help direct patient triage and transfers during times of disaster or patient surge
CRPC	**0720-31-.04 (5) (c) 2**	**385**	prearranged transfer agreements for pediatric patients needing specialized care not available at the Comprehensive Regional Pediatric Center		If not available at CRPC, transfer agreements for any specialties not routinely provided for. These specialties may include but are not limited to: • burn specialty unit • spinal cord injury unit • specialized trauma care • rehabilitation facility • acute hemodialysis
	0720-31-.04 (5) (d)		Assure a pediatric transport service that:		
CRPC	**0720-31-.04 (5) (d) 1**	**386**	is available to all regional facilities;		Transport service policy that includes: • Schedule providing 24/7 availability • Region served • Team activation procedure • Medical control • Triage process

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
CRPC	**0720-31-.04 (5) (d) 2**	**387**	provides a network for transport of appropriate patients from all regional hospitals to the Comprehensive Regional Pediatric Center or to an alternative facility when necessary; and		Transfer agreement(s) with CRPC(s) and any other facility routinely used for definitive care.
CRPC	**0720-31-.04 (5) (d) 3**	**388**	transports children to the most appropriate facility in their region for emergency and trauma care. Local destination guidelines for EMS should assure that in regions with two (2) Comprehensive Regional Pediatric Centers, or one (1) Comprehensive Regional Pediatric Center and another facility with Level 1 Adult Trauma capability, that seriously injured children are cared for in the facility most appropriate for their injuries.	Online communication refers to any means of direct real-time communication that the CRPC uses in its role as medical control in a transport.	Evidence may include documentation of: • local destination guidelines for pediatric trauma patients. • Review of transfers, triage, and QI/QA of on-line communication with trauma control if the CRPC is not the institution with highest trauma capability.
	0720-31-.05		**BASIC FUNCTIONS**		
	0720-31-.05 (1)		Medical Services.		
Basic	**0720-31-.05 (1) (a)**	**407**	A Basic Pediatric Emergency Facility shall have an on-call physician who shall be promptly available and provide direction for the emergency department nursing staff. The physician and associated mid-level practitioner(s) providing care in the emergency department shall be currently PALS certified and competent in the care of pediatric emergencies including the recognition and management of shock and respiratory failure, the stabilization of pediatric trauma patients, advanced airway skills, vascular access skills, and be able to perform a screening neurologic assessment and to interpret diagnostic tests, laboratory values, physical signs and vital signs appropriate for the patient's age. ATLS certification is strongly encouraged. A system shall be developed for access to	All physicians and associated midlevel providers on the roster shall be able to demonstrate competency through PALS. Physicians who are board certified or board eligible by the following: American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, Pediatric Emergency Medicine by the American Board of Pediatrics, or by the	Evidence may include documentation of: • ED on-call roster for MD & RN demonstrating coverage • Provider PALS certification • Documentation of pediatric competencies for board certified/board eligible providers without PALS certification • Processes for accessing physicians with advanced airway or vascular access skills, and access to general

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
			physicians who have advanced airway and vascular access skills as well as for general surgery and pediatric specialty consultation. A back-up system must be in place for additional registered nurse staffing for emergencies. ATLS certification is strongly encouraged.	American Board of Emergency Medicine shall be considered as having sufficient education training and are not required to hold an additional PALS certification.	surgery and/or pediatric specialty consultation. • Designated facility committee meeting minutes reflecting periodic review of response time issues for on-call physicians.
Primary	**0720-31-.05 (1) (b)**	**408**	A Primary Pediatric Emergency Facility shall have an emergency physician in-house twenty-four (24) hours per day, seven (7) days per week. The emergency department physician shall be currently PALS certified and competent in the care of pediatric emergencies including the recognition and management of shock and respiratory failure, the stabilization of pediatric trauma patients, advanced airway skills, vascular access skills, and be able to perform a screening neurologic assessment and to interpret diagnostic tests, laboratory values, physical signs and vital signs appropriate for the patient's age. A pediatrician or family practitioner, general surgeon with trauma experience, anesthetist/anesthesiologist, and radiologist shall be promptly available twenty-four (24) hours per day. ATLS certification is strongly encouraged.	All physicians and associated midlevel providers on the-roster shall be able to demonstrate competency through PALS. Physicians who are board certified or board eligible by the following: American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, Pediatric Emergency Medicine by the American Board of Pediatrics, or by the American Board of Emergency Medicine shall be considered as having sufficient education training and are not required to hold an additional PALS certification. Family practitioner is defined as an MD or DO license under Title 63, Chapter 6 or 9. Teleradiology services	Evidence may include documentation of: • ED on-call roster for MD & RN demonstrating coverage • Provider PALS certification • Documentation of pediatric competencies for board certified/board eligible providers without PALS certification • Processes for accessing physicians with advanced airway or vascular access skills, and access to general surgery and/or pediatric specialty consultation. • Designated facility committee meeting minutes reflecting periodic review of response time issues for all required specialties • Board certified / admissible by American Board of Emergency

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
				are acceptable at primary facilities as equivalent to radiologists available 24 hours per day.	medicine, or on-call rosters for: • pediatrician, or family practitioner, • general surgeon with trauma experience, • anesthetist / anesthesiologist, • radiologist (tele-radiology services acceptable at Primary facilities).
General and General with a PICU	**0720-31-.05 (1) (c)**	**409**	A General Pediatric Emergency Facility shall have a board certified or board eligible emergency physician or pediatrician in the emergency department twenty-four (24) hours per day, seven (7) days per week. The emergency department physician shall be currently PALS certified and competent in the care of pediatric emergencies including the recognition and management of shock and respiratory failure, the stabilization of pediatric trauma patients, advanced airway skills, vascular access skills, and be able to perform a screening neurologic assessment and to interpret diagnostic tests, laboratory values, physical signs and vital signs appropriate for the patient's age. A General Pediatric Emergency Facility shall have an emergency department medical director who is board certified or board eligible/admissible in pediatrics or emergency medicine. A record of the appointment and acceptance shall be in writing. The physician director shall work with administration to assure physician coverage that is highly skilled in pediatric	All physicians and associated midlevel providers on the roster shall be able to demonstrate competency through PALS. Physicians who are board certified or board eligible by the following: American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, Pediatric Emergency Medicine by the American Board of Pediatrics, or by the American Board of Emergency Medicine shall be considered as having sufficient education training and are not required to hold an additional PALS certification.	Evidence may include documentation of: • ED on-call roster for MD & RN demonstrating coverage • Provider PALS certification • Documentation of pediatric competencies for board certified/board eligible providers without PALS certification • Processes for accessing physicians with advanced airway or vascular access skills, and access to general surgery and/or pediatric specialty consultation. • Designated facility committee meeting minutes reflecting periodic review of response time issues

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
			emergencies. ATLS certification is strongly encouraged.	Family practitioner is defined as an MD or DO license under Title 63, Chapter 6 or 9. Teleradiology services are acceptable at primary facilities as equivalent to radiologists available 24 hours per day.	for all required specialties **On-call rosters for:** Required specialties and ancillary services as outlined in Table #1 • Identification of ED Medical Director with required credentialing: • CV of ED Medical Director • Record of appointment / acceptance.
CRPC and PTC	**0720-31-.05 (1) (d)**	**410**	A CRPC and a PTC shall have a emergency department medical director who is board certified or board eligible in pediatric emergency medicine. A record of the appointment and acceptance shall be in writing.		Identification of ED Medical Director with required credentialing: • CV of ED Medical Director • Record of appointment / acceptance • Documentation of board certification or board eligibility • Description of job roles and responsibilities for emergency department medical director
CRPC and PTC	**0720-31-.05 (1) (e)**	**411**	A CRPC and a PTC shall have twenty-four (24) hours ED coverage by physicians who are board eligible or board certified and meeting the requirements of maintenance		Evidence may include documentation of:

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance

			of certification in pediatric emergency medicine, or credentialed pediatric emergency medicine providers in Tennessee prior to the promulgation of these rules. The medical director shall work with administration to assure highly skilled pediatric emergency physician coverage. All physicians in pediatric emergency medicine shall participate on at least an annual basis, in continuing medical education activities relevant to pediatric emergency care and shall have successfully completed the ATLS course at least once. Maintenance of current ATLS status is strongly encouraged.		• ED on-call roster for physician demonstrating coverage
					• Provider PALS certification
					• Documentation of pediatric competencies for board certified/board eligible providers without PALS certification
					• Processes for accessing physicians with advanced airway or vascular access skills, and access to general surgery and/or pediatric specialty consultation.
					  • Documentation of ATLS (current ATLS strongly encouraged)
					  • Designated facility committee meeting minutes reflecting periodic review of response time issues for all required specialties
					On-call rosters for:
					Required specialties and ancillary services as outlined in Table #1
					  • Identification of ED Medical Director with required credentialing:
					  • CV of ED Medical Director

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					• Record of appointment / acceptance.
CRPC and General with a PICU	**0720-31-.05 (1) (f)**	**412**	A CRPC and a General Facility with a PICU shall have an appointed medical director of the pediatric intensive care unit. A record of the appointment and acceptance shall be in writing. The medical director of the pediatric intensive care unit shall have a minimum of three (3) years experience as an attending in pediatric critical care and shall be board certified and meeting the requirements of maintenance of certification or be an existing medical director of a PICU prior to the promulgation of these rules.		• Written record of the appointment and acceptance of the PICU Medical Director with required credentials • PICU Medical Director credentials (CV) showing board certification/admissible status.
CRPC and General with a PICU	**0720-31-.05 (1) (g)**	**413**	In a CRPC and General Facility with a PICU, PICU physicians shall be credentialed by the facility to practice pediatric critical care medicine and be board eligible or board-certified and meeting the requirements of maintenance of certification in pediatric critical care medicine or be a credentialed pediatric critical care provider in Tennessee prior to the promulgation of these rules.		PICU roster showing: • board certification/board prepared status in Pediatric Critical Care Medicine
CRPC and General with a PICU	**0720-31-.05 (1) (h)**	**414**	In a CRPC and General Facility with a PICU the pediatric intensive care unit and ED medical director shall participate in developing and reviewing their respective unit policies, promote policy implementation, participate in budget preparation, help coordinate staff education, maintain a database which describe unit experience and performance, supervise resuscitation techniques, lead quality improvement activities and coordinate research.		Documentation of participation in policy review and development, budget, staff education, and other activities should be evidenced by: • PICU/ED Standards, policy, and procedure • PICU/ED Leadership committee membership

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					• Staff education activities • PICU/ED database describing unit experience & performance • QI / Research activities • PICU/ED Medical Director Job description
CRPC and General with a PICU	**0720-31-.05 (1) (i)**	**415**	In a CRPC and General Facility with a PICU, the pediatric intensive care unit medical director shall name qualified substitutes to fulfill his or her duties during absences. The pediatric intensive care unit medical director or designated substitute shall have the institutional authority to consult on the care of all pediatric intensive care unit patients when indicated. He or she may serve as the attending physician on all, some or none of the patients in the unit	.	**Policies:** • Naming an acting director of PICU during absence of PICU medical director. • Hospital bylaws/policies reflect authority of PICU medical director to consult on any PICU patient when indicated.
CRPC and General with a PICU	**0720-31-.05 (1) (j)**	**416**	The CRPC and General Facility with a PICU shall have at least one pediatric critical care physician promptly available to the PICU twenty-four (24) hours per day and an in-house physician with minimum of post graduate year level 3 training with current PALS certification and is approved by the PICU medical director and/or a mid-level practitioner credentialed by the institution to provide pediatric critical care services, is PALS trained, and is approved by the PICU medical director. All providers in pediatric critical care shall participate in continuing medical education activities as		• Documentation of attendance for past 3 years of critical care physicians at regional of national pediatric critical care meetings and participation in continuing medical education. • Policy outlining which in-house physician is responsible for

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
			per facility policies relevant to pediatric intensive care medicine.		responding to emergencies in the PICU. This physician must be pediatric > PGY-3.
CRPC	**0720-31-.05 (1) (k)**	**417**	The CRPC shall have pediatric subspecialty trained surgical and medical providers who are board eligible or board certified and meeting the requirements of maintenance of certification in their subspecialty or who are credentialed providers in their subspecialty in Tennessee prior to the promulgation of these rules in their respective subspecialty as listed in Table 1.		Physician roster and credentialing for all required specialties in Table 1
	0720-31-.05 (2)		**NURSING SERVICES**		
All	**0720-31-.05 (2) (a)**	**418**	Emergency staff in all facilities shall be able to provide information on patient encounters to the patient's medical home through telephone contact with the primary care provider at the time of encounter, by faxing or by electronic means. Follow-up visits shall be arranged or recommended with the primary care provider whenever necessary.		• Methods of providing information regarding patient visit to primary care provider, and/or patient. • Policy stating indications for notification of PCP at time of visit and for reporting of test results to a patient physician in a timely manner.
All	**0720-31-.05 (2) (b)**	**419**	In all Pediatric Emergency Facilities at least one RN shall be physically present 24 hours per day, 7 days per week, and capable of recognizing and managing pediatric shock and respiratory failure and stabilizing pediatric patients, including early recognition and stabilization of problems		• Roster of nurses staffing ED with training records • Staffing schedule reflecting that RN with pediatric training (listed

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
			that may lead to shock and respiratory failure. At least one emergency room nurse per shift must be PALS certified. Certification in ENPC and TNCC is strongly encouraged.		above) is always on duty.
General and General with a PICU	**0720-31-.05 (2) (c)**	**420**	A Pediatric General Emergency Facility shall have an emergency department nursing director/manager and at least one nurse per shift with pediatric emergency nursing experience. Nursing administration shall assure adequate staffing for data collection and performance monitoring as well as a registered nurse responsible for ongoing coordination of education in pediatric emergency care.		• Roster of nurses staffing ED with training records • Staffing schedule reflecting that RN with pediatric training (listed above) is always on duty.
CRPC	**0720-31-.05 (2) (d)**	**421**	In a Comprehensive Regional Pediatric Center, administration shall provide nursing director/manager dedicated to the pediatric emergency department. The nurse director/manager shall have specific training and experience in pediatric emergency care and shall participate in the development of written policies and procedures for the pediatric emergency department, coordination of staff education, coordination of research, patient- and family-centered care, QI, and budget preparation in collaboration with the pediatric emergency department medical director. The nurse director/manager shall name qualified substitutes to fulfill the nurse director/manager's duties during absences.		Job descriptions, organization chart: • ED nursing director/manager • RN staff educator • Documentation of staff education programs
CRPC	**0720-31-.05 (2) (e)**	**422**	In a Comprehensive Regional Pediatric Center nursing administration shall provide nursing staff experienced in pediatric emergency and trauma nursing care and a registered nurse trained in pediatric specific education/competencies responsible for ongoing staff education.		• Nursing staff roster with documentation of annual facility competencies in pediatric emergency and trauma care.

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					• Documentation of a nursing staff educator. • Documentation of nursing staff to include: a. job descriptions • orientation program • educational attendance
CRPC & General with a PICU	**0720-31-.05 (2) (f)**	**423**	In a Comprehensive Regional Pediatric Center, or a General Facility with a PICU, administration shall provide a nurse director/manager dedicated to the pediatric intensive care unit. The nurse director/manager shall have specific training and experience in pediatric critical care and shall participate in the development of written policies and procedures for the pediatric intensive care unit, coordination of staff education, coordination or research, patient and family centered care, QI and budget preparation in collaboration with the PICU medical director. The nurse director/manager shall name qualified substitutes to fulfill the nurse director/manager's duties during absences.		• PICU nursing director/manager job Description to include involvement in policy development, review & implementation, budget, staff education, coordination of research and FCC issues. • Org chart • PICU staff education programs • Policy for nurse manager duties to be fulfilled during manager's absence.
CRPC	**0720-31-.05 (2) (g)**	**424**	In a Comprehensive Regional Pediatric Center, or a General Facility with a PICU, administration shall provide a pediatric nurse educator for pediatric emergency care and pediatric critical care education		ED / PICU nurse educator(s) • job description, • organizational chart • schedule of classes

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CRPC and General With a PICU	**0720-31-.05 (2) (h)**	**425**	In a Comprehensive Regional Pediatric Center, or a General Facility with a PICU, administration shall provide an orientation to the pediatric emergency department and the pediatric intensive care unit staff and specialized nursing staff shall be Pediatric Advanced Life Support certified. Administration shall assure staff competency in pediatric emergency care and intensive care.		ED / PICU staff competency: • Orientation schedules • Orientation check list • Employee education records • Annual performance evaluations and competencies • PALS certification
	0720-31-.05 (3)		**OTHER PERSONNEL**		
CRPC and General with a PICU	**0720-31-.05 (3) (a)**	**426**	In a Comprehensive Regional Pediatric Center or a General Facility with a PICU, the respiratory therapy department shall have a supervisor responsible for performance and pediatric training of staff, maintaining equipment and monitoring QI and review. Under the supervisor's direction, respiratory therapy staff assigned primarily to the pediatric intensive care unit and the emergency department shall be in-house twenty-four (24) hours per day and shall be PALS certified and maintain ongoing competencies.		Respiratory therapy • Schedule showing RT staff assigned to the ED and PICU 24 hours per day. • Supervisor job description and responsibilities • RT staff certification and competencies
CRPC and General with a PICU	**0720-31-.05 (3) (b)**	**427**	In a Comprehensive Regional Pediatric Center or a General Facility with a PICU, Biomedical technicians shall be available within one (1) hour. Unit secretaries or trained designees shall be available to the pediatric intensive care unit and emergency department twenty-four (24) hours per day. A radiology technician and pharmacist with pediatric training must be in-house 24 hours per day. In addition, social workers, case managers, physical therapists,		Job description, standards, and staffing plan for the following: • Radiology Technician • Biomedical Technician • Radiology technician • Pharmacist

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			occupational therapists, speech therapists, child life specialists, clergy and nutritionists/registered dietician must be available.		• Physical / Occupational Therapists • Social Work • Nutritionists • Child Life • Clergy
All	**0720-31-.05 (3) (c)**	**428**	In all PECF, the radiology department shall have guidelines for reducing radiation exposure that are age and size specific in accordance with ALARA or current American College of Radiology guidelines.		Protocol or guideline specific to pediatric radiation exposure in accordance with ALARA or current American College of Radiology guidelines.
	0720-31-.05 (4)		**FACILITY STRUCTURE AND EQUIPMENT**		
All	**0720-31-.05 (4) (a)**	**429**	Equipment for communication with EMS mobile units is essential if there is no higher-level facility capable of receiving ambulances or there are no resources for providing medical control to the pre-hospital system.		Evidence of mechanism to provide or participate in regional medical control 24hrs/day and to receive call-ahead ambulance information. Communication system to link pre-hospital personnel with designated medical personnel at CRPC
All	**0720-31-.05 (4) (b)**	**430**	An emergency cart or other systems to organize supplies including resuscitation equipment, drugs, printed pediatric drug doses and pediatric reference materials must be readily available. Equipment, supplies, trays, and medications shall be easily accessible, labeled and logically organized. Antidotes necessary for a specific geographic area should be determined through consultation with a poison control center. If the listed medications are not kept in the emergency department, they should be kept well		• Medication dosing resources • Length based tape • Scales locked in kilograms.

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			organized and together in a location easily accessible and proximate to the emergency department.		
CRPC	**0720-31-.05 (4) (c)**	**431**	A Comprehensive Regional Pediatric Center emergency department must have geographically separate and distinct pediatric medical/trauma areas that have all the staff, equipment and skills necessary for comprehensive pediatric emergency care. Separate fully equipped pediatric resuscitation rooms must be available and capable of supporting at least two simultaneous resuscitations.		The pediatric emergency department shall be physically distinct and architecturally separate from adult ED care areas 24hrs/day. There should be a separate pediatric waiting room with two separate resuscitation areas/rooms, each fully equipped with pediatric resuscitation equipment.
All	**0720-31-.05 (5)**	**432**	Infection Control. A Pediatric Emergency Care Facility shall have an annual influenza vaccination program which shall include at least:		
All	**0720-31-.05 (5) (a)**	**433**	The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Pediatric Emergency Care Facility will encourage all staff and independent practitioners to obtain an influenza vaccination;		Facility policy regarding vaccination.
All	**0720-31-.05 (5) (b)**	**434**	A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at http://tennessee.gov/health/topic/hcf-provider);		Facility policy regarding vaccination.
All	**0720-31-.05 (5) (c)**		Education of all employees about the following:		
All	**0720-31-.05 (5) (c) 1**	**435**	Flu vaccination,		
All	**0720-31-.05 (5) (c) 2**	**436**	Non-vaccine control measures, and		

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All	**0720-31-.05 (5) (c) 3**	**437**	The diagnosis, transmission, and potential impact of influenza;		
All	**0720-31-.05 (5) (d)**	**438**	An annual evaluation of the influenza vaccination program and reasons for non-participation; and		
All	**0720-31-.05 (5) (e)**	**439**	A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage as declared by the Commissioner or the Commissioner's designee.		
	0720-31-.06		**PEDIATRIC TRAUMA**		
CRPC and PTC	**0720-31-.06 (1)**	**440**	A CRPC and a state designated pediatric trauma center shall have a pediatric trauma program with the following requirements:		
CRPC and PTC	**0720-31-.06 (1) (a)**	**441**	A pediatric trauma medical director who shall be a pediatric surgeon, board certified/board eligible in pediatric surgery, with demonstrated competence in care of the injured child. The director shall have full responsibility and authority for the pediatric trauma program and shall meet the following requirements:		Documentation of trauma medical director designation. • CV of ED Medical Director • Record of appointment / acceptance • Documentation of board certification or board eligibility • Description of job roles and responsibilities for trauma medical director
CRPC and PTC	**0720-31-.06 (1) (a) 1**	**442**	36 hours of category I external trauma/critical care CME every three (3) years or twelve (12) hours each year, and attend one national meeting whose focus is pediatric trauma or critical care every three (3) years;	Three years is a rolling three-year period to maintain consistency with ACS standards.	Documentation of category I external CMEs. Proof of meeting attendance (i.e. meeting minutes) within the past 3 years.
CRPC and PTC	**0720-31-.06 (1) (a) 2**	**443**	Participates in call;		• Call schedule for cycle's 12-month period

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CRPC and PTC	**0720-31-.06 (1) (a) 3**	**444**	Trauma Medical Director has the authority to manage all aspects of trauma care;		Documentation of delegated authority including, but not limited to, the following responsibilities: • Development and enforcement of policies and procedures relevant to • care of the injured patient • Ensuring providers meet all requirements and adhere to • institutional standards of practice • Work across departments and/or other administrative • units to address deficiencies in care • Determining (with their liaisons) provider participation • in trauma care, which might be guided by findings from • the PIPS process or an Ongoing Professional Practice • Evaluation (OPPE)

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					Oversight of the structure and process of the trauma PIPS Program
CRPC and PTC	**0720-31-.06 (1) (a) 4**	**445**	Authorizes trauma service privileges of the on-call providers;		Documentation of preview and authorization process for on-call providers • List of authorized on-call providers with privileges
CRPC and PTC	**0720-31-.06 (1) (a) 5**	**446**	Works in cooperation with nursing administration to support the nursing needs of trauma patients;		Documentation of routine collaboration between the Trauma Medical Director and Trauma Program manager. Documentation may include but is not limited to: Examples demonstrating Trauma Medical Director involvement in nursing process improvement
CRPC and PTC	**0720-31-.06 (1) (a) 6**	**447**	Develops treatment protocols along with the trauma team;		Copy of Clinical Practice Guidelines with last review date. Documentation of facility's Clinical Practice Guidelines review process. This may include but is not limited to: Meeting minutes
CRPC and PTC	**0720-31-.06 (1) (a) 7**	**448**	Coordinates performance improvement and peer review processes;	The Trauma Medical director should be active in the coordination of process improvement and peer review processes. This leadership is best implemented in conjunction with the	Pediatric Trauma Committee minutes that include, but are not limited to: • Review of all trauma related deaths • Source of patients • Review of care

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
				Trauma Program Manager	• Morbidity and mortality registry data Trauma Medical Director Job Descriptions reflects required participation in performance improvement and peer review.
CRPC and PTC	**0720-31-.06 (1) (a) 8**	**449**	With the assistance of the facility administration and the trauma program coordinator, be involved in coordinating the budgetary process for the trauma program;		Trauma Medical Director Job Descriptions reflects required participation in budgetary review.
CRPC and PTC	**0720-31-.06 (1) (a) 9**	**450**	Participates in regional and national trauma organizations; and		Written documentation that demonstrates participation, such as meeting agendas Examples of participation may include the following: • Participation in state and regional trauma advisory committees • Leadership in state and regional medical audit committees • Collaboration with regional trauma advisory committees, EMS, or other agencies to promote the development of state and regional systems

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					• Participation in media and legislative education to promote and develop trauma systems • Participation in state and regional trauma needs assessment or injury surveillance • Participation in the development of a state or regional trauma plan or state trauma registry • Provision of technical assistance and education to hospitals and their providers within the region to improve System performance
CRPC and PTC	**0720-31-.06 (1) (a) 10**	**451**	Retains a current ATLS certification and participates in the provision of trauma-related instruction to other health care personnel		Documentation of current ATLS certification. Documentation of participation in trauma-related instruction including but not limited to: • Training agendas • Conference brochures Education planning meeting minutes

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CRPC and PTC	**0720-31-.06 (1) (b)**	**452**	Current board certified/board eligible pediatric surgeons on the trauma service who shall have successfully completed the ATLS course at least once. Maintenance of current ATLS status is strongly encouraged.		Roster of pediatric surgeons on trauma service, including documentation of: • Most recent ATLS certification • Proof of current board certification/board eligibility
CRPC and PTC	**0720-31-.06 (1) (c)**	**453**	Shall be involved in local/regional EMS agencies/facilities and/or personnel and assist in trauma education, performance improvement, and feedback regarding care.		Documentation of the process for reviewing and providing feedback. Evidence of communication (feedback) between trauma center, EMS agencies, and referring providers Rosters demonstrating routine trauma education for local EMS agencies and common referral hospitals.
CRPC and PTC	**0720-31-.06 (1) (d)**		A Trauma Program Leader who shall:		
CRPC and PTC	**0720-31-.06 (1) (d) 1**	**454**	Be an RN with experience in Pediatric Emergency and/or Critical Care Nursing;		Documentation of current Tennessee RN license. Curriculum Vitae demonstrating experience in pediatric emergency and/or critical care nursing.
CRPC and PTC	**0720-31-.06 (1) (d) 2**	**456**	Have a defined job description and organizational chart delineating roles and responsibilities;	A trauma program leader is responsible, in collaboration with the Pediatric Trauma Medical Director, for meeting overall responsibilities for the trauma service. The leader should have the	Provide job description and organizational chart. • The reporting structure must, at minimum, include a "dotted line" to the TMD to ensure that the

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
				responsibility to monitor and promote all trauma related activities associated with pediatric patient care and is responsible for monitoring the quality of care provided as the trauma patient moves through the hospital system.	TMD and TPM are aligned in setting goals for the benefit of the trauma program and its patients. Trauma program leader job description including but not limited the following responsibilities: • •Oversight of the trauma program • Assist with the budgetary process for the trauma program • Develop and implement clinical protocols and practice management guidelines • Provide educational opportunities for staff development • Monitor performance improvement activities in conjunction with a PI coordinator (where applicable) • Serve as a liaison to administration and represent the trauma program on hospital and regional

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					committees to enhance trauma care
CRPC and PTC	**0720-31-.06 (1) (d) 3**	**457**	Be provided the administrative and budgetary support to complete educational, clinical, administrative and outreach activities for the trauma program; and		Evidence of budget for fiscal year.
CRPC and PTC	**0720-31-.06 (1) (d) 4**	**458**	Show evidence of educational preparation with a minimum of 12 hours internal or external of trauma related continuing education per year. This shall include attending one (1) national meeting within a three (3) year trauma program designated cycle.		Certificate of attendance at national meeting/ convention within the last rolling 3 year period. Documentation of 12 hours of continuing education credits per review year.
CRPC and PTC	**0720-31-.06 (1) (e)**	**459**	Shall submit Trauma Registry data electronically to the state trauma registry on all closed patient files for the Board to analyze.	Facilities are provided with receipts with each quarterly submission to the state database	Confirmation of data submission to the state within 90 days of close of quarter. Variances should be communicated and documented, along with a plan for compliance remediation.
CRPC and PTC	**0720-31-.06 (1) e 1**	**460**	Data shall be transmitted to the state trauma registry in accordance with the state trauma rules. Failure to submit data may result in the delinquent facility's necessity to appear before the Board for any disciplinary action it deems appropriate.		
CRPC and PTC	**0720-31-.06 (1) e 2**	**461**	Shall have a full-time equivalent trauma registrar for each five hundred (500) through seven hundred fifty (750) trauma patients per year.	The full-time equivalent trauma registrar shall be dedicated to the trauma program when assigned to the standard 500-750 trauma patients.	Documentation of trauma volume for review period. Documentation of trauma registrar employment for review period. FTE ratio must not exceed 1 trauma registrar for every 500 to 750 patients If a facility does not meet the standard, documentation of current

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					open position and recruitment efforts shall be available. Organizational chart demonstrating reporting structure to trauma program leader
CRPC and PTC	**0720-31-.06 (1) (f)**	**462**	The pediatric trauma program must annually admit two hundred (200) or more pediatric trauma patients younger than fifteen (15) years of age. These admissions may include inpatient or twenty-three (23) hour observations, but should exclude patients admitted for drowning, poisoning, foreign bodies, asphyxiation or suffocation without presence of injury, patients who are dead on arrival to the facility or other pediatric patients excluded as per the most recent version of the Resources for Optimal Care of the Injured Patient by the American College of Surgeons Committee on Trauma.	Admission standards ensure adequate volume to maintain competency and expertise in pediatric trauma management.	Confirmation of annual admissions of trauma patients less than 15 years of age, exceeding 199. Trauma registry report listing trauma patient volumes meeting the states inclusionary criteria.
CRPC and PTC	**0720-31-.06 (1) (g)**	**463**	Shall have a pediatric trauma committee chaired by the pediatric trauma medical director with designated representation from pediatric general surgery and liaisons to the trauma program from pediatric emergency medicine, pediatric critical care, neurosurgery, pediatric anesthesia, pediatric radiology, pediatric orthopedics, and the pediatric trauma program leader. The pediatric trauma committee shall meet at least quarterly. Members or designees shall attend at least fifty percent (50%) of meetings	.	Compliance with the Pediatric Trauma Committee as evidenced by: • bylaws • membership • committee agenda, including attendance • standards • QI activities • organization outcome

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					measurements Documentation of committee attendance for the following subspecialties demonstrating a minimum of 50% attendance for the review period: • Pediatric general surgery • Pediatric emergency medicine • Pediatric critical care • Neurosurgery • Pediatric anesthesia • Pediatric radiology • Pediatric orthopedics • Pediatric program leader Variances in meeting attendance should be documented and addressed with a plan for attendance improvement.
CRPC and PTC	**0720-31-.06 (1) (g) 1**		This committee shall assure participation in a pediatric trauma process improvement program with the following requirements and responsibilities:		
CRPC	**0720-31-.06 (1) (g) 1 (i)**	**464**	Administration shall provide resources to support the trauma process improvement program;		Meeting attendance records documenting committee attendance of administrative representative.
CRPC and PTC	**0720-31-.06 (1) (g) 1 (ii)**	**465**	A performance improvement coordinator shall be designated with dedicated time for this responsibility;	Performance improvement (PI) coordinator may have other responsibilities but shall have adequate time	Job description listing performance improvement responsibilities, including designated trauma performance improvement.

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				dedicated to trauma specific performance improvement. The trauma PI coordinator, at a minimum, should have a dotted line indicating a reporting structure to the Trauma Program Leader.	Organizational chart demonstrating reporting structure to trauma program leader. If a facility does not meet the standard, documentation of current open positions and recruitment efforts should be available.
CRPC and PTC	**0720-31-.06 (1) (g) 1 (iii)**	**466**	The trauma registry shall be used to support the PIPS process;	Trauma data should be reviewed routinely to identify patterns in care and opportunities for performance improvement.	Meeting agendas demonstrating review of trauma registry data. Examples of PIPS utilizing trauma registry data.
CRPC and PTC	**0720-31-.06 (1) (g) 1 (iv)**	**467**	Identify process and outcome measures;	Trauma centers must include process of identifying outliers or other quality measures in their data quality plan.	Data quality plan must include process for identifying outliers and how those outliers are addressed and measured.
CRPC and PTC	**0720-31-.06 (1) (g) 1 (v)**	**468**	Have a morbidity and mortality review of trauma patients;		Meeting agenda to confirm discussion for all morbidity and mortality cases.
CRPC and PTC	**0720-31-.06 (1) (g) 1 (vi)**	**469**	Maintain a Trauma Bypass/Diversion log:	"Diversion" is defined as the time during which the trauma center is not accepting trauma patients from the scene or via interfacility transfer Trauma center diversions may occur due to the following (this is not an exhaustive list): • Equipment failure (e.g., CT scan down) • Critical infrastructure	A diversion log to record reasons for and duration of diversions Diversion protocol, approved by the TMD, that includes; • Agreement of a trauma surgeon in the decision to divert • A process for notification of
CRPC and PTC	**0720-31-.06 (1) (g) 1 (vi) (I)**	**470**	Trauma bypass/diversion shall not exceed five percent (5%).		
CRPC and PTC	**0720-31-.06 (1) (g) 1 (vi) (II)**	**471**	Pediatric surgery on-call shall be involved in bypass/diversion decisions.		
CRPC and PTC	**0720-31-.06 (1) (g) 1 (vi) (III)**	**472**	All bypass/diversions shall be reviewed.		

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				failure (e.g., weather, electrical, IT) • Lack of essential services (e.g., neurosurgeon, trauma surgeon, or encumbered) • Bed availability Trauma Centers must not exceed 400 hours of diversion in a reporting year (365 days) Designated facility committee must review each diversion for appropriateness and timely resolution	dispatch and EMS agencies • A diversion log to record reasons for and duration of diversions Review diversion log to reflect each diversion event and its resolution
CRPC and PTC	**0720-31-.06 (1) (g) 1 (vii)**	**473**	Document and review response/consult times for pediatric surgeons, neurosurgeons, pediatric anesthesia, and pediatric orthopedists, all of whom must demonstrate eighty percent (80%) compliance with facility determined timed guidelines;		Policy and procedure reflecting physician response expectations Review of documentation showing response criteria and percentage of compliance for the following specialties: • Pediatric surgeons • Neurosurgeons Pediatric orthopedics
CRPC and PTC	**0720-31-.06 (1) (g) 1 (viii)**	**474**	Monitor team notification times. For highest level of trauma activation, the pediatric trauma surgeon must be present within fifteen (15) minutes of patient arrival eighty percent (80%) of the time;		Review of documentation showing response criteria and percentage of compliance.
CRPC and PTC	**0720-31-.06 (1) (g) 1 (ix)**	**475**	Review pre-hospital trauma care to include patients dead on arrival;		Documentation of the following: • Process to review prehospital quality indicators

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					• Agenda demonstrating routine review of prehospital data • Process for escalation of any clinical care issues. • Document process for review
CRPC and PTC	**0720-31-.06 (1) (g) 1 (x)**	**476**	Review times, reasons and appropriateness of care for transport of injured patients;	All trauma transfers in and out of the facility should be assessed for timeliness and appropriateness of transfer decision and execution.	Documentation showing transfer protocols and documenting a process for review Policies & protocols demonstrating transfer process. Committee agendas demonstrating routine review of transfer data.
CRPC and PTC	**0720-31-.06 (1) (g) 1 (xi)**	**477**	Demonstrate that action taken as a result of issues identified in the Process Improvement Program created a measurable improvement. Documentation shall include where appropriate: problem identification, analysis, preventability, action plan, implementation and reevaluation;	Pediatric trauma centers should have a process for quality improvement that aligns with current standards in a peer reviewed setting	Committee meeting agenda demonstrating routine review of identified problems. Documentation of the following for each identified problem: • Problem identification • Problem analysis • Preventability • Action Plan • Implementation Reevaluation
CRPC and PTC	**0720-31-.06 (1) (g) 1 (xii)**	**478**	Evaluation of Operational Process Improvement (evaluation of systems issues) shall occur to address, assess, and correct global trauma program and system issues, and correct overall program deficiencies to continue to optimize patient care.		Committee meeting agendas demonstrating routine review of identified problems.

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CRPC and PTC	**0720-31-.06 (1) (h)**	**479**	Shall have clearly defined graded activation criteria		Policy and procedure showing activation criteria
CRPC and PTC	**0720-31-.06 (1) (h) 1**	**480**	Criteria for the highest level of activation shall be clearly defined and evaluated by the pediatric trauma committee.		Policy and procedure outlining the facility's process for highest level of activation
CRPC and PTC	**0720-31-.06 (1) (h) 2**	**481**	For the highest level of activation, the trauma team shall be immediately available and the pediatric trauma attending available within fifteen (15) minutes of patient arrival eighty percent (80%) of the time, and shall include a trauma chief resident with three (3) to five (5) years of post-graduate year training or a Pediatric Emergency Physician.		Policy and procedure reflecting trauma team response expectations Documentation showing response criteria and percentage of compliance
CRPC and PTC	**0720-31-.06 (1) (i)**		Shall have an injury prevention program which:		
CRPC and PTC	**0720-31-.06 (1) (i) 1**	**482**	Shall have an organized and effective approach to injury prevention and must prioritize those efforts based on trauma registry and epidemiologic data,	Review of trauma registry data shall be used to identify areas of focus for the injury prevention team.	• Prioritizes injury prevention work based on trends identified in the trauma registry and local epidemiological data Graphs/tables highlighting recent injury mechanism trends from registry Report of injury prevention activities including the following: • Activity name • Activity date • Participation data Evaluation of outcomes (where

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					applicable) • Program objectives and deliverables for each injury prevention activity • Any materials (including posters, flyers, press releases, etc.) relevant to the injury prevention initiatives
CRPC and PTC	**0720-31-.06 (1) (i) 2**	**483**	Shall have a full-time injury prevention coordinator dedicated to the trauma program to ensure community and regional injury prevention activities are implemented and evaluated for effectiveness,	Injury prevention is a key component of decreasing morbidity and mortality in the pediatric trauma population. The dedicated injury prevention coordinator works under the trauma program leader, along with the performance improvement coordinator and trauma registrar to identify and target common injury mechanisms affecting pediatric trauma patients.	Job description for an injury prevention coordinator. Documentation of a full-time injury prevention coordinator with direct reporting structure to trauma program leader. If the facility is without a full-time injury prevention coordinator, documentation of current open position and recruitment efforts should be available.
CRPC and PTC	**0720-31-.06 (1) (i) 3**	**484**	Shall implement at least two programs that address one of the major causes of injury in the community, and	Injury prevention programs shall be a reflection of common mechanisms of injury specific to facility's trauma registry data. Programs shall be selected based on either commonality of	1. Implements at least two activities over the course of the verification cycle with specific objectives and deliverables that address separate major causes of injury in the community

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
				mechanism or severity of injury. Programs should be routinely monitored for effectiveness.	2. Documentation of injury prevention programs including the following: • Identification of need • Intervention planning • Intervention implementation • Review of injury prevention outcomes • Revaluation of need 3.Demonstrates evidence of partnerships with community organizations to support their injury prevention efforts In Level I trauma centers, the injury prevention professional must be someone other than the TPM or PI personnel.
CRPC and PTC	**0720-31-.06 (1) (i) 4**	**485**	Shall screen for alcohol and drug abuse in admitted patients.	Age-appropriate screening for alcohol and drug abuse shall be completed on all admitted trauma patients including/excluding 23-hour observation patients.	Facility policy and protocol for screening patients for alcohol and drug abuse. Policy should include but is not limited to: • Age parameters for screening (minimum of >12 years of age) Escalation of care for patients who screen positive
CRPC and PTC	**0720-31-.06 (1) (j)**	**486**	The PTC shall also have other subspecialty trained surgical and medical providers who are board eligible or board certified and meeting the requirements of maintenance of certification, or who are credentialed		Documentation of board certification/board eligibility for required specialties.

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			providers in Tennessee prior to the promulgation of these rules in their respective subspecialty as listed in Table 1.		Call schedules for listed specialties in Table 1.
PTC	**0720-31-.06 (2)**	**487**	State Pediatric Trauma Center Designation		
PTC	**0720-31-.06 (2) (a)**	**488**	The Board shall implement the designation process.		
PTC	**0720-31-.06 (2) (b)**	**489**	The preliminary designation process for facilities aspiring for designation as a Pediatric Trauma Center shall consist of the following:		
PTC	**0720-31-.06 (2) (b) 1**	**490**	Each facility desiring designation shall submit an application to the Board;		
PTC	**0720-31-.06 (2) (b) 2**	**491**	A Department site visit team ("team") shall review each submitted application and shall act in an advisory capacity to the Board;		
PTC	**0720-31-.06 (2) (b) 3**	**492**	The team shall communicate deemed application deficiencies to the facility in writing;		
PTC	**0720-31-.06 (2) (b) 4**	**493**	The facility shall have thirty (30) days to submit required information;		
PTC	**0720-31-.06 (2) (b) 5**	**494**	Arrangements shall be made for a provisional site visit for those facilities meeting application requirements.		
PTC	**0720-31-.06 (2) (c)**	**495**	The site visit team shall consist of the following for Pediatric Trauma Centers		
PTC	**0720-31-.06 (2) (c) 1**	**496**	A pediatric trauma surgeon medical director or a pediatric trauma surgeon who has previously been a medical director from an out-of-state pediatric trauma center who shall serve as team leader		
PTC	**0720-31-.06 (2) (c) 2**	**497**	A pediatric trauma surgeon from an in-state pediatric trauma center.		
PTC	**0720-31-.06 (2) (c) 3**	**498**	An in-state pediatric trauma leader from a pediatric trauma center.		
PTC	**0720-31-.06 (2) (c) 4**	**499**	The state trauma program manager and/or state EMS director.		

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
PTC	**0720-31-.06 (2) (d)**	**500**	The team shall be appointed by the state trauma system director and/or state trauma system assistant director.		
PTC	**0720-31-.06 (2) (e)**	**501**	The team shall conduct a provisional visit to ensure compliance with all criteria required for designation as a Pediatric Trauma Center. During the provisional visit, the applicant shall demonstrate that the required mechanisms to meet the criteria for the desired designation level are in place.		
PTC	**0720-31-.06 (2) (f)**	**502**	The team shall identify deficiencies and areas for improvement it deems necessary for designation.		
	0720-31-.06 (2) (g)	**503**	If the team does not cite any deficiencies and concludes that the facility is otherwise in compliance with all applicable standards it shall approve the applicant to function with provisional status for a period of one (1) year.		
PTC	**0720-31-.06 (2) (h)**	**504**	If, during the provisional visit, the team cites deficiencies, it shall not approve provisional status for the applicant to function as a Pediatric Trauma Center. Centers with deficiencies shall have fifteen (15) days from receipt of the deficiency report to provide documentation demonstrating compliance. If the facility is unable to correct the deficiencies within fifteen (15) days, the application shall be denied, and the applicant may not resubmit an application for trauma center designation for at least one (1) year from the date of denial.		
PTC	**0720-31-.06 (2) (i)**	**505**	Facilities granted provisional status as a Pediatric Trauma Center shall adhere to the following:		
PTC	**0720-31-.06 (2) (i) 1**	**506**	The facility shall be prepared to provide:		

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
PTC	**0720-31-.06 (2) (i) 1 (i)**	**507**	A description of changes made after the grant of provisional status;		
PTC	**0720-31-.06 (2) (i) 1 (ii)**	**508**	A description of areas of improvement cited during the provisional visit; and		
PTC	**0720-31-.06 (2) (i) 1 (iii)**	**509**	A summary of the facility's trauma service based on the trauma registry report.		
PTC	**0720-31-.06 (2) (i) 2**	**510**	The team shall conduct a site visit at the termination of the applicant's one (1) year provisional designation as a Pediatric Trauma Center.		
PTC	**0720-31-.06 (2) (i) 3**	**511**	During the follow-up visit, the team shall identify the presence of deficiencies and areas of improvement.		
PTC	**0720-31-.06 (2) (j)**	**512**	Upon completion of the follow-up visit, the team shall submit its findings and designation recommendation to the Board.		
PTC	**0720-31-.06 (2) (j) 1**	**513**	If the team cites deficiencies found during its follow-up visit, they shall be included in its report to the Board.		
PTC	**0720-31-.06 (2) (j) 2**	**514**	At the time that the team's report is presented to the Board, the facility requesting Pediatric Trauma Center designation shall be allowed to present evidence to the Board demonstrating action taken to correct the cited deficiencies.		
PTC	**0720-31-.06 (2) (k)**	**515**	The final decision regarding Pediatric Trauma Center designation shall be rendered by the Board. If granted, the designation is in effect for a period of three (3) years.		
PTC	**0720-31-.06 (2) (l)**	**516**	If the Board denies the application, the facility may not reapply for at least one (1) year. If provisional status was granted, such status will be revoked.		
PTC	**0720-31-.06 (2) (m)**	**517**	The facility applying for Pediatric Trauma Center designation shall bear all costs of the application process, including the costs of a site visit.		

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
PTC	**0720-31-.06 (2) (n)**	**518**	A facility seeking a consultation/verification site visit through the American College of Surgeons as a Level I Pediatric Trauma Center shall coordinate with state trauma system director and/or state trauma system assistant director to ensure his/her attendance at the ACS site visit. If state trauma system director and/or state trauma system assistant director is unable to attend the site visit, the finalized report from the site visit shall be shared with the state trauma system director and/or state trauma system assistant director for presentation to the Board if the facility seeks a reciprocal designation as a Pediatric Trauma Center.		
PTC	**0720-31-.06 (2) (o)**	**519**	Denial of Provisional or Full Designation. When the Board denies provisional or full designation, it must provide the facility with a written notification of the action and the basis for the action. The notice will inform the facility of the right to appeal and the procedure to appeal the action under the provisions of the Uniform Administrative Procedures Act		
PTC	**0720-31-.06 (3)**	**520**	State Pediatric Trauma Center Verification		
PTC	**0720-31-.06 (3) (a)**	**521**	Following designation as a pediatric trauma center, a verification site visit shall be conducted at the facility every three (3) years.		
PTC	**0720-31-.06 (3) (b)**	**522**	The team shall advise the center of an upcoming verification visit at least sixty (60) days prior to the visit. After the facility receives notice of the upcoming verification site visit, it shall prepare all materials the team requests for submission.		
PTC	**0720-31-.06 (3) (c)**	**523**	The team shall conduct an exit interview with the facility at the conclusion of the verification visit.		

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
PTC	**0720-31-.06 (3) (d)**	**524**	During the exit interview the team shall communicate the following:		
PTC	**0720-31-.06 (3) (d) 1**	**525**	The presence of deficiencies;		
PTC	**0720-31-.06 (3) (d) 2**	**526**	The facility's strengths and weaknesses; and		
PTC	**0720-31-.06 (3) (d) 3**	**527**	Recommendations for improvements and correction of deficiencies.		
PTC	**0720-31-.06 (3) (e)**	**528**	The team shall submit a site visit report within sixty (60) days of completion of the site visit. It shall submit a copy of the report to the Board, the Chief Executive Officer of the facility, the Pediatric Trauma Medical Director and the Pediatric Trauma Program Manager (TPM).		
PTC	**0720-31-.06 (3) (f)**	**529**	If the team does not cite deficiencies and the center is in compliance with all applicable standards, it shall recommend that the facility maintain its designation as a Pediatric Trauma Center for a period of three (3) additional years.		
PTC	**0720-31-.06 (3) (g)**	**530**	If during the site visit the team identifies deficiencies, the center shall have a period not to exceed sixty (60) days to correct deficiencies.		
PTC	**0720-31-.06 (3) (h)**	**531**	If the team ascertains that deficiencies have not been corrected within sixty (60) days, whether through desk review or an on-site visit, the center must present an explanation to the Board at its next scheduled meeting.		
PTC	**0720-31-.06 (3) (i)**	**532**	The facility shall bear all costs of the verification process, including the costs of a site visit		
PTC	**0720-31-.06 (3) (j)**	**533**	If a Pediatric Trauma Center already designated by the board elects to undergo an American College of Surgeons Pediatric Level I trauma center consultation/verification site visit, the facility shall coordinate with the state trauma system director and/or state trauma system		

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Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
			assistant director to ensure his/her attendance at the review. If the state trauma system director and/or state trauma system assistant director is unable to attend the site visit, the finalized report from the site visit shall be shared with the state trauma system director and/or state trauma system assistant director for presentation to the Board if the facility seeks a reciprocal state designation as a Pediatric Trauma Center.		
PTC	**0720-31-.06 (4)**	**534**	State Pediatric Trauma Center Disciplinary Action		
PTC	**0720-31-.06 (4) (a)**	**535**	The Board may, in accordance with the Uniform Administrative Procedures Act, revoke, suspend, place on probation, or otherwise discipline, a facility's trauma center designation.		
PTC	**0720-31-.06 (4) (b)**	**536**	The Board may revoke, suspend, place on probation, or otherwise discipline, the designation or provisional status of a center when an owner, officer, director, manager, employee or independent contractor:		
PTC	**0720-31-.06 (4) (b) 1**	**537**	Fails to comply with the provisions of these rules;		
PTC	**0720-31-.06 (4) (b) 2**	**538**	Makes a false statement of material fact about the center's capabilities or other pertinent circumstances in any record or matter under investigation for any purposes connected with these rules;		
PTC	**0720-31-.06 (4) (b) 3**	**539**	Prevents, interferes with, or attempts to impede in any way, the work of a representative of the Board;		
PTC	**0720-31-.06 (4) (b) 4**	**540**	Falsely advertises, or in any way misrepresents the facility's ability to care for patients based on its designation status;		
PTC	**0720-31-.06 (4) (b) 5**	**541**	Fails to provide reports required by the trauma registry or the Commission in a timely and complete fashion;		
PTC	**0720-31-.06 (4) (b) 6**	**542**	Fails to comply with or complete a plan of correction in the time or manner specified.		

Pediatric Emergency Care Facilities Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
PTC	**0720-31-.06 (4) (c)**	**543**	Denial of Provisional or Full Designation, When the Board denies provisional or full designation, it must provide the center with a written notification of the action and the basis for the action. The notice will inform the center of the right to appeal and the procedure to appeal the action under the provisions of the Uniform Administrative Procedures Act.		
PTC	**0720-31-.06 (5)**	**544**	State Pediatric Trauma Center Prohibitions		
PTC	**0720-31-.06 (5) (a)**	**545**	It shall be a violation of these regulations for any health care facility to hold out, advertise or otherwise represent itself to be a “trauma center” as licensed by the Board unless it has complied with the regulations set out herein and the Board has so designated it.		
PTC	**0720-31-.06 (5) (b)**	**546**	Any facility the Board designates as a trauma center, at any level, shall comply with the requirements of EMTALA. The medical needs of a patient and the available medical resources of the facility, rather than the financial resources of a patient, shall be the determining factors concerning the scope of service provided.		
PTC	**0720-31-.06 (5) (c)**	**547**	The term “trauma center” refers to a main facility campus that has met all requirements to satisfy trauma center rule designation. Off campus sites are excluded in this designation.		

TABLE 1.	PEDIATRIC EMERGENCY CARE FACILITIES						
Part 1/6	FACILITY DESIGNATION/LEVEL						
	CRPC	**General w/PICU**	**General**	**Primary**	**Basic**	**PTC**	**Comments**
1. PERSONNEL							
Physician with pediatric emergency care experience	EED	EED	EED	EED	EP	EED	
RN with pediatric training	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Full time ED RN personnel 24 hours a day trained in pediatric trauma specific education/competencies	E					E	
Respiratory therapist	EED&EPI	EED&EPI	EF	EF	SE	EED&EPI	
Trauma program leader	E	SE				E	
CRPC Coordinator	E						Position may be labeled coordinator, manager, leader or other similar title
Nurse educator	EED&EPI	EED&EPI	E	SE	SE	E	
Trauma team	E	SE	SE	SE		E	
Physician Pediatric Emergency Care Coordinator	EED	EED	EED	EED	EED	E	
Nursing Pediatric Emergency Care Coordinator	EED	EED	EED	EED	EED	E	
Pediatric Anesthesia Services	EP	EP	EP	EP		EFI	
Specialist consultants							
Pediatrician	EP	EP	EP	EP	SE	EP	
Child Abuse Pediatrician	E	SE	SE			E	
Pediatric Radiologist	EP	SE	SE	SE	SE	EP	

	CRPC	General w/PICU	General	Primary	Basic	PTC	Comments
Radiologist		EP	EP	EP	SE		A primary or basic facility may use teleradiology.
Anesthesiologist			EP	EP	SE		Anesthesiologist/Anesthetist (See tag 408)
Pediatric Anesthesiologist	EP	EP				EP	
Pediatric Cardiologist	EP	EP				EP	
Pediatric Critical Care Physician	EP	EP				EFI	
Pediatric Nephrologist	EP	SE				EP	
Pediatric Hematologist/Oncologist	EP	SE				EP	
Pediatric Endocrinologist	EP	SE				EP	
Pediatric Gastroenterologist	EP	SE				EP	
Neurologist		EP					
Pediatric Neurologist	EP	SE				EP	
Pediatric Pulmonologist	EP	SE				EP	
Psychiatrist/Psychologist	EP	SE				EP	
Pediatric Infectious Disease Physician	EP	SE				EP	
Physical Medicine/Rehabilitation Physician	E					E	
Interventional Radiologist						EP	
Pathology	EP[2]	E					
Surgical specialists							
General surgeon			EP	EP	SE		
Pediatric surgeon	EP	EP	SE			EFI[4]	

	CRPC	General w/PICU	General	Primary	Basic	PTC	Comments
Radiologist		EP	EP	EP	SE		A primary or basic facility may use teleradiology.
Neurosurgery	EP						
Pediatric Neurosurgeon	SE	SE	SE			EP[5]	
Pediatric Orthopedic surgeon	EP	E	SE	SE		EP	
Otolaryngologist		EP					
Pediatric Otolaryngologist	EP	SE				EP	
Pediatric Urologist	EP					EP	
Pediatric Plastic surgeon *	EP					EP	
Oral/Maxillofacial surgeon	EP					EP	
Gynecologist	EP					EP	
Microvascular surgeon *	EP					EP	
Hand surgeon *	EP					EP	
Pediatric Ophthalmologist	EP	E				EP	
Pediatric Cardiac surgeon *	EP					EP	
Vascular surgeon *	EP[6]					EP[6]	
Rehabilitation Program							
Physical Therapy	E	E				E	
Occupational Therapy	E	E				E	
Speech Therapy	E	E				E	
School Education Program	E					E	

Part 2/6	FACILITY DESIGNATION/LEVEL						
	CRPC	**General w/ PICU**	**General**	**Primary**	**Basic**	**PTC**	**Comments**
2. Equipment and Supplies							

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	CRPC	General w/PICU	General	Primary	Basic	PTC	Comments
Radiologist		EP	EP	EP	SE		A primary or basic facility may use teleradiology.
EMS communication equipment	E	E	E	E	E	E	
Organized emergency cart	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
A length-based resuscitation tape and precalculated pediatric drug dosing reference in mg and mL	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Tourniquets for hemorrhage control	EED	EED	EED	EED	EED	EED	
Ultrasound for performing FAST examination	EED	SE				EED	
Monitoring Devices							
Continuous pulse oximeter monitoring with alarms (adult/pediatric probes)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Blood pressure cuffs (infant, child, adult)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Rectal thermometer probe	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Otoscope, ophthalmoscope, stethoscope	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Cardiopulmonary monitor and defibrillator with pacing capabilities and pediatric paddles or pads and hard copy capability, visible/audible alarms, routine testing, and maintenance	EED&EPI	EED&EPI	EED	EED	EF	EED&EPI	
Noninvasive blood pressure monitoring (infant, child, adult)	EED&EPI	EED&EPI	EED	EF	EF	EED&EPI	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
End tidal CO2 detector for neonate and child	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
End tidal CO2 monitor	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Monitor for central venous pressure, arterial lines, temperature	EF&EPI	EF&EPI				EF&EPI	
Monitor for intracranial pressure	EPI	SE				EPI	
Transportable monitor	EED&EPI	EED&EPI	EED	EF	EF	EED&EPI	
Airway control/ ventilation equipment							
Bag-valve-mask device: neonatal, pediatric, and adult with oxygen reservoir and without pop-off valve. Infant, child, and adult masks	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Oxygen delivery device with flow meter	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Oral airway (1 set of sizes 0-5 or equivalent)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Clear non-rebreathing oxygen masks (neonatal to adult size)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Nasal cannula (infant, child, adult)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
PEEP valve	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Suction devices-catheters 6-14 fr, rigid-tip/suction equipment	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Nasal airways (infant, child, adult)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Nasogastric tubes (sizes 8-16 fr)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Laryngoscope handle and blades							
- curved 2, 3, 4	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
- straight 0, 1, 2, 3	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Endotracheal tubes: sizes 2.5 – 3.0 uncuffed and sizes 3.0-8.0 cuffed	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Stylets for endotracheal tubes (pediatric, adult)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Lubricant, water soluble	EED	EED&EPI	EED	EED	EED	EED	
Magill forceps (pediatric, adult)	EED	EED&EPI	EED	EED	EED	EED	
Spirometers and chest physiotherapy equipment	EF	EF	EF	EF		EF	
Inhalation therapy equipment (pediatric and adult sizes)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Tracheostomy tubes (sizes 3 - 6)	EF	EF	EF	EF		EF	
Nasal atomizer	EED	EED	EED	EED	EED	EED	
Pediatric endoscopes and bronchoscopes available	EF	EF	EF			EF	
Pediatric conventional ventilators	EED&EPI	EED&EPI	EF	SE		EED&EPI	Should have coordinating pediatric circuit
High frequency oscillatory ventilator	EPI	EPI				EPI	
Difficult airway equipment and protocol for the management of patients with a difficult airway	EED&EPI	EED&EPI	EED	EF	SE	EED&EPI	Examples of difficult airway equipment include laryngeal mask airways, fiberoptic scopes, lighted stylets, and others.

Vascular access supplies							
	CRPC	**General w/ PICU**	**General**	**Primary**	**Basic**	**PTC**	**Comments**
Arm boards (infant, child, and adult sizes)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Catheters for intravenous lines (16-24 gauge)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Needles (various sizes ranging 18-27 gauge)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Intraosseous needles	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Umbilical vessel catheters (3,5 fr) and cannulation tray	EED	EED	EED	EF	SE	EED	3.5fr UVC catheter may be accepted in lieu of 3fr catheter
IV administration sets and extension tubing, stopcocks, luer to luer connectors and T-connectors	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Ultrasound machine for vascular access	EED&EPI	EED&EPI				EED&EPI	
Infusion device able to regulate rate and volume of infusate	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Central venous access catheters (4-7 fr)	EED&EPI	EED&EPI	EED			EED&EPI	
IV fluid/blood warmer	EED&EPI	EED&EPI	EED	EF	SE	EED&EPI	
Blood gas kit	EED&EPI	EED&EPI	EED	EF	SE	EED&EPI	
Rapid infusion device	EED&EPI	EED&EPI	EF	SE	SE	EED&EPI	
Specialized pediatric trays							
Lumbar puncture	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Urinary catheterization: Foley 6-14 fr (may accept a 5 or 6 fr feeding tube or umbilical catheter as compliant for the 6 fr Foley)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Thoracostomy tray with chest tube sizes 10-28 fr	EED&EPI	EED&EPI	EED	SE		EED&EPI	
Intracranial pressure monitor tray	EED&EPI	SE				EED&EPI	
Obstetrical Kit	EED	EED	EED	EED	EED	EED	
Thoracotomy Tray	EED					EED	
Pediatric Pericardiocentesis Tray	EED					EED	
Fracture management devices							
Cervical immobilization equipment suitable for ped. patients	EED	EED	EED	EED	EED	EED	
Spine board (child/adult)	EED	EED	EED	EED	EED	EED	
Extremity splints	EED	EED	EED	EED	EED	EED	
Femur splint; child, adult	EED	EED	EED	EED	EED	EED	
Medications[3]							
Beta-2 agonist for inhalation	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Calcium chloride	EED&EPI	EED&EPI	EED	EF	EF	EED&EPI	
Corticosteroids (dexamethasone, methylprednisolone, & Hydrocortisone	EED	EED&EPI	EED	EED	EED	EED	
Cyanide kit	EED	EF	EF	SE	SE	EED	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Dantrolene	EF	EF	EF	EF	EF	EF	
Dextrose – 10%	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Digoxin antibody	EF	EF	EF	EF	SE	EF	
Diphenhydramine	EED	EED	EED	EED	EED	EED	
Epinephrine (1:1,000 or 1mg/mL)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Epinephrine (1:10,000 or 0.1mg/mL)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Factor VIII, IX concentrates, DDAVP	EF	EF	EF	EF		EF	
Flumazenil	EED	EED	EED	EED	EED	EED	
Furosemide	EED&EPI	EED&EPI	EED	EED	EF	EED&EPI	
Glucagon	EED	EED	EED	EED		EED	
Hypertonic 3% sodium chloride IV solution	EF	EF	EF	EF	EF	EF	
Insulin	EF	EF	EF	EF	EF	EF	
Intralipid	EF	EF	EF	SE		EF	
Isotonic balanced salt solution and D5NS	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Kayexalate	EF	EF	EF	EF		EF	
Magnesium sulfate	EED&EPI	EED&EPI	EED	EED	EF	EED&EPI	
Mannitol-20%	EED&EPI	EED&EPI	EED	EF	EF	EED&EPI	
Methylene blue	EF	EF	EF	EF	EF	EF	
N-acetyl cysteine	EF	EF	EF	EF	SE	EF	
Naloxone	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Nitric oxide	EF	EF				EF	
Ondansetron	EF	EF	EF	EF	EF	EF	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Potassium chloride	EF	EF	EF	EF	EF	EF	
Prostaglandin	EF	EF	EF	SE		EF	
Sodium bicarbonate 4.2% and 8.4%	EED&EPI	EED&EPI	EED	EED	EED	EF	
Whole bowel irrigation solution	EF	EF	EF	EF	EF	EF	
Medication classes							
Analgesics	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Antibiotics	EED	EED	EED	EED	EF	EED	
Anticonvulsants	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Antihypertensive agents	EED&EPI	EED&EPI	EED	EF	EF	EED&EPI	
Antipyretics	EED&EPI	EED&EPI	EED	EED	EF	EED&EPI	
PALS and ACLS medications	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	Based on current American Heart Association guidelines.
Chelating agents for heavy metal poisonings	EF	EF				EF	
Nondepolarizing neuromuscular blocking agents	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Rapid sequence intubation medications	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	Must include both a sedative/anxiolytic/analgesic medication and a neuromuscular blocking agent.
Sedatives and antianxiety medications	EED&EPI	EED&EPI	EED	EF	EF	EED&EPI	
Miscellaneous							

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Resuscitation board	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Infant and child scale (measure in kg)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	
Heating source (for infant warming)	EED&EPI	EED&EPI	EED	EED	EED	EED&EPI	This may include a heat lamp, incubator, radiant warmer or other heating source.
Pediatric restraint equipment	EED	EED	EED	EED		EED	
Portable radiography	EED&EF	EED&EF	EF	EF		EED&EPI	
Slit Lamp	EF	EF	EF	EF		EF	
Infant incubators	EF	EF				EF	
Bilirubin lights	EF	EF				EF	May include bililights or biliblankets or other phototherapy equipment.
Thermal control for patient and/or resuscitation room	EED	EED	EED	EED		EED	
Part 3/6	FACILITY DESIGNATION/LEVEL						
	CRPC	**General w/ PICU**	**General**	**Primary**	**Basic**	**PTC**	**Comments**
3. FACILITIES							
Emergency Department							
Two or more areas with capacity and equipment to resuscitate medical/surgical/trauma pediatric patients	E					E	
One or more areas as above		E	E				
Access to helicopter landing site	E	E	E	E	E	E	
Facility Support Services							
Pediatric inpatient care	E	E	E			E	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Pediatric intensive care unit	E	E				E	
Child abuse team	E	E	E			E	
Child life support	EF	EF				EF	
Operating Room							
Operating room staff	EP	EP	EP	SE*		EP	
One PALS certified RN physically present in the OR for pediatric procedures	E	E	E	E*		E	
Operating room with adequate staff and promptly available within 30 minutes of notification	E					E	
Operating room, dedicated to the trauma service, with adequate staff in-house and immediately available 24 hours a day with a second operating room promptly available and staffed within 30 minutes of notification						E	
Thermal control equipment	E	E	E	E*		E	
X-ray capability, including C-arm	E	E	E	E*		E	
Endoscopes, all varieties	E					E	
Craniotomy equipment, including ICP monitoring equipment	E					E	
Invasive and non-invasive monitoring equipment	E	E	E			E	
Pediatric anesthesia and ventilation equipment	E	E	E	E*		E	
Pediatric airway control equipment	E	E	E	E*		E	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Defibrillator, monitor, including internal and external paddles	E	E	E	E*		E	
Laparotomy tray	E	E	E			E	
A rapid volume infuser for the utilization of transfusion protocol	E	E	E			E	
Thoracotomy tray and chest retractors of appropriate size	E					E	
Synthetic grafts of all sizes	E					E	
Spinal and neck immobilization equipment	E					E	
Fracture table with pediatric capability	E					E	
Auto-transfusion with pediatric capability	E					E	
Precalculated pediatric drug dosing reference in mg and mL	E	E	E	E	E	E	
Tracheostomy tubes, neonatal through adolescent	E	E	E			E	
Pediatric Intensive Care Unit							
Distinct, controlled access unit	E	E				E	
Proximity to elevators	E	E				E	
MD on-call room	E	E				E	
Waiting room and separate family counseling room	E	E				E	
Patients' personal effects storage and privacy provision	E	E				E	
Patient isolation capacity and isolation cart	E	E				E	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Medication station with drug refrigerator and locked cabinet	E	E				E	
Precalculated pediatric drug dosing reference in mg and mL	E	E				E	
Emergency equipment storage	E	E				E	
Separate clean and soiled utility rooms	E	E				E	
Nourishment station	E	E				E	
Separate staff and patient toilets	E	E				E	
Two oxygen, two vacuum, and > 2 compressed air outlets/bed	E	E				E	
Computerized lab reporting	E	E				E	
Easy, rapid access to head of beds and cribs	E	E				E	
Pressure monitoring capability, with 4 simultaneous pressures	E	E				E	
Patient isolation capability	E	E				E	
Recovery Room							
RNs and other essential personnel on call 24 hrs./ day	E	E	E	E*		E	E* = If surgery is performed on pediatric patients
Staff competent in the post-anesthesia care of the pediatric pt.	E	E	E	E*		E	
Pediatric Airway equipment	E	E	E	E*		E	
Blood Pressure monitoring capability	E	E	E	E*		E	
Thermal control equipment	E	E	E	E*		E	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Blood warmer	E	E	E	E*		E	
Resuscitation cart	E	E	E	E*		E	
Immediate access to sterile surgical supplies for emergency	E	E	E	E*		E	
Pediatric drug dosage chart	E	E	E	E*		E	
Laboratory Services							
Hematology	E	E	E	E	E	E	
Chemistry	E	E	E	E	E	E	
Microbiology	E	E	E	E	SE	E	
Microcapabilities	E	E	E			E	
Blood bank	E	E	E	SE		E	
Shall have a pediatric transfusion protocol	E					E	
Drug levels/toxicology	E	E	SE	SE		E	
Blood gases	E	E	E	E		E	
Radiology Services							
Routine services 24 hours per day	EF	EF	EF	E	E	EF	
Computed tomography scan 24 hours per day	EF	EF	E	SE		EF	
Ultrasound 24 hours per day	E	E	E	SE		E	
Magnetic Resonance Imaging Availability	E	E	E			E	
Nuclear medicine	E	SE	SE			E	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Fluoroscopy/contrast studies 24 hours per day	E	E	E	SE		E	
Angiography 24 hours per day	E	E	E	SE		E	Facilities may also have prearranged transfer agreements to fulfill this requirement.
Interventional Radiology Services						E	
Other							
Pediatric Echocardiography	EP	EP				EP	
Pediatric Cardiac Catheterization *	E					E	Facilities may also have prearranged transfer agreements to fulfill this requirement.
Electroencephalography	EP	EP				EP	
Access to:							
Regional poison control center	E	E	E	E	E	E	
Hemodialysis capability						E	
Rehabilitation medicine						E	
Acute spinal cord injury management capability						E	
Hyperbaric oxygen chamber availability/transfer agreement when appropriate	E					E	

FACILITY DESIGNATION/LEVEL

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
4. ACCESS, TRIAGE, TRANSFER AND TRANSPORT							
Support of medical control	E	E	E	SE	SE	E	

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	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Accept call-ahead ambulance information	E	E	E	E	E	E	
Transfer agreements for:							
In-patient pediatric care	E	E	E	E	E		
ICU pediatric care	E	E	E	E	E		
Major trauma care	ES	E	E	E	E		
Burn care	ES	E	E	E	E	ES	
Hemodialysis and Extracorporeal Life Support	ES	E	E	E	E		
Spinal injury care	ES	E	E	E	E		
Rehabilitation care	ES	E	E	E	E		
Reimplantation, hand & microvascular surgery						ES	
Accept all critically ill patients from lower-level facilities within a region	E	SE					
Access to transport services appropriate for pediatrics	E	E	E	E	E	E	
Provide 24-hour consultation to lower-level facilities	E					E	
Consultation agreements with CRPC		E	E	E	E	E	
Accepts all critically ill pediatric trauma patients from lower-level facilities within a region	E					E	

Part 5/6	FACILITY DESIGNATION/LEVEL						
	CRPC	**General w/ PICU**	**General**	**Primary**	**Basic**	**PTC**	**Comments**
5. EDUCATION, TRAINING, RESEARCH, and QUALITY ASSESSMENT and IMPROVEMENT							
Education and Training							
Accepts all critically ill pediatric trauma patients from lower-level facilities within a region	E					E	
Public education, injury prevention	E	E	E	SE	SE	E	
Assure staff training in resuscitation and stabilization	E	E	E	E	E	E	
Assist with pre-hospital education	E	E	SE	SE	SE	E	
CPR certification for PICU nurses and RTs	E	E				E	Current certification in both PALS **and** ACLS may be accepted in lieu of CPR certification
CPR certification for ED nurses and RTs	E	E	E	E	E	E	Current certification in both PALS **and** ACLS may be accepted in lieu of CPR certification
Multidisciplinary resuscitation simulation with physician engagement	E	E	E	E	E	E	Should include all geographical departments that care for pediatric patients
Ongoing Pediatric CE for RNs and RTs from the PICU	E	E				E	
Ongoing Pediatric CE for RNs and RTs from the ED	E	E	E	E	E	E	
Ongoing Pediatric Trauma-related CE for PICU and PACU RNs	E					E	
Research							
Support state EMSC research efforts and data collection	E	E	E	E	E	E	

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Participate in and/or maintain trauma registry	E	E	E	SE	SE	E	
Participate in regional pediatric critical care education	E					E	
Quality Assessment and Improvement							
Structured QA/QI program with indicators and periodic review	E	E	E	E	E	E	
Participate in regional quality review by CRPC and/or local EMS authority	E	E	E	E	E	E	
Part 6/6	FACILITY DESIGNATION/LEVEL						
	CRPC	**General w/ PICU**	**General**	**Primary**	**Basic**	**PTC**	**Comments**
6. ADMINISTRATIVE SUPPORT and FACILITY COMMITMENT							
Make available clinical resources for training pre-hospital personnel	E	SE	SE	SE		E	
Assure properly trained ED staff	E	E	E	E	E	E	
Assure availability of all necessary equipment/supplies/protocols/agreements/policies	E	E	E	E	E	E	
Provide emergency care and stabilization for all pediatric patients	E	E	E	E	E	E	
Support networking education/training for health care professionals	E	E	E	E	E	E	
Assure appropriate medical control and input to ED management and pediatric care	E	SE	SE	SE	SE	E	
Participate in network pediatric emergency care	E	E	E	E	E	E	
Assure conformity with building and federal codes for PICU	E	E				E	

Pediatric Emergency Care Facilities Licensure Survey

	CRPC	General w/ PICU	General	Primary	Basic	PTC	Comments
Assure availability of interfacility transfer guidelines and interfacility transfer agreements for pediatric patients	E	E	E	E	E	E	
Assure resources available for data collection	E	E	E	E	E	E	
Assure availability of:							
Social services	E	E	E	E		E	
Child life specialists	E	E				E	
Case Management	E	E				E	
Chaplain Support	E	E				E	
Biomedical Technician	E	E				E	
Nutritionist/Registered Dietician	E	E				E	
Pharmacist with Pediatric Training	E	E				E	
Radiology Technician	E	E				E	
On-line pre-hospital control	E	SE	SE	SE	SE	E	
Respiratory care	EED&EPI	EED&EPI	EF	EF	SE	E	
Pediatric Critical Care Committee	E	E				E	
Pediatric Trauma Committee	E					E	
Child development services	E					E	

Pediatric Emergency Care Facilities Licensure Survey

Chapter 0720-31 is being amended by deleting Table 1 in its entirety and replacing it with the following language, so that, as amended, the new Table 1 shall read:

Table 1 (Parts 1-6) provides a summary for emergency care facilities for each level of pediatric health care. Personnel, equipment, and issues that are essential at each designation or level are described as either being essential in the emergency department (EED), essential in the pediatric intensive care unit (EPI), essential within the facility (EF), essential in the facility and immediately available within 15 minutes (EFI), or promptly available (EP). An optional but strongly encouraged category (SE) is used to describe personnel, activities or issues that may be essential to network a comprehensive regionalized EMS-EMSC system in rural areas. Although these are not generally required of a specific facility, they are strongly encouraged if such services are not available within a reasonable distance. *

*Some services are usually available at a Comprehensive Regional Pediatric Center but, if not provided, then transfer agreements must be in place (ES). Other capabilities must be available in the pediatric intensive care units but should be promptly available to the emergency department and facility (EPI and EP).

0720-31 TABLE 1.

Table 1 (Parts 1-6) provides a summary for emergency care facilities for each level of pediatric health care. Personnel, equipment, and issues that are essential at each designation or level are described as either being essential in the emergency department (EED), essential in the pediatric intensive care unit (EPI), essential within the facility (EF), essential in the facility and immediately available within 15 minutes (EFI), or promptly available (EP). An optional but strongly encouraged category (SE) is used to describe personnel, activities or issues that may be essential to network a comprehensive regionalized EMS-EMSC system in rural areas. Although these are not generally required of a specific facility, they are strongly encouraged if such services are not available within a reasonable distance. *

*Some services are usually available at a Comprehensive Regional Pediatric Center but, if not provided, then transfer agreements must be in place (ES). Other capabilities must be available in the pediatric intensive care units but should be promptly available to the emergency department and facility (EPI and EP).

1. All medical specialists shall have pediatric expertise as evidenced by board certification, fellowship training, or demonstrated commitment and continuing medical education in their subspecialty area.

2. Forensic pathologist must be available either as part of the facility staff or on a consulting basis.

3. Medications may be exempted if the facility can demonstrate PALS recommendation changes, manufacturer recalls or shortages, or Food and Drug Administration requirement issues.

4. A resident in postgraduate year >3 or a pediatric emergency attending physician who is part of the trauma team may be approved to begin resuscitation while awaiting the arrival of the pediatric surgery attending/fellow, but cannot independently fulfill the responsibilities of, or substitute for, the pediatric surgery attending/fellow. The presence of such a resident or attending pediatric emergency physician may allow the surgery attending/fellow to take call from outside the facility.

5. This requirement can also be met by having one surgeon who is board certified or board eligible with demonstrated interest and skills in pediatric neurosurgical trauma care. This is evidenced by 12 hours of pediatric neurosurgical CMEs per year, of which 8 are pediatric trauma care.

6. The Vascular surgeon requirement may be provided by a pediatric trauma surgeon.