CoPEC Standards Committee
Williamson County EOC, Classroom 134

September 20, 2017
10 a.m. – 3 p.m. CST

Present: Deena Kail, Michele Walsh, Lee Blair, Miguel Rodriguez, Yvette Devaughn, Seth Brown, Amanda Yarber, Ben Welch, Christy Cooper, Amber Greeno, Kate Copeland, Maureen O'Connor, Brad Strohler, Chris Clarke, Patty Anderson, Ann Rutherford Reed, Marisa Moyers, Joel Dishroon, Debe Newton, Oseana Bratton, James Tabor, Anissa Revels, Rob Seesholtz, John Wright, Kevin Brinkmann, Rhonda Phillippi, Samir Shah, Rich Wendorf, Cristina Estrada

The CoPEC Standards Committee reviewed the draft of Standards for Pediatric Emergency Care Facility Rules. Proposed changes to the rules were made as noted below.

Ms. Patricia Anderson, RN, chief Nursing Office at Riverview Regional Medical Center gave a presentation during the meeting. Further data is being requested by the CoPEC Standards Committee to further review the current proposed PECF Rule change regarding Basic Facilities admitting pediatric patients. Data to be presented at the next CoPEC Meeting.

Approved: 11 December 2017

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OF
THE TENNESSEE DEPARTMENT OF HEALTH BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-08-30
STANDARDS FOR PEDIATRIC EMERGENCY CARE

FACILITIES TABLE OF CONTENTS

1200-08-30-.01 DEFINITIONS.

(1) Abuse. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish

(2) ACLS. Advanced Cardiac Life Support.

(3) ALARA. As Low as Reasonably Achievable

(4) APLS. Advanced Pediatric Life Support.

(5) 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. A basic facility shall not admit a pediatric patient to inpatient admission status or observation status outside the emergency department.

(6) Board. Board for Licensing Health Care Facilities.

(7) CoPEC. Committee on Pediatric Emergency Care.

(8) 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 including but not limited to a dedicated 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.

(9) CPR. Cardiopulmonary Resuscitation.

(10) DNR. Do-Not-Resuscitate order A written order, other than a Physician Orders for Scope of Treatment (POST), not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(11) E. Essential.

(12) ECG. Electrocardiogram.

(13) ED. Emergency Department.

(14) EED. Essential in Emergency Department.

(15) EH. Essential in Hospital.

(16) EMS. Emergency Medical Service.

(17) EMSC. Emergency Medical Service for Children.
(REMOVE SPACE)

Add Advanced Practice Clinician

(18) ENPC. Emergency Nursing Pediatric Course.

(19) EP. Promptly available within 30 minutes

(20) EPI. Essential in Pediatric Intensive Care Unit.

(21) ES. Essential if service not provided at hospital.

(22) General Pediatric Emergency 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.

(23) General Pediatric Emergency Facility with a Pediatric Intensive Care Unit. A facility that meets the requirements of a General Pediatric Emergency Facility and has a dedicated Pediatric Intensive Care Unit meeting the requirements defined herein. The facility may accept appropriate referrals of pediatric patients. ~~from Basic, Primary, and General Pediatric Emergency Facilities as part of prearranged transfer and transport agreements~~

(24) ICP. Intracranial Pressure.

(25) IM. Intramuscular.

(26) IV. Intravenous.

(27) Misappropriation of patient/resident property. The deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(28) Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(29) OR. Operating Room.

(30) Advanced Practice Provider (APP) means a health care professional such as a registered nurse practitioner or a physician assistant.

(31) PALS. Pediatric Advanced Life Support.

(32) PECF. Pediatric Emergency Care Facilities. Hospital facilities that provide emergency 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

(Rule 1200-08-30-.01,

Emergency Facility with Pediatric Intensive Care Unit, 5) Comprehensive Regional Pediatric Center.

(33) Physician. A person currently licensed as such by the Tennessee Board of Medical Examiners or currently licensed by the Tennessee Board of Osteopathic Examination.

(34)

(35) PICU/ 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 with a PICU or Comprehensive Regional Pediatric Emergency Care Facility.

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 or observations.

(36) QA. Quality Assessment.

(37) QI. Quality Improvement.

(38) RA. Readily available is defined as within one hour

(39) RN. Registered Nurse.

RT. Licensed Respiratory Therapist

(40) SE. Strongly encouraged.

(41) Trauma. A physical injury or wound caused by external force.

(42) Trauma Registry. A central registry compiled of injury incidence information supplied by designated trauma centers and Comprehensive Regional Pediatric Centers (CRPCs)

(43) TRACS. Trauma Registry of American College of Surgeons.

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.

1200-08-30-.02 LICENSING PROCEDURE.

(Rule 1200-08-30-.01,

(1) The hospital 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 to the level at which it provides service and will be surveyed at that level.

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.*

1200-08-30-.03 ADMINISTRATION.

(1) The hospital administration shall provide the following:

(a) Adequate and properly trained personnel to provide the services expected at the designated Pediatric Emergency Care Facility (PECF) classification. All personnel caring for pediatric patients shall annually attend or participate in pediatric continuing education. This includes the identification of both a Physician Pediatric Care Coordinator and a Nurse Pediatric Care Coordinator responsible for assuring readiness of staff and facility to provide emergency services to children at the facility's designated level of care.

(b)

(c) 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.

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

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

(f) 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;

2. refer seriously and critically ill patients and special needs patients to an appropriate facility; and

3. assure the support of agreements to receive or transfer appropriate patients.

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

4.

(g) A collaborative environment with the Emergency Medical Services (EMS) and Emergency Medical Services for Children (EMSC) systems to educate pre-hospital personnel, nurses and physicians.

(h) Participation in data collection to assure that the quality indicators determined by CoPEC are monitored, and make data available to a central data monitoring agency as defined by CoPEC.

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

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

1. All Pediatric Emergency Care Facilities shall aassure a QI program in all areas that provide pediatric care as a component of the overall hospital quality assessment performance improvement process. . These shall include but are not limited to:
   a. collaborative morbidity and mortality review,
   b. utilization review,
   c. medical records review,
   d. discharge criteria
   e. planning and safety review.
   f. deaths;
   g. incident reports;
   h. child abuse cases;
   i. cardiac and/or respiratory arrests;
   j. admissions or surgerieswithin 48 hours after being discharged from the emergency department.;
   k. quality indicators as reasonably requested by CoPEC or EMSC program.pediatric transferspediatric inpatient and observation status, illness and injury outcome datapediatric admissions to non-pediatric ICUs
   j. inpatient admissions of children with special healthcare needs, chronic illnesses and disabilities.

i. CRPC and General Facilities with a PICU shall participate in a QI program which compares their PICU

performance with similar PICUs.

b. 1. All Pediatric Emergency Care Facilities shall assure that staff is trained and can demonstrate competency in patient care delivery appropriate for the area in which they practice to include but not limited to the following required pediatric skills: recognition, interpretation and recording of various physiological variables, drug administration, fluid administration, resuscitation (including cardiopulmonary resuscitation certification), respiratory care techniques, preparation and maintenance of patient monitors, principles of family-centered care and psychosocial skills to meet the needs of both the patient and his/herfamily.

c. In a Comprehensive Regional Pediatric Center, hospital administration shall also:

d. 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:

i. provides transfer and transport agreements with other classifications of facilities;

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

iii. provides necessary consultation to participating network hospitals;

iv. provides indirect (off-line) consultation, support and education to regional pre- hospital systems and supports the efforts of regional and state pre-hospital committees;

v. provides medical support to assure quality direct (on-line) medical control for all pre-hospital systems within the region;

vi. organizes and implements a network of educational support that:

1. trains instructors to teach pediatric pre-hospital, nursing and physician- level emergency care;

2. assures that training courses are available to all hospitals and health care providers utilizing pediatric emergency care facilities within the region;

3. supports EMS agencies and EMSDirectors in maintaining a regional network of pre-hospital provider education and training;

4. assures dissemination of new information and maintenance of pediatric emergency skills;

5. updates standards of care protocols for pediatric emergency care;

6. assures that emergency departments and pediatric intensive care units within the hospital shall participate in regional education for emergency medical service providers, emergency departments and the general public;

7. provides public education and promotes family-centered care in relation to policies, programs and environments for children treated in emergency departments.

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

1. defines the population served;

2. maintains and monitors pediatric specific quality indicators;

3. includes injury and illness epidemiology;

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

e. Each CRPC shall submit TraumaRegistry data electronically to the state trauma registry on all closed patient files at least quarterly for CoPEC and/or the Board to analyze.

a. 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. is adaptable to answer questions for clinical research; and

3. supports active institutional and collaborative regionaland statewide research.

f. Organize a structured QI program with the assistance and support of local/state EMS and the EMSC program that allows ongoing review and:

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

ii. provides feedback, quality review and information to all participating hospitals, EMS and transport systems, and appropriate state agencies;

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

iv. reviews all pediatric trauma and medical related morbidity and mortality including those that are primary admitted patients versus secondary transferred patients. 2

v. evaluates the emergency services provided for children with an emphasis on family- centered philosophy of care, family participation in care, family support during emergency visits, transfers, family information and decision-making.

g. Have an organized trauma training program by and for staff physicians, nurses, allied health personnel, community physicians and pre-hospital providers;

h. Have an organized organ donation protocol with Tennessee Donor Services to identify possible organ donors and assist in procuring for donation, consistent with state and federal law in addition to an annual review of donation rates;

i. Establish within its organization a defined pediatric trauma program for the injured child. The pediatric trauma medical director shall be a pediatric surgeon, board certified/board eligible in pediatric surgery, with demonstrated competenc in care of the injured child. The director shall have full responsibility and authority for the pediatric trauma program.

j. Provide the following pediatric emergency department/traumapersonnel:

i. a A physician on duty in the emergency department who is (1) board eligible or board-certified and meeting the requirements of maintenance of certification in pediatric emergency medicine; (2) or is a credentialed pediatric emergency medicine provider in Tennessee prior to the promulgation of these rules.

ii. Physicians who are (1) board eligible or board certified and meeting the requirements of maintenance of certification, (2) or who are credentialed providers in Tennessee prior to the promulgation of these rules in the following subspecialties: pediatric surgery, pediatric orthopedic surgery, neurosurgery and pediatric anesthesiology.

1. These physicians shall be readily available to the emergency department 24 hours per day, 7 days per week and shall also be promptly available during this same time as determined by the patient's acuity.
2. 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.

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

iv. The CRPC shall also have other pediatric subspecialty trained surgical and medical providers who are (1) board

eligible or board certified and meeting the requirements of maintenance of certification, (2) or who are credentialed providers in Tennessee prior to the promulgation of these rules in their respective subspecialty as listed in Table 1.

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

vi. a computer tomography technician in-house

vii. available support services to the emergency department to as included in table x

viii. a pediatric physician coordinator and pediatric nursing coordinator who is responsible for coordination of all levels of pediatric trauma/emergency activity including data collection, QI, nursing education and may include case management;

(Rule 1200-08-30-.03, continued)

ix. the pediatric trauma committee chaired by the director of the pediatric trauma program with representation from pediatric surgery, pediatric emergency medicine, pediatric critical care, neurosurgery, anesthesia, radiology, orthopedics, pathology, respiratory therapy, nursing and rehabilitation therapy. This committee shall assure participation in a pediatric process improvement. There must be documentation of the subject matter discussed and attendance at all committee meetings. Periodic review should include mortality and morbidity, mechanism of injury, review of the EMS system locally and regionally, specific care review, trauma system review, and identification and solution of specific problems including organ procurement and donation;

x. a full-time equivalent trauma registrar for each 500-750 trauma patients per year is required to assure high-quality data collection.

xi. a CRPC coordinator position whose responsibilities include:

1. being a regional liaison and coordinator with the statewide EMSC project;

2. planning and providing educational activities to meet the needs of the emergency network hospitals and pre-hospital providers;

3. maintaining and updating the CRPC Pediatric Facility Notebook, which may be in electronic format.

4. Review and coordination of quality improvement indicators for emergency network hospitals and pre-hospital providers

k. Assure that resuscitation equipment and a metric weight-based medication resource are available in any area caring for a pediatric patient.

l.

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.

1200-08-30-.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. are

(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.

(c) Have transfer agreements and transfer guidelines for all levels of Pediatric Emergency Care Facilities in accordance with the current HRSA performance measures requirements.

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

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

(2)

(3) A Comprehensive Regional Pediatric Center shall:

(a) Assist with the provision of regional pre-hospital direct medical control for pediatric patients.

(Rule 1200-08-30-.04, continued)

(b) Promote a regional network of direct medical control by non-CRPC hospitals within the region by working closely with the EMS 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 hospitals;

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 regions with 2 Comprehensive Regional Pediatric Centers, or 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.

(e)

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.

1200-08-30-.05 Essential Functions.

(1) Medical Services.

(Rule 1200-08-30-.05, continued)

(a) In a Basic Pediatric Emergency Facility an on-call physician shall be promptly available and provide direction for the emergency department nursing staff. The 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 (intubation, needle thoracostomy), vascular access skills (including intraosseous needle insertion), 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. Documentation of current expiration date for the above courses shall be maintained by the facility and available upon request.

(b) A Primary Pediatric Emergency Facility shall have an emergency physician in-house 24 hours per day, 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 (intubation, needle thoracostomy), vascular access skills (including intraosseous needle insertion), 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 pediatrician or family practitioner, general surgeon with trauma experience, anesthetist/anesthesiologist, and radiologist shall be promptly available 24 hours per day. Documentation of current expiration date for the above courses shall be maintained by the facility and available upon request.

A General Pediatric Emergency Facility shall have an emergency physician in the emergency department 24 hours per day, 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 (intubation, needle thoracostomy), vascular access skills (including intraosseous needle insertion), and be able to perform a thorough 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 General Pediatric Emergency Facility shall have a physician director who is board certified in an appropriate primary care board. 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

(c)

(d) In a Comprehensive Regional Pediatric Center, the emergency department medical director shall be board certified/board eligiblein pediatric emergency medicine. A record of the appointment and acceptance shall be in writing.

i. A Comprehensive Regional Pediatric Center shall have 24 hours ED coverage by physicians who are (1) board eligible or board certified and

meeting (not meets) the requirements of maintenance of certification in pediatric emergency medicine, (2) or is a credentialed pediatric emergency medicine provider 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 maintain ATLS certification

(e) In a Comprehensive Regional Pediatric Center and General Pediatric Emergency Facility with a pediatric intensive care unit, there shall be an appointed medical director. A record of the appointment and acceptance shall be in writing. The medical director of pediatric intensive care unit shall (1) have a minimum of 3 years experience as an attending in pediatric critical care and shall be board-certified and meeting the requirements of maintenance of certification in pediatric critical care medicine; (2)or be an existing medical director of a PICU prior to the promulgation of these rules.

(f) In a Comprehensive Regional Pediatric Center and General Pediatric Emergency Facility with a pediatric intensive care unit, pediatric ICU physicians shall be credentialed by the facility to practice pediatric critical care medicine and meet one of the following criteria: (1) board eligible or board-certified and meeting the requirements of maintenance of certification in pediatric critical care medicine; (2) or be a credentialed pediatric critical care provider in Tennessee prior to the promulgation of these rules.

- In a CRPC or a General Facility with a PICU, the pediatric intensive care unit medical director 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, and coordinate QI activities, performance improvement activities, and morbidity and mortality reviews..

- In a CRPC or a 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.

- The CRPC and General Facility with a pediatric intensive care unit shall have at least one pediatric critical care physician promptly available to the pediatric intensive care unit 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 PICU Medical Director and/or an Advanced Practice Clinician credentialed by the institution to provide pediatric critical care services, is PALS trained, and is approved by PICU Medical DirectorAll providers in pediatric critical care shall participate in continuing medical education activities as per hospital policies relevant to pediatric intensive care medicine.

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ii. The CRPC shall have pediatric subspecialty trained surgical and medical providers readily available who are (1) board eligible or board certified and meeting the requirements of maintenance of certification in their subspecialty, (2) 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.

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(2) Nursing Services.

(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, electronic means.Follow-up visits shall be arranged or recommended with the primary care provider whenever necessary.

(b) In Basic, Primary or General 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 shock and respiratory failure and stabilizing pediatric trauma 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. Documentation of current expiration date for the above courses shall be maintained by the facility and available upon request.

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(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 an RN for ongoing staff pediatric education.

(d) A Comprehensive Regional Pediatric Center shall have a pediatric emergency department director/manager and a registered nurse responsible for ongoing staff education.

(e) In a Comprehensive Regional Pediatric Center nursing administration shall provide nursing staff experienced in pediatric emergency and trauma nursing care.

(f) In a Comprehensive Regional Pediatric Center, or a General Facility with a PICU, nursing administration shall provide nursing leadership dedicated to the pediatric intensive care unit. The nurse leader 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 of research, family-centered care, QI, and budget preparation in collaboration with the pediatric intensive care medical director. The nurse leader shall name qualified substitutes to fulfill his or her duties during absences.

(g) In a Comprehensive Regional Pediatric Center, or a General Facility with a PICU, nursing 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, nursing 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. Nursing administration shall assure staff competency in pediatric emergency care and intensive care.

(3) Other Personnel.

(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 training of staff, maintaining equipment and monitoring QIand 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 24 hours per day and shall be Pediatric Advanced Life Support certified.

(b) In a Comprehensive Regional Pediatric Center, or a General Facility with a PICU, biomedical technicians shall be available within 1 hour, 24 hours per day. Unit secretaries (clerks) shall be available to the pediatric intensive care unit and emergency department 24 hours per day. A radiology technician and pharmacist

must be in-house 24 hours per day. In addition, social workers, case managers, physical , occupational and speech therapists and nutritionists, child life specialists and clergy must be available.

(c) In all PECF, the radiology department should have the skills and capability to provide imaging studies of pediatric patients and have the equipment necessary to do so. They must have guidelines for reducing radiation exposure that are age and size specific in accordance with ALARA or current American College of Radiology guidelines.

(d)

(4) Facient.

(a) A General Pediatric Emergency Facility shall have access to a pediatric intensive care unit. This requirement shall be fulfilled by having transfer and transport agreements available for moving critically ill or injured patients to a facility with a PICU.. In addition, a General Facility with a PICU shall have a transfer and transport agreements with a CRPC.

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(b) A Comprehensive Regional Pediatric Center shall be qualified and competent as a pediatric trauma center, and satisfy the requirements in Table 1. A CRPC may fulfill this requirement by having written agreements with another CRPC that meets the State's criteria for level I trauma or an Adult Level I trauma center within the same region.

(c) 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.

(d) 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.

(e) 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. A pediatric intensive care unit must be available within the institution.

(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:

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

(Rule 1200-08-30-.05,
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, 68-11-209, 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.

Table 1 (Parts 1-7) 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 hospital (EH), 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 hospital, 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 hospital (EPI and EP).

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

[2] Or substituted by a current signed transfer agreement with an institution with cardiothoracic surgery and cardiopulmonary bypass capability.

[3] Forensic pathologist must be available either as part of the hospital staff or on a consulting basis.

[4] Resuscitative medications may be exempted if the hospital can demonstrate PALS recommendation changes, manufacturer recalls or shortages, or Food and Drug Administration requirement issues.

(Rule 1200-08-30-Table 1,

TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES					
Part 1/7		FACILITY DESIGNATION/LEVEL			
1. PERSONNEL	CRPC	General with PICU	General	Primary	Basic
Physician with pediatric emergency care experience	EED	EED	EED	EED	EP
RN with pediatric training	EED & EPI	EED & EPI	EED	EED	EED
Respiratory therapist	EED &EPI	EED & EPI	EH	EH	
Trauma coordinator	E	SE			
CRPC Coordinator	E				
Nurse educator	EED & EPI	EED & EPI	E	SE	SE
Trauma team need to add definition	E	SE	SE	SE	
Physician Pediatric Care Coordinator	EED	EED	EED	EED	EED
Nursing Pediatric Care Coordinator	EED	EED	EED	EED	EED
Specialist consultants * [1]					
Pediatrician	EP	EP	EP	SE	SE
Pediatric Radiologist add another line for radiologist primary	EP	SE	SE	SE	SE
Radiologist		EP	EP	EP	SE
Anesthesiologist	EP	EP	EP	EP	SE
Pediatric Cardiologist	EP	EP			
Pediatric Critical Care Physician	EP	EP			
Nephrologist	EP	SE			
Hematologist/Oncologist	EP	SE			
Endocrinologist	EP	SE			
Gastroenterologist	EP	SE			
Neurologist	EP	SE			
Pulmonologist	EP	SE			
Psychiatrist/Psychologist	EP	SE			
Infectious Disease Physician	EP	SE			
Surgical specialists					
General surgeon			EP	EP	SE
Pediatric surgeon	EP	EP	SE		
Neurosurgeon	EP	EP	SE		
Orthopedic surgeon	EP	E	SE	SE	
Otolaryngologist	EP	EP			
Urologist	EP				
Plastic surgeon	EP				
Oral/Maxillofacial surgeon	EP				
Gynecologist	EP				
Microvascular surgeon	EP				
Hand surgeon	EP				
Ophthalmologist	EP	E			
Cardiac surgeon	EP				
Pathologist	EP	E			
Physical Medicine/Rehabilitation physician Add Vascular	E				
Rehabilitation Program					
Physical Therapy	E	E			
Occupational Therapy	E	E			
Speech Therapy	E	E			
School Education Program	E				

(Rule 1200-08-30-Table 1,

	TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES				
Part 2/7		FACILITY DESIGNATION/LEVEL			
2. EQUIPMENT	CRPC	General with PICU	General	Primary	Basic
EMS communication equipment	E	E	E	E	E

Organized emergency cart	EED&EPI	EED&EPI	EED	EED	EED
Pre-calcuated drug dosing reference mg and ml doses/tape	EED&EPI	EED&EPI	EED	EED	EED
Monitoring devices					
Pulse oximeter (adult/pediatric probes)	EED&EPI	EED&EPI	EED	EH	EH
Blood pressure cuffs (infant, child, adult, thigh)	EED&EPI	EED&EPI	EED	EED	EED
Rectal thermometer probe	EED&EPI	EED&EPI	EED	EH	EH
Otoscope, ophthalmoscope, stethoscope	EED&EPI	EED&EPI	EED	EED	EED
Cardiopulmonary monitor and defibrillator with pediatric paddles or pads and hard copy capability, visible/audible alarms,	EED&EPI	EED&EPI	EED	EED	EH
NonInvasive blood pressure monitoring (infant, child, adult)	EED&EPI	EED&EPI	EED	EH	EH
End tidal CO2 detector both neonate and child	& EPI	EED&EPI	EED	EED	EED
End tidal CO2 monitor	EED&EPI	EED&EPI	EED	EED	EED
Monitor for central venous pressure, arterial lines, temperature	EH&EPI	EH&EPI			
Monitor -lintracranial pressure	EPI				
Transportable monitor	EED&EPI	EED&EPI	EED	EH	EH
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
Oxygen delivery device with flow meter	EED&EPI	EED&EPI	EED	EED	EED
Clear oxygen masks, standard and non-rebreathing (neonatal to adult size)	EED&EPI	EED&EPI	EED	EED	EED
Nasal cannula (infant, child, adult)	EED&EPI	EED&EPI	EED	EED	EED
PEEP valve	EED&EPI	EED&EPI	EED		
Suction devices-catheters 6-14 fr, yankauer-tip/suction equipment	EED&EPI	EED&EPI	EED	EED	EED
Nasal airways (infant, child, adult)	EED&EPI	EED&EPI	EED	EED	EED
Nasogastric tubes (sizes 6-16 fr)	EED&EPI	EED&EPI	EED	EED	EED
Laryngoscope handle and blades:					
- curved 2,3, 4	EED&EPI	EED&EPI	EED	EED	EED
- straight or Miller 0,1,, 2,3	EED&EPI	EED&EPI	EED	EED	EED
Endotracheal tubes:					
2.5 -9	EED&EPI	EED&EPI	EED	EED	EED
	EED&EPI	EED&EPI	EED	EED	EED
Stylets for endotracheal tubes (pediatric, adult)	EED&EPI	EED&EPI	EED	EED	EED
Lubricant, water soluble	EED&EPI	EED&EPI	EED	EED	EED
Magill forceps (pediatric, adult)	EED&EPI	EED&EPI	EED	EED	EED
Spirometers, chest physiotherapy	EH	EH	EH	EH	
Continuous oxygen analyzers with alarms	EED&EPI	EED&EPI			
Inhalation therapy equipment	EED & EPI	EED&EPI	EED	EED	EED
Tracheostomy tubes (sizes 3.0 – 8 mm)	EH	EH	EH	EH	
Nasal atomizer EED all levels		EED			
Pediatric endoscopes and bronchoscopes available	EH	EH	EH		
Respired gas humidifiers - available look into this?	EH move to surgery equipment				
Pediatric ventilators conventional separate line add HFOV just epi	EED & EPI	EED&EPI	EH		
Difficult airway kit define at beginning	EED&EPI	EED&EPI	EED	SE	SE
Vascular access supplies					
Arm boards (infant, child, and adult sizes)	EED&EPI	EED&EPI	EED	EED	EED
Catheters for intravenous lines (16-24 gauge)	EED&EPI	EED&EPI	EED	EED	EED
Needles (18-27 gauge)	EED&EPI	EED&EPI	EED	EED	EED
Intraosseous needles 15 and 18 gauge	EED&EPI	EED&EPI	EED	EED	EED
Umbilical vessel catheters (3,5 fr) and cannulation tray	EED	EED	EED	EH	SE
IV administration sets and extension tubing, stopcocks,leur to leur connectors and T-connectors	EED&EPI	EED&EPI	EED	EED	EED
Ultrasound machine vas acc	EED&EPI	EED&EPI			

Infusion device able to regulate rate and volume of infusate	EED&EPI	EED&EPI	EED	EED	EED
Move to medication Isotonic balanced salt solution and D[5[NSnormal	EED&EPI	EED&EPI	EED	EED	EED
Central venous access utilizing Seldinger technique (4-7 fr)	EED&EPI	EED&EPI	EED		
IV fluid/blood warmer	EED&EPI	EED&EPI	EED	EH	SE
Blood gas kit	EED &EPI	EED&EPI	EED	EH	SE
Rapid infusion device	EED&EPI	EED&EPI	EH	SE	SE

TABLE 1. PEDIATRIC EMERGENCYCARE FACILITIES					
Part 3/7		FACILITY DESIGNATION/LEVEL			
2. EQUIPMENT AND SUPPLIES (Cont.)	CRPC	General with PICU	General	Primary	Basic
Specialized pediatric trays					
Lumbar puncture	EED&EPI	EED&EPI	EED	EED	EH
Urinary catheterization: Foley 6-14 fr	EED&EPI	EED&EPI	EED	EED	EED
Thoracostomy tray with chest tube sizes 10-28 fr	EED&EPI	EED&EPI	EED	SE	
Needle cricothyrotomy set move with airway will be in diff airway kit	EED&EPI	EED&EPI	EED	EH	
Intracranial pressure monitor tray	EED&EPI				
Obstetrical Kit	EED	EED	EED	EED	EED
Oral Airway (1 set in 0-5) move with airway	EED&EPI	EED&EPI	EED	EED	EED
Tracheostomy tray move with airway	EED&EPI	EED&EPI	EED	SE	
Fracture management devices					
Cervical immobilization equipment suitable for ped. patients	EED	EED	EED	EED	EED
Spine board (child/adult)	EED	EED	EED	EED	EED
Extremity splints	EED	EED	EED	EED	EED
Femur splint; child, adult	EED	EED	EED	EED	EED
Activated charcoal	EH	EH			
Beta2-agonist for inhalation	EED&EPI	EED&EPI	EED	EED	EH
Calcium chloride	EED&EPI	EED&EPI	EED	EH	EH
Corticosteroids (dexamethasone, methylprednisolone)	EED&EPI	EED&EPI	EED	EED	EH
Cyanide kit and pediatric doses	EED	EH	EH	SE	SE
Dextrose-10%, 25% and 50%	EED&EPI	EED&EPI	EED	EED	EH
Digoxin antibody dantrolene EH for all	EH	EH	EH	EH	SE
Diphenhydramine	EED	EED	EED	EED	EH
Epinephrine (1:1000 or 1mg/ml &1:10,000 or 0.1mg/ml) two lines	EED&EPI	EED&EPI	EED	EED	EED
Factor VIII, IX concentrates, DDAVP	EH	EH	EH	EH	
Flumazenil	EH	EH	EH	EH	EH
Furosemide	EED&EPI	EED&EPI	EED	EED	EH
Glucagon	EED	EED	EED	EED	
Insulin	EH	EH	EH	EH	
Intralipids EH CRPC and general		EH			
Kayexalate	EH	EH	EH	EH	
Ketamine	EED&EPI	EED&EPI	EED	EED	EH
Magnesium sulfate	EED&EPI	EED&EPI	EED	EH	EH
Mannitol-20% hypertonic sodium chloride 3%	EED&EPI	EED&EPI	EH	EH	EH
Methylene blue	EH	EH	EH	EH	EH
N-acetylcysteine	EH	EH	EH	EH	SE
Naloxone	EED&EPI	EED&EPI	EED	EED	EH
Potassium chloride	EH	EH	EH	EH	EH
Prostaglandin Nitric Oxide EH	EH	EH	EH	EH	
Sodium bicarbonate 4.2%, and 8.4%	EED&EPI	EED&EPI	EED	EED	EH
Succinylcholine	EED	EED	EED	EH	
Whole bowel irrigation solution	EH	EH	EH	EH	

TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES					
Part 4/7		FACILITY DESIGNATION/LEVEL			
2. EQUIPMENT AND SUPPLIES (Cont.)	CRPC	General with PICU	General	Primary	Basic
MEDICATION CLASSES					
Analgesics	EED	EED	EED	EH	EH
Antibiotics	EED	EED	EED	EED	EH
Anticonvulsants	EED&EPI	EED&EPI	EED	EED	EH
Antihypertensive agents	EED	EED	EED	EH	EH
Antipyretics add ondansetron EH all levels medication list	EED	EED	EED	EED	EH
PALS and ACLS medications need to add those in adenosine etc	EED&EPI	EED&EPI	EED	EED	EED
Chelating agents for heavy metal poisonings	EH	EH			
Nondepolarizing neuromuscular blocking agents	EED	EED	EED	EED	
Rapid sequence intubation medications	EED&EPI	EED&EPI	EED	EH	SE
Sedatives and antianxiety medications	EED&EPI	EED&EPI	EED	EH	EH
MISCELLANEOUS					
Resuscitation board	EED&EPI	EED&EPI	EED	EED	EED
Infant and child scale (kg only)	EED&EPI	EED&EPI	EED	EED	EED
Heating source (for infant warming)	EED&EPI	EED&EPI	EED	EED	EED
Precalculated drug sheets or length-base tape	EED&EPI	EED&EPI	EED	EED	EED
Pediatric restraint equipment (to use for painful or difficult procedures)	EED	EED	EED	EED	
Portable radiography	EED&EH	EED&EH	EH	EH	
Slit lamp	EH	EH	EH	EH	
Infant incubators	EH	EH			
Bilirubin lights	EH	EH			
Pacemaker capability	EH	EH	EH		
Thermal control for patient and/or resuscitation room	EED	EED	EED	EED	
3. FACILITIES					
Emergency Department					
Two or more areas with capacity and equipment to resuscitate medical/surgical/trauma pediatric patients	E				
One or more areas as above		E	E		
Separate Pediatric designated site	E				
Access to helicopter landing site	E	E	E	E	E
Hospital support services					
Pediatric inpatient care	E	E	E		
Pediatric intensive care unit	E	E			
Child abuse team	E	E	E		
Child life support	EH	EH			
Operating Room					
Operating room staff	EP	EP	EP	SE	
One RN physically present in OR	E	EP	EP		
Second operating room available and staffed within 30 minutes	E				
Thermal control equipment	E	E	E		
X-ray capability, including C-arm	E	E	E		
Endoscopes, all varieties	E				
Craniotomy equipment, including ICP monitoring equipment	E				
Invasive and noninvasive monitoring equipment	E	E	E		
Pediatric anesthesia and ventilation equipment	E	E	E		
Pediatric airway control equipment	E	E	E		

Defibrillator, monitor, including internal and external paddles	E	E	E		
Laparotomy tray	E	E	E		
Thoracotomy tray and chest retractors of appropriate size	E				
Synthetic grafts of all sizes	E				
Spinal and neck immobilization equipment	E				
Fracture table with pediatric capability	E				
Auto-transfusion with pediatric capability	E				
Pediatric drug dosage chart	E	E	E		

	TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES				
Part 5/7		FACILITY DESIGNATION/ LEVEL			
3. FACILITIES (Cont.)	CRPC	General with PICU	General	Primary	Basic
OPERATING ROOM (CONT.)					
Tracheostomy tubes, neonatal through adolescent	E	E	E		
Anesthesia and surgical suite promptly available	EP	EP	EP	SE	
PEDIATRIC INTENSIVE CARE UNIT					
Distinct, controlled access unit	E	E			
Proximity to elevators	E	E			
MD on-call room	E	E			
Waiting room and separate family counseling room	E	E			
Patients' personal effects storage and privacy provision	E	E			
Patient isolation capacity and isolation cart	E	E			
Medication station with drug refrigerator and locked cabinet	E	E			
Emergency equipment storage	E	E			
Separate clean and soiled utility rooms	E	E			
Nourishment station	E	E			
Separate staff and patient toilets	E	E			
REMOVE	E	E			
Two oxygen, two vacuum, and > 2 compressed air outlets/bed	E	E			
Computerized lab reporting	E	E			
Easy, rapid access to head of beds and cribs	E	E			
Pressure monitoring capability, with 4 simultaneous pressures	E	E			
Electric patient isolation capability – Patient isolation capability	E	E			
Recovery Room					
RNs and other essential personnel on call 24 hrs/ day	E	E	E	E*	
Staff competent in the post-anesthesia care of the pediatric pt.	E	E	E	E*	
Airway equipment	E	E	E	E*	
Pressure monitoring capability	E	E	E	E*	
Thermal control equipment	E	E	E	E*	
Radiant warmer	E	E	E	E*	
Blood warmer	E	E	E	E*	
Resuscitation cart	E	E	E	E*	
Immediate access to sterile surgical supplies for emergency	E	E	E	E*	
Pediatric drug dosage chart	E	E	E	E	
E* If surgery performed on pediatric patients					
Laboratory services					
Hematology	E	E	E	E	E
Chemistry	E	E	E	E	E
Microbiology	E	E	E	E	SE
Microcapabilities	E	E	E		
Blood bank	E	E	E	SE	
Drug levels/toxicology	E	E	SE	SE	
Refractometer REMOVE	EPI				
Blood gases	E	E	E	E	

Radiology Service					
Routine services 24 hours per day	EH	EH	EH	E	E
Computed tomography scan 24 hours per day	EH	EP	E	SE	
Ultrasound 24 hours per day	E	E	E	SE	
Magnetic Resonance Imaging Availability	E	E	E		
Nuclear medicine	E	SE	SE		
Fluoroscopy/contrast studies 24 hours per day	E	E	E	SE	
Angiography 24 hours per day	E	E	E	SE	

TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES

Part 6/7

	FACILITY DESIGNATION/LEVEL				
3. FACILITIES (Cont.)	CRPC	General with PICU	General	Primary	Basic
OTHER					
Pediatric Echocardiography	EP	EP			
Pediatric Cardiac Catheterization	E				
Electroencephalography	EP	EP			
Access to:					
Regional poison control center	E	E	E	E	E
Hemodialysis capability/transfer agreement	E	E	E	E	
Rehabilitation medicine/transfer agreement	E	E	E	SE	
Acute spinal cord injury management capability/transfer agreement	E	E	E	SE	
Hyperbaric oxygen chamber availability/transfer agreement when appropriate	E				
4. Access, Triage, Transfer, and Transport					
Support of medical control*	E	E	E	SE	SE
Accept call-ahead ambulance information	E	E	E	E	E
Transfer agreements for: In-patient pediatric care				E	E
ICU pediatric care		E	E	E	E
Major trauma care	ES	E	E	E	E
Burn care	ES	E	E	E	E
Hemodialysis – ECLS	ES	E	E	E	E
~~ECMO~~	ES	E	E	E	E
Rehabilitation care	ES	E	E	E	E
Accept all critically ill patients from lower-level hospitals within a region	E	SE	SE		
Access to transport services appropriate for pediatrics	E	E	E	E	E
Provide 24-hour consultation to lower-level facilities	E				
Consultation agreements with CRPC		E	E	E	E
5. Education, Training, Research, and Quality Assessment and Improvement*					
Education and Training					
Public education, injury prevention	E	E	E	SE	SE
Assure staff training in resuscitation and stabilization	E	E	E	E	E
Assist with pre-hospital education	E	SE	SE	SE	SE
CPR certification for PICU nurses and respiratory therapists	E	E			
CPR certification for ED nurses and RRTs	E	E	E	E	E
Multi-disciplinary resuscitation simulation with physician engage	E	E	SE - E	SE - E	SE - E
Ongoing Pediatric CME for RNs and RRTs from the PICU	E	E			
Ongoing Pediatric CME for RNs and RRTs from the ED	E	E	E	E	E

Network educational resources for training all levels of health professionals	E	SE	SE		
RESEARCH					
Support state EMSC research efforts and data collection	E	E	E	E	E
Participate in and/or maintain trauma registry	E	E	E	SE	SE
Participate in regional pediatric critical care education	E				

	TABLE 1. PEDIATRIC EMERGENCYCARE FACILITIES				
Part 7/7		FACILITY DESIGNATION/LEVEL			
5. Education, Training, Research, and Quality Assessment and Improvement* (Cont.)	CRPC	General with PICU	General	Primary	Basic
	QUALITY ASSESSMENT AND IMPROVEMENT				
Structured QA/QI program with indicators and periodic review	E	E	E	E	E
Participate in regional quality review by CRPC and/or local EMS authority	E	E	E	E	E
	6. ADMINISTRATIVE SUPPORT AND HOSPITAL COMMITMENT				
Make available clinical resources for training pre-hospital personnel	E	SE	SE	SE	
Assure properly trained ED staff	E	E	E	E	E
Assure availability of all necessary equipment/supplies/protocols/agreements/policies	E	E	E	E	E
Provide emergency care and stabilization for all pediatric patients	E	E	E	E	E
Support networking education/training for health care professionals	E	E	E	E	E
Assure appropriate medical control and input to ED management and pediatric care	E	SE	SE	SE	SE
Participate in network pediatric emergency care	E	E	E	E	E
Assure conformity with building and federal codes for PICU	E	E			
Assure transport services and agreements are available	E	E	E	E	E
Assure resources available for data collection	E	E	E	E	E
Assure availability of: Social services	E	E	E	E	
Child abuse support services	EP	EP	EP	EP	
Child life support	E	E			
On-line pre-hospital control	E	SE	SE	SE	SE
Respiratory care	EED&EPI	EHEED&E	EH	EH	SE
Pediatric Critical Care Committee	E	E			
Pediatric Trauma Committee	E				
Child development services	E				

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-251.* ***Administrative History:***
Amendment filed March 27, 2015; effective June 25, 2015.