RULES
OF
THE TENNESSEE HEALTH FACILITIES COMMISSION

CHAPTER 0720-31
STANDARDS FOR PEDIATRIC EMERGENCY CARE FACILITIES

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0720-31-.01 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 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.

(Rule 0720-31-.01, continued)

(17) EFI. Essential in Facility and Immediately available within 15 minutes.

(18) EMS. Emergency Medical Services.

(19) EMSC. Emergency Medical Services for Children.

(20) ENPC. Emergency Nursing Pediatric Course.

(21) EP. Promptly available. 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 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 5) Comprehensive Regional Pediatric Center.

(Rule 0720-31-.01, continued)

(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 Pediatric Emergency Care 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. Available 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.

(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 with the level of trauma activation.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-251.* ***Administrative History:*** *Original rule filed November 30, 1999; effective February 6, 2000. Amendment filed October 15, 2002; effective December 29, 2002. Amendment filed August 16, 2006; effective October 30, 2006. Amendment filed December 4, 2007; effective February 17, 2008. Amendment filed March 27, 2015; effective June 25, 2015. Transferred from chapter 1200-08-30 pursuant to Public Chapter 1119 of 2022 effective July 1, 2022. Amendments filed July 10, 2025; effective October 8, 2025.*

0720-31-.02 LICENSING PROCEDURE.

(1) 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.

(Rule 0720-31-.02, continued)

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-251.* ***Administrative History:*** *Original rule filed November 30, 1999; effective February 6, 2000. Transferred from chapter 1200-08-30 pursuant to Public Chapter 1119 of 2022 effective July 1, 2022. Amendments filed July 10, 2025; effective October 8, 2025.*

0720-31-.03 ADMINISTRATION.

(1) The facility administration shall provide the following:

(a) 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:

1. Recognition, interpretation and recording of age-appropriate physiological variables;

2. Capable of managing pediatric shock and respiratory failure including early recognition and stabilization of problems that may lead to shock and respiratory failure;

3. Medication administration and fluid administration;

4. Resuscitation (including cardiopulmonary resuscitation certification and PALS or similar certification);

5. Respiratory care techniques;

6. Preparation and maintenance of patient monitors; and

7. Principles of patient and family centered care and psychosocial skills to meet the needs of both the patient and his/her family.

(b) A policy requiring annual pediatric multidisciplinary mock codes for staff caring for pediatric patients.

(c) 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. 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.

2. The physician and nurse PECCs may be concurrently assigned other roles in the ED 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.

3. PECC roles may be shared through formal agreements with administrative entities when applied within facility systems.

(Rule 0720-31-.03, continued)

(d) 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.

(e) Facilities designed for easy access and appropriate for the care of pediatric patients at the designated PECF classification.

(f) Access to emergency care for all urgent and emergent pediatric patients regardless of financial status.

(g) 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:

1. Guarantee transfer and transport agreements to include at least one CRPC, and

2. Refer critically ill patients to an appropriate facility.

(h) Basic, Primary, General, and General with a PICU facilities shall have one education agreement with a CRPC.

(i) A collaborative environment with EMS and EMSC systems to educate pre-hospital personnel, nurses and physicians.

(j) Collaboration with pre-hospital care and transport.

(k) Public education regarding access to pediatric emergency care, injury prevention, first aid and cardiopulmonary resuscitation.

(l) A QA and QI program in all areas that provide pediatric care that shall include, but is not limited, to the following indicators:

1. Deaths;

2. Incident reports;

3. Child abuse cases;

4. Cardiopulmonary or respiratory arrests;

5. Admissions within forty-eight (48) hours after being discharged from the emergency department;

6. Surgery within forty-eight (48) hours after being discharged from an emergency department;

7. Pediatric transfers;

8. Pediatric inpatient illness and injury outcome data;

9. Participation in a QI program in both a CRPC and a General Facility with a PICU which compares their PICU performance with PICUs of similar census and capabilities;

10. Program specific objectives for hospital pediatric readiness as defined by the current version of the U.S. Department of Health and Human Services' Health

(Rule 0720-31-.03, continued)

Resources and Services Administration's Maternal and Child Health Bureau's Emergency Medical Services for Children Program's National EMSC Performance Measures; and

11. 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.

(m) Resuscitation equipment and a metric weight-based medication resource are available in any area caring for a pediatric patient.

(2) In a Comprehensive Regional Pediatric Center, facility administration shall also:

(a) 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:

1. Provides transfer and transport agreements with other classifications of facilities;

2. Provides transport services when needed for receiving critically ill or injured patients within the regional network;

3. Provides necessary consultation to participating network facilities;

4. Organizes and implements a network of educational support that:

(i) Trains instructors to teach pediatric pre-hospital, nursing and physician-level emergency care;

(ii) Assures that training courses are available to all facilities and health care providers utilizing pediatric emergency care facilities within the region;

(iii) Supports EMS agencies and EMS Directors in maintaining a regional network of pre-hospital provider education and training;

(iv) Assures dissemination of new information and maintenance of pediatric emergency skills;

(v) Updates standards of care protocols for pediatric emergency care;

(vi) Assures that emergency departments and pediatric intensive care units within the facility shall participate in regional education for emergency medical service providers, emergency departments and the general public;

(vii) Provides public education and promotes patient and family centered care in relation to policies, programs and environments for children treated in emergency departments.

5. Assists in organizing and providing support for regional, state and national data collection efforts for EMSC that:

(i) Defines the population served;

(ii) Maintains and monitors pediatric specific quality indicators;

(iii) Includes injury and illness epidemiology;

(iv) Includes trauma/illness registry (this shall include severity, site, mechanism and classification of injury/illness, plus demographic information, outcomes and transport information);

(v) Is adaptable to answer questions for clinical research; and

(vi) Supports active institutional and collaborative regional and statewide research.

(b) Organize a structured QI program with the assistance and support of local/state EMS and EMSC programs that allows ongoing review and:

1. Reviews all issues and indicators described under all classifications of Pediatric Emergency Care Facilities emergency departments;

2. Provides feedback, quality review and information to all participating facilities, EMS and transport systems, and appropriate state agencies;

3. Develops quality indicators for the review of pediatric care which are linked to periodic continuing education and reviewed at all participating institutions;

4. Reviews all pediatric trauma and medical related morbidity and mortality, including those that are primary admitted patients versus secondary transferred patients; and

5. 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.

(c) Provide the following pediatric emergency department/trauma center personnel:

1. A physician on duty in the emergency department who is board eligible or board certified and meets the requirements of maintenance of certification in pediatric emergency medicine; or was a credentialed pediatric emergency medicine provider in Tennessee prior to the promulgation of these rules.

2. Physicians who are board eligible or board certified and meet the requirements of maintenance of certification, or who were credentialed providers in Tennessee prior to the promulgation of these rules in the following subspecialties: pediatric surgery, pediatric orthopedic surgery, neurosurgery and pediatric anesthesiology.

(i) 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 around the clock as determined by the patient’s acuity.

(ii) 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.

3. The CRPC shall also have other subspecialty trained surgical and medical providers who are board eligible or board certified and meet the requirements of maintenance of certification, or who were credentialed providers in Tennessee

(Rule 0720-31-.03, continued)

prior to the promulgation of these rules in their respective subspecialty as listed in Table 1.

4. Registered nurses with pediatric emergency, pediatric critical care or pediatric surgical experience as well as training in trauma care;

5. Laboratory personnel, a radiology technician and a respiratory therapist with pediatric experience;

6. Available support services to the emergency department as included in Table 1;

7. A CRPC Coordinator position whose responsibilities include, but are not limited to:

(i) Being a regional liaison and coordinator for the statewide EMSC project, including participation in CRPC Coordinator meetings quarterly;

(ii) Planning and providing educational activities to meet the needs of the emergency network facilities and pre-hospital providers;

(iii) Support of maintaining and updating the CRPC Pediatric Facility Notebook, which may be in electronic format;

(iv) Review and coordination of quality improvement indicators for emergency network facilities and pre-hospital providers;

(v) Attending a conference on pediatric emergency and/or critical care on a yearly basis;

(vi) 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

(vii) Utilizing data collected by the CRPC from pre-hospital and facility records to provide data for performance improvement, education and research.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-251.* ***Administrative History:*** *Original rule filed November 30, 1999; effective February 6, 2000. Amendment filed October 15, 2002; effective December 29, 2002. Amendment filed August 16, 2006; effective October 30, 2006. Amendment filed December 4, 2007; effective February 17, 2008. Transferred from chapter 1200-08-30 pursuant to Public Chapter 1119 of 2022 effective July 1, 2022. Amendments filed July 10, 2025; effective October 8, 2025.*

0720-31-.04 ADMISSIONS, DISCHARGES AND TRANSFERS.

(1) All levels of Pediatric Emergency Care Facilities shall:

(a) Be capable of providing appropriate triage, resuscitation, stabilization and, when appropriate, timely transfer of pediatric patients for a higher level of care;

(b) Be responsible for having appropriate transfer agreements to assure that all pediatric patients receive timely emergency care at the most appropriate pediatric facility available;

(Rule 0720-31-.04, continued)

(c) Have transfer agreements and transfer guidelines in accordance with the current Health Resources and Services Administration (HRSA) EMSC performance measures requirements;

(d) Have the ability to communicate with a Comprehensive Regional Pediatric Center for pediatric consultation; and

(e) Develop policies that describe safe transport and handoff of patients between all patient care areas of the facility and between other facilities.

(2) A Primary Pediatric Emergency Facility shall support 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.

(3) A General Pediatric Emergency Facility shall support the Basic and Primary Facilities within a region by having triage and transfer agreements to receive appropriate patients as a part of a regional pediatric care network.

(4) A General Pediatric Emergency Facility shall have a defined separate pediatric inpatient service with a department of pediatrics within the medical staff structure.

(5) A Comprehensive Regional Pediatric Center shall:

(a) Assist with the provision of regional pre-hospital indirect (off-line) and direct (on-line) medical control for pediatric patients.

(b) Promote a regional network of indirect and direct medical control by non-CRPC facilities within the region by working closely with the regional Emergency Medical Services medical directors to assure:

1. Standards for pre-hospital care;

2. Triage and transfer guidelines; and

3. Quality indicators for pre-hospital care.

(c) Accept all patients who require a higher level of care not available at non-CRPC facilities through:

1. 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

2. Prearranged transfer agreements for pediatric patients needing specialized care not available at the Comprehensive Regional Pediatric Center.

(d) Assure a pediatric transport service that:

1. Is available to all regional facilities;

2. 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

3. Transports children to the most appropriate facility in their region for emergency and trauma care. Local destination guidelines for EMS should assure that in

(Rule 0720-31-.04, continued)

regions with two (2) Comprehensive Regional Pediatric Centers, or one (1) Comprehensive Regional Pediatric Center and another facility with Level 1 Adult Trauma capability, seriously injured children are cared for in the facility most appropriate for their injuries.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-251.* ***Administrative History:*** *Original rule filed November 30, 1999; effective February 6, 2000. Transferred from chapter 1200-08-30 pursuant to Public Chapter 1119 of 2022 effective July 1, 2022. Amendments filed July 10, 2025; effective October 8, 2025.*

0720-31-.05 BASIC FUNCTIONS.

(1) Medical Services.

(a) 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 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.

(b) 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.

(c) 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 emergencies. ATLS certification is strongly encouraged.

(d) A CRPC and a PTC shall have an 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.

(Rule 0720-31-.05, continued)

(e) A CRPC and a PTC shall have twenty-four (24) hours ED coverage by physicians who are board eligible or board certified and meet the requirements of maintenance of certification in pediatric emergency medicine, or who were 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 certification status is strongly encouraged.

(f) 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 meet the requirements of maintenance of certification in pediatric critical care medicine or have been an existing medical director of a PICU prior to the promulgation of these rules.

(g) 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 meet the requirements of maintenance of certification in pediatric critical care medicine or have been a credentialed pediatric critical care provider in Tennessee prior to the promulgation of these rules.

(h) 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 describes unit experience and performance, supervise resuscitation techniques, lead quality improvement activities and coordinate research.

(i) 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.

(j) 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 as well as an in-house physician with a minimum of post graduate year level 3 training with current PALS certification and is approvedal by the PICU medical director and/or a mid-level practitioner credentialed by the institution to provide pediatric critical care services, who 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 per facility policies relevant to pediatric intensive care medicine.

(k) 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 were credentialed providers in their subspecialty in Tennessee prior to the promulgation of these rules in their respective subspecialty as listed in Table 1.

(2) Nursing Services.

(Rule 0720-31-.05, continued)

(a) 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.

(b) 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 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.

(c) 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.

(d) In a Comprehensive Regional Pediatric Center, administration shall provide a 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.

(e) 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.

(f) 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.

(g) 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.

(h) 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.

(3) Other Personnel.

(Rule 0720-31-.05, continued)

(a) 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.

(b) 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, occupational therapists, speech therapists, child life specialists, clergy and nutritionists/registered dieticians must be available.

(c) 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.

(4) Facility Structure and Equipment.

(a) 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.

(b) 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 organized and together in a location easily accessible and proximate to the emergency department.

(c) 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.

(5) Infection Control. A Pediatric Emergency Care Facility shall have an annual influenza vaccination program which shall include at least:

(a) 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;

(b) 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);

(c) Education of all employees about the following:

(Rule 0720-31-.05, continued)

1. Flu vaccination,

2. Non-vaccine control measures, and

3. The diagnosis, transmission, and potential impact of influenza;

(d) An annual evaluation of the influenza vaccination program and reasons for non-participation; and

(e) 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.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-206, 68-11-209, and 68-11-251.* ***Administrative History:*** *Original rule filed November 30, 1999; effective February 6, 2000. Amendment filed October 15, 2002; effective December 29, 2002. Amendment filed December 4, 2007; effective February 17, 2008. Amendments filed July 18, 2016; effective October 16, 2016. Transferred from chapter 1200-08-30 pursuant to Public Chapter 1119 of 2022 effective July 1, 2022. Amendments filed July 10, 2025; effective October 8, 2025.*

0720-31-.06 PEDIATRIC TRAUMA.

(1) A CRPC and a state designated pediatric trauma center shall have a pediatric trauma program with the following requirements:

(a) 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:

1. 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;

2. Participates in the physician call schedule;

3. Has the authority to manage all aspects of trauma care;

4. Authorizes trauma service privileges of the on-call providers;

5. Works in cooperation with nursing administration to support the nursing needs of trauma patients;

6. Develops treatment protocols along with the trauma team;

7. Coordinates performance improvement and peer review processes;

8. With the assistance of the facility administration and the trauma program coordinator, be involved in coordinating the budgetary process for the trauma program;

9. Participates in regional and national trauma organizations; and

10. Retains a current ATLS certification and participates in the provision of trauma-related instruction to other health care personnel.

(Rule 0720-31-.06, continued)

(b) 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.

(c) Shall be involved in local/regional EMS agencies/facilities and/or personnel and assist in trauma education, performance improvement, and feedback regarding care.

(d) A trauma program leader who shall:

1. Be an RN with experience in pediatric emergency and/or critical care nursing;

2. Have a defined job description and organizational chart delineating roles and responsibilities;

3. Be provided the administrative and budgetary support to complete educational, clinical, administrative and outreach activities for the trauma program; and

4. 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.

(e) Shall submit trauma registry data electronically to the state trauma registry on all closed patient files for the Board to analyze.

1. 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.

2. Shall have a full-time equivalent trauma registrar for each five hundred (500) through seven hundred fifty (750) trauma patients per year.

(f) 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.

(g) 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.

1. This committee shall assure participation in a pediatric trauma process improvement program with the following requirements and responsibilities:

(i) Administration shall provide resources to support the trauma process improvement program;

(ii) A performance improvement coordinator shall be designated with dedicated time for this responsibility;

(iii) The trauma registry shall be used to support the PIPS process;

(iv) Identify process and outcome measures;

(v) Have a morbidity and mortality review of trauma patients;

(vi) Maintain a trauma bypass/diversion log:

(I) Trauma bypass/diversion shall not exceed five percent (5%).

(II) Pediatric surgery on-call shall be involved in bypass/diversion decisions.

(III) All bypass/diversions shall be reviewed.

(vii) 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;

(viii) 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;

(ix) Review pre-hospital trauma care to include patients dead on arrival;

(x) Review times, reasons and appropriateness of care for transfer of injured patients;

(xi) 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;

(xii) 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.

(h) Shall have clearly defined graded activation criteria.

1. Criteria for the highest level of activation shall be clearly defined and evaluated by the pediatric trauma committee.

2. 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.

(i) Shall have an injury prevention program which:

1. Shall have an organized and effective approach to injury prevention and must prioritize those efforts based on trauma registry and epidemiologic data;

(Rule 0720-31-.06, continued)

2. 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;

3. Shall implement at least two programs that address one of the major causes of injury in the community; and

4. Shall screen for alcohol and drug abuse in admitted patients.

(j) 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 providers in Tennessee prior to the promulgation of these rules in their respective subspecialty as listed in Table 1.

(2) State Pediatric Trauma Center Designation

(a) The Board shall implement the designation process.

(b) The preliminary designation process for facilities aspiring for designation as a Pediatric Trauma Center shall consist of the following:

1. Each facility desiring designation shall submit an application to the Board;

2. A Department site visit team (“team”) shall review each submitted application and shall act in an advisory capacity to the Board;

3. The team shall communicate deemed application deficiencies to the facility in writing;

4. The facility shall have thirty (30) days to submit required information; and

5. Arrangements shall be made for a provisional site visit for those facilities meeting application requirements.

(c) The site visit team shall consist of the following for Pediatric Trauma Centers:

1. 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.

2. A pediatric trauma surgeon from an in-state pediatric trauma center.

3. An in-state pediatric trauma leader from a pediatric trauma center.

4. The state trauma program manager and/or state EMS director.

(d) The team shall be appointed by the state trauma system director and/or state trauma system assistant director.

(e) 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.

(f) The team shall identify deficiencies and areas for improvement it deems necessary for designation.

(g) 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.

(h) 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.

(i) Facilities granted provisional status as a Pediatric Trauma Center shall adhere to the following:

1. The facility shall be prepared to provide:

(i) A description of changes made after the grant of provisional status;

(ii) A description of areas of improvement cited during the provisional visit; and

(iii) A summary of the facility's trauma service based on the trauma registry report.

2. The team shall conduct a site visit at the termination of the applicant's one (1) year provisional designation as a Pediatric Trauma Center.

3. During the follow-up visit, the team shall identify the presence of deficiencies and areas of improvement.

(j) Upon completion of the follow-up visit, the team shall submit its findings and designation recommendation to the Board.

1. If the team cites deficiencies found during its follow-up visit, they shall be included in its report to the Board.

2. 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.

(k) 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.

(l) 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.

(m) The facility applying for Pediatric Trauma Center designation shall bear all costs of the application process, including the costs of a site visit.

(n) 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

(Rule 0720-31-.06, continued)

system assistant director for presentation to the Board if the facility seeks a reciprocal designation as a Pediatric Trauma Center.

(o) 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.

(3) State Pediatric Trauma Center Verification

(a) Following designation as a pediatric trauma center, a verification site visit shall be conducted at the facility every three (3) years.

(b) 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.

(c) The team shall conduct an exit interview with the facility at the conclusion of the verification visit.

(d) During the exit interview the team shall communicate the following:

1. The presence of deficiencies;

2. The facility's strengths and weaknesses; and

3. Recommendations for improvements and correction of deficiencies.

(e) 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).

(f) 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.

(g) If during the site visit the team identifies deficiencies, the center shall have a period not to exceed sixty (60) days to correct deficiencies.

(h) 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.

(i) The facility shall bear all costs of the verification process, including the costs of a site visit.

(j) 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 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

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to the Board if the facility seeks a reciprocal state designation as a Pediatric Trauma Center.

(4) State Pediatric Trauma Center Disciplinary Action

(a) 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.

(b) 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:

1. Fails to comply with the provisions of these rules;

2. 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;

3. Prevents, interferes with, or attempts to impede in any way, the work of a representative of the Board;

4. Falsely advertises or in any way misrepresents the facility's ability to care for patients based on its designation status;

5. Fails to provide reports required by the trauma registry or the Commission in a timely and complete fashion; or

6. Fails to comply with or complete a plan of correction in the time or manner specified.

(c) 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.

(5) State Pediatric Trauma Center Prohibitions

(a) 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.

(b) 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.

(c) 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.

Authority: *T.C.A. §§ 68-11-202, 68-11-209, and 68-11-251.* ***Administrative History:*** *New rule filed July 10, 2025; effective October 8, 2025.*

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] A 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 participate in the physician call schedule 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.

TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES						
Part 1/6	FACILITY DESIGNATION/LEVEL					
1. PERSONNEL	CRPC	General w/PICU	General	Primary	Basic	PTC
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		EED& EPI
Trauma program leader	E	SE				E
CRPC Coordinator	E					
Nurse educator	EED&EPI	EED&EPI	E	SE	SE	E
Trauma team	E	SE	SE	SE		E

(Rule 0720-31-Table 1, continued)

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
Pediatric Radiologist	EP	SE	SE	SE	SE	EP
Radiologist		EP	EP	EP	SE	
Anesthesiologist			EP	EP	SE	
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]
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					
2. EQUIPMENT AND SUPPLIES	CRPC	General w/ PICU	General	Primary	Basic	PTC
EMS communication equipment	E	E	E	E	E	E
Organized emergency cart	EED&EPI	EED&EPI	EED	EED	EED	EED
A length based resuscitation tape and precalculated pediatric drug dosing reference in	EED&EPI	EED&EPI	EED	EED	EED	EED

(Rule 0720-31-Table 1, continued)

mg and mL						
Tourniquets for hemorrhage control	EED	EED	EED	EED	EED	EED
Ultrasound for performing FAST examination						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	EF	EF	EED& EPI
Otoscope, ophthalmoscope, stethoscope	EED&EPI	EED&EPI	EED	EED	EED	EED& EPI
Cardiopulmonary monitor and defibrillator with 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		EED& EPI
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&E PI
Monitor for intracranial pressure	EPI					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& 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
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

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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			EED& EPI
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	SE	SE	EED& EPI
Vascular access supplies						
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
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	EF	EED& EPI
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					EED& EPI
Obstetrical Kit	EED	EED	EED	EED	EED	EED
Thoracotomy Tray	EF					EF
Pediatric Pericardiocentesis Tray	EF					EF
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

(Rule 0720-31-Table 1, continued)

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)	EED	EED&EPI	EED	EED	EED	EED
Cyanide kit and pediatric doses	EED	EF	EF	SE	SE	EED
Dantrolene	EF	EF	EF	EF	EF	EF
Dextrose – 10% and 25%	EED&EPI	EED&EPI	EED	EED	EED	EED& EPI
Digoxin antibody	EF	EF	EF	EF	SE	EF
Diphenhydramine	EED	EED	EED	EED	EF	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	EF	EF	EF	EF	EF	EF
Furosemide	EED&EPI	EED&EPI	EED	EED	EF	EED& EPI
Glucagon	EED	EED	EED	EED		EED
Hypertonic 3% sodium chloride IV solution	EED&EPI	EED&EPI	EF	EF	EF	EED& EPI
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
Ketamine	EED&EPI	EED&EPI	EED	EED	EF	EED& EPI
Magnesium sulfate	EED&EPI	EED&EPI	EED	EF	EF	EED& EPI
Mannitol-20%	EED&EPI	EED&EPI	EF	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
Potassium chloride	EF	EF	EF	EF	EF	EF
Prostaglandin	EF	EF	EF	EF		EF
Sodium bicarbonate 4.2% and 8.4%	EED&EPI	EED&EPI	EED	EED	EED	EF
Succinylcholine	EED	EED	EED	EF		EF
Whole bowel irrigation solution	EF	EF	EF	EF		EF
Medication classes						
Analgesics	EED	EED	EED	EF	EF	EED
Antibiotics	EED	EED	EED	EED	EF	EED
Anticonvulsants	EED&EPI	EED&EPI	EED	EED	EED	EED& EPI
Antihypertensive agents	EED	EED	EED	EF	EF	EED
Antipyretics	EED	EED	EED	EED	EF	EED
PALS and ACLS medications	EED&EPI	EED&EPI	EED	EED	EED	EED& EPI

(Rule 0720-31-Table 1, continued)

Chelating agents for heavy metal poisonings	EF	EF				EF
Nondepolarizing neuromuscular blocking agents	EED	EED	EED	EED	EED	EED
Rapid sequence intubation medications	EED&EPI	EED&EPI	EED	EF	EED	EED& EPI
Sedatives and antianxiety medications	EED&EPI	EED&EPI	EED	EF	EF	EED& EPI
Miscellaneous						
Resuscitation board	EED&EPI	EED&EPI	EED	EED	EED	EED& EPI
Infant and child scale (measure in kg only)	EED&EPI	EED&EPI	EED	EED	EED	EED& EPI
Heating source (for infant warming)	EED&EPI	EED&EPI	EED	EED	EED	EED& EPI
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
Pacemaker capability	EF	EF	EF			EF
Thermal control for patient and/or resuscitation room	EED	EED	EED	EED		EED

Part 3/6	FACILITY DESIGNATION/LEVEL					
3. FACILITIES	CRPC	General w/ PICU	General	Primary	Basic	PTC
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
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
Operating room, dedicated to the trauma service, with adequate staff in-house and immediately available 24 hours a day						E
Second operating room available and staffed within 30 minutes	E					E
Thermal control equipment	E	E	E			E
X-ray capability, including C-arm	E	E	E			E
Endoscopes, all varieties	E					E
Craniotomy equipment, including ICP monitoring equipment	E					E
Invasive and noninvasive monitoring equipment	E	E	E			E
Pediatric anesthesia and ventilation equipment	E	E	E			E
Pediatric airway control equipment	E	E	E			E

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Defibrillator, monitor, including internal and external paddles	E	E	E			E
Laparotomy tray	E	E	E			E
A rapid volume infuser for the utilization of transfusion protocol						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
Precalulated pediatric drug dosing reference in mg and mL	E	E	E	E	E	E
Tracheostomy tubes, neonatal through adolescent	E	E	E			E
Anesthesia and surgical suite promptly available	EP	EP	EP	SE		
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
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
Staff competent in the post-anesthesia care of the pediatric pt.	E	E	E	E*		E
Airway equipment	E	E	E	E*		E
Pressure monitoring capability	E	E	E	E*		E
Thermal control equipment	E	E	E	E*		E
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
E* If surgery performed on pediatric patients						
Laboratory Services						
Hematology	E	E	E	E	E	E
Chemistry	E	E	E	E	E	E

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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 developed collaboratively between the trauma service and the blood bank (i.e. MTP)						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
Fluoroscopy/contrast studies 24 hours per day	E	E	E	SE		E
Angiography 24 hours per day	E	E	E	SE		E
Interventional Radiology Services						E
Other						
Pediatric Echocardiography	EP	EP				EP
Pediatric Cardiac Catheterization *	E					E
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

Part 4/6	FACILITY DESIGNATION/LEVEL					
4. ACCESS, TRIAGE, TRANSFER AND TRANSPORT	CRPC	General w/ PICU	General	Primary	Basic	PTC
Support of medical control	E	E	E	SE	SE	E
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

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Part 5/6	FACILITY DESIGNATION/LEVEL					
5. EDUCATION, TRAINING, RESEARCH, and QUALITY ASSESSMENT and IMPROVEMENT	CRPC	General w/ PICU	General	Primary	Basic	PTC
Education and Training						
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
CPR certification for ED nurses and RTs	E	E	E	E	E	E
Multidisciplinary resuscitation simulation with physician engagement	E	E	E	E	E	E
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
Network educational resources for training all levels of health professionals	E	SE	SE			E
Research						
Support state EMSC research efforts and data collection	E	E	E	E	E	E
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					
6. ADMINISTRATIVE SUPPORT and FACILITY COMMITMENT	CRPC	General w/ PICU	General	Primary	Basic	PTC
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
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 abuse support services	EP	EP	EP	EP		E

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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

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