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

**CHAPTER 1200-08-30**
**STANDARDS FOR PEDIATRIC EMERGENCY CARE FACILITIES**

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## 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. Advance Cardiac Life Support.

(3) APLS. Advanced Pediatric Life Support.

(4) 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.

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

(6) Comprehensive Regional Pediatric Center (CRPC). The facility shall be capable of providing comprehensive specialized pediatric medical and surgical care to all acutely ill and injured children. 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.

(7) CPR. Cardiopulmonary Resuscitation.

(8) 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.

(9) E. Essential.

(10) ECG. Electrocardiogram.

(11) ED. Emergency Department.

(12) EED. Essential in emergency department.

(13) EED&EPI. Essential in emergency department and pediatric intensive care unit.

(14) EH. Essential in hospital.

(15) EMS. Emergency medical service.

(16) EMSC. Emergency medical service for children.

(Rule 1200-08-30-.01, continued)

(17) ENPC. Emergency Nursing Pediatric Course.

(18) EP. Promptly available.

(19) EPI. Essential in pediatric intensive care unit only.

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

(21) 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 from Basic and Primary Pediatric Emergency Facilities as part of prearranged triage, transfer and transport agreements.

(22) ICP. Intracranial Pressure.

(23) IM. Intramuscular.

(24) IV. Intravenous.

(25) 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.

(26) 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.

(27) OR. Operating Room.

(28) PA. Physician's Assistant.

(29) PALS. Pediatric Advanced Life Support.

(30) 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, and 4) Comprehensive Regional Pediatric Center.

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

(32) Physician Assistant. A person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(33) PICU/PI. Pediatric Intensive Care Unit.

(34) Primary Pediatric Emergency Facility. The facility shall provide the same services as a Basic Pediatric Emergency Facility and shall have limited capabilities for the management of minor pediatric inpatient problems and may accept appropriate transfers of pediatric patients when there is no facility with more comprehensive capabilities available within a region.

(Rule 1200-08-30-.01, continued)

(35) QA. Quality Assurance.

(36) QI. Quality Intervention.

(37) RN. Registered Nurse.

(38) RRT. Registered Respiratory Therapist.

(39) SE. Strongly encouraged if such services are not available within a reasonable distance.

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

(41) Trauma Registry. A central registry compiled of injury incidence information supplied by designated trauma centers and Comprehensive Regional Pediatric Centers (CRPC's) for the purposes of allowing the Board to analyze data and conduct special studies regarding the causes and consequences of traumatic injury.

(42) 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.**

(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.

***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 classification.

(b) 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.

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

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

(e) 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;

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

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.

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

(g) Participation in data collection to assure that the quality indicators established by the regional resource center are monitored, and make data available to the regional resource center or a central data monitoring agency.

(h) Linkage with pre-hospital care and transport.

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

(j) Incorporation into the hospital existing quality assessment and improvement program, a review of the following pediatric issues and indicators:

1. deaths;

2. incident reports;

3. child abuse cases;

4. cardiopulmonary or respiratory arrests;

5. admissions within 48 hours after being discharged from the emergency department.;

6. surgery within 48 hours after being discharged from an emergency department;

7. quality indicators requested by the Comprehensive Regional Pediatric Center or state/local Emergency Medical Services for Children authority regarding nursing care, physician care, pre-hospital care and the medical direction for pre-hospital providers of Emergency Medical Services systems;

8. pediatric transfers; and

9. pediatric inpatient illness and injury outcome data.

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

(a) Provide assistance to local and state agencies for Emergency Medical Services and Emergency Medical Services for Children 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 hospitals;

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

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

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

6. 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 hospitals and health care providers utilizing pediatric emergency care facilities within the region;

   (iii) supports Emergency Medical Service agencies and Emergency Medical Services 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 hospital shall participate in regional education for emergency medical service providers, emergency departments and the general public;

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

7. 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);

      (I) Each CRPC shall submit TRACS Registry data electronically to the state trauma registry on all closed patient files no less often than quarterly for the sole purpose of allowing the board to analyze causes and medical consequences of serious trauma while promoting the continuum of care that provides timely and appropriate delivery of emergency medical treatment for people with acute traumatic injury.

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

(II) TRACS data shall be transmitted to the state trauma registry and received no later than one hundred twenty (120) days after each quarter.

(III) Failure to timely submit TRACS data to the state trauma registry for three (3) consecutive quarters shall result in the delinquent facility's necessity to appear before the Board for any disciplinary action it deems appropriate, including, but not limited to, citation of civil monetary penalties and/or loss of CRPC designation status.

(IV) CRPC's shall maintain documentation to show that timely transmissions have been submitted to the state trauma registry on a quarterly basis.

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

(vi) supports active institutional and collaborative regional research.

(b) Organize a structured quality assessment and improvement program with the assistance and support of local/state Emergency Medical Services and Emergency Medical Services for Children agencies that allows ongoing review and:

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

2. provides feedback, quality review and information to all participating hospitals, emergency medical services 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 trauma-related deaths, including those that are primary admitted patients versus secondary transferred patients. This review should include a morbidity and mortality review;

5. assures quality assessment in the Emergency Department and the Pediatric Intensive Care Unit to include collaborative quality assessment, morbidity and mortality review, utilization review, medical records review, discharge criteria, planning and safety review; and

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

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

(d) Have an organized organ donation protocol with a transplant team or service to identify possible organ donors and assist in procuring for donation, consistent with state and federal law;

(e) Have a pediatric intensive care unit and emergency department (ED) in which the staff train health care professionals in basic aspects of pediatric emergency and critical care and serve as a focus for continuing education programs in pediatric emergency and critical care. In addition, staff workers in the pediatric intensive care unit and ED shall

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

routinely attend or participate in regional and national meetings with course content pertinent to pediatric emergency and critical care.

(f) Assure training for pediatric intensive care unit and ED nurses in the following required skills: recognition, interpretation and recording of various physiological variables, drug administration, fluid administration, resuscitation (including cardiopulmonary resuscitation certification), respiratory care techniques (chest physiotherapy, endotracheal suctioning and management, tracheotomy care), preparation and maintenance of patient monitors, family-centered principles and psychosocial skills to meet the needs of both patient and family. PICU nurse-to-patient ratios vary with patient needs, but should range from 4 to 1 to 1 to 3.

(g) Establish within its organization a defined pediatric trauma/emergency service program for the injured child. The pediatric trauma/emergency program director shall be a pediatric surgeon, certified “or eligible for certification” in pediatric surgery, with demonstrated special competence in care of the injured child. The director shall have full responsibility and authority for the pediatric trauma/ emergency service program.

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

1. an emergency physician on duty in the emergency department;

2. a pediatric trauma surgeon promptly available within 30 minutes;

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

4. a cardiothoracic surgeon who is promptly available or a transfer agreement to Level 1 trauma center;

5. an orthopedic surgeon who is promptly available;

6. an anesthesiologist who is promptly available. An anesthesia resident post graduate year 3 capable of assessing emergency situations and initiating proper treatment or a certified registered nurse anesthetist credentialed by the chief of anesthesia may fulfill this requirement, but a staff anesthesiologist must be available within 30 minutes;

7. a neurosurgeon who is promptly available;

8. a pediatric respiratory therapist, laboratory technician and radiology technician;

9. a computer tomography technician in-house (or on-call and promptly available if the specific clinical needs of the hospital make this necessary and it does not have an adverse impact on patient care);

10. available support services to the emergency department to include social services, chaplain support, and a child and sexual abuse team that are promptly available. These support services shall include family counseling and coordination with appropriate services to support the psychological, financial or other needs of families;

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

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

12. 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 trauma registry. 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 Emergency Medical Services system locally and regionally, specific care review, trauma center/system review, and identification and solution of specific problems including organ procurement and donation;

13. a trauma register function shall be provided in organizations that have 500-1000 trauma admissions/observations per year; and

14. a CRPC coordinator position whose responsibilities include:

    (i) acting as a regional liaison and coordinator for the statewide EMSC project;

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

    (iii) maintaining and updating the CRPC Pediatric Facility Notebook.

***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) A Basic, Primary, or General Facility shall be capable of providing resuscitation, stabilization and timely triage for all pediatric patients and, when appropriate, transfer of patients to a higher-level facility. A Basic, Primary, or General Pediatric Emergency Facility is responsible for having appropriate transfer agreements to assure that all pediatric patients receive timely emergency care at the most appropriate pediatric facility available to a specific region. Each facility shall be linked with a Comprehensive Regional Pediatric Center for pediatric consultation.

(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 direct medical control for pediatric patients.

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

(b) Promote a regional network of direct medical control by lower-level hospitals within the region by working closely with the regional Emergency Medical Services medical director 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 from a defined region who require specialized care not available at lower-level hospitals within the region through:

1. prearranged transfer agreements that network hospitals within a region to assure appropriate inter-emergency department triage and transfer to assure optimum care for seriously and critically ill or injured pediatric patients; and

2. prearranged transfer agreements for pediatric patients needing specialized care not available at the Comprehensive Regional Pediatric Center (e.g., burn specialty unit, spinal cord injury unit, specialized trauma care or rehabilitation facility).

(d) Assure a pediatric transport service that:

1. is available to all regional participating 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 trauma care. Local destination guidelines for emergency medical services 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) Provide 24-hour consultation to all lower-level facilities for issues regarding:

1. emergency care and stabilization;

2. triage and transfer; and

3. transport.

(f) Develop policies that describe mechanisms to achieve smooth and timely exchange of patients between emergency department, operating room, imaging facilities, special procedure areas, regular inpatient care areas, and the pediatric intensive care unit.

***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 BASIC 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 in-house nursing staff. The physician shall be 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 physical signs and laboratory values in an age-appropriate manner. For physicians not board-certified/prepared by the American Board of Emergency Medicine, successful completion of courses such as Pediatric Advanced Life Support (PALS) or the American Academy of Pediatrics and American College of Emergency Physician's Advanced Pediatric Life Support (APLS) can be utilized to demonstrate this clinical capability. An on-call 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.

(b) A Primary or General Pediatric Emergency Facility shall have an emergency physician in-house 24 hours per day, 7 days per week. The emergency department physician shall be 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 physical signs and laboratory values in an age-appropriate manner. For physicians not board-certified board prepared by the American Board of Emergency Medicine, successful completion of courses such as Pediatric Advanced Life Support (PALS) or the American Academy of Pediatrics and American College of Emergency Physician's Advanced Pediatric Life Support (APLS) can be utilized to demonstrate this clinical capability. A pediatrician or family practitioner, general surgeon with trauma experience, anesthetist/anesthesiologist, and radiologist shall be promptly available 24 hours per day.

(c) A General Pediatric Emergency Facility shall have a physician director who is board certified/admissible 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.

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

(e) A Comprehensive Regional Pediatric Center shall have 24 hours ED coverage by physicians who are board certified in pediatrics or emergency medicine, and preferably board certified, board admissible, or fellows (second year level or above) in pediatric emergency medicine. 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.

(f) In a Comprehensive Regional Pediatric Center the pediatric intensive care unit shall have an appointed medical director. A record of the appointment and acceptance shall be in writing. Medical directors of the pediatric intensive care center shall meet one of the following criteria: (1) board-certified in pediatrics and board-certified or in the process of certification in pediatric critical care medicine; (2) board-certified in anesthesiology with practice limited to infants and children and with special qualifications (as defined by the American Board of Anesthesiology) in critical care

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

medicine; or (3) board-certified in pediatric surgery with added qualifications (as defined by the American Board of Surgery) in surgical critical care medicine. The pediatric intensive care unit medical director shall achieve certification within five years of their initial acceptance into the certification process for critical care medicine.

(g) The pediatric intensive care unit and ED medical director shall participate in developing and reviewing their respective unit policies, promote policy implementation, participate in budget preparation, help coordinate staff education, maintain a database which describe unit experience and performance, supervise resuscitation techniques, lead quality improvement activities and coordinate research.

(h) 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.

(i) The pediatric intensive care unit shall have at least one physician of at least the postgraduate year 2 level available to the pediatric intensive care units in-house 24 hours per day. All physicians in pediatric critical care shall participate on at least an annual basis, in continuing medical education activities relevant to pediatric intensive care medicine.

(j) Specialist consultants shall be board certified or board prepared and actively seeking certification in disciplines in which a specialty exists. A Comprehensive Regional Pediatric Center shall be staffed with specialist consultants with pediatric subspecialty training.

(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 or mailing the medical record to the primary care provider, or by providing the patient with a copy of the medical record to take to the physician. Follow-up visits shall be arranged or recommended with the primary care provider whenever necessary.

(b) In Basic Pediatric Emergency Facilities at least one RN or physician's assistant 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 registered nurse or physician's assistant per shift shall have successfully completed courses such as the Emergency Medical Services for Children/American Heart Association Pediatric Advanced Life Support (EMSC/PALS) course, or the Emergency Nurses Association Emergency Nursing Pediatric Course (ENPC) and can demonstrate this clinical capability. Documentation of current expiration date for the above courses shall be maintained by the facility and available upon request.

(c) In 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 shall have successfully completed courses such as the PALS or ENPC and can demonstrate this clinical capability.

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

(d) 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.

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

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

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

(h) In a Comprehensive Regional Pediatric Center nursing administration shall provide a nurse educator for pediatric emergency care and critical care education.

(i) In a Comprehensive Regional Pediatric Center 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 Comprehensive Regional Pediatric Center Personnel.

(a) The respiratory therapy department shall have a supervisor responsible for performance and training of staff, maintaining equipment and monitoring quality improvement and review. Under the supervisor's direction, respiratory therapy staff assigned primarily to the pediatric intensive care unit shall be in-house 24 hours per day.

(b) Biomedical technicians shall be either in-house or 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, physical therapists, occupational therapists and nutritionists must be available. The availability of child life specialists and clergy is strongly encouraged.

(4) Facility Structure and Equipment.

(a) A General Pediatric Emergency Facility shall have access to a pediatric intensive care unit. This requirement may be fulfilled by having transfer and transport agreements available for moving critically ill or injured patients to a Comprehensive Regional Pediatric Center.

(b) A Comprehensive Regional Pediatric Center shall have a pediatric intensive care unit.

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

(c) 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.

(d) Equipment for communication with Emergency Medical Services 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.

(e) 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.

(f) 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.

***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, continued)

TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES

| Part 1/7 | FACILITY DESIGNATION/LEVEL | | | |
|---|---|---|---|---|
| **1. PERSONNEL** | CRPC | General | Primary | Basic |
| Physician with pediatric emergency care experience | EED | EED | EED | EP |
| RN with pediatric training | EED & EPI | EED | EED | EED |
| Respiratory therapist | EH | EH | EH | |
| Trauma coordinator | E | | | |
| Nurse educator | E | E | | |
| Trauma team * | E | SE | SE | |
| **Specialist consultants * (Available in less than 1 hour)** [1] | | | | |
| Pediatrician | EP | EP | EP | SE |
| Radiologist | EP | EP | EP | SE |
| Anesthesiologist * | EP | EP | EP | SE |
| Cardiologist | EP | | | |
| Critical Care Physician | EP | | | |
| Nephrologist | EP | | | |
| Hematologist/oncologist | EP | | | |
| Endocrinologist | EP | | | |
| Gastroenterologist | EP | | | |
| Neurologist | EP | | | |
| Pulmonologist | EP | | | |
| Psychiatrist/Psychologist | EP | | | |
| Infectious Disease Physician | EP | | | |
| **Surgical specialists* (Available in less than 1 hour)** | | | | |
| General surgeon | | EP | EP | SE |
| Pediatric surgeon * | EP | SE | | |
| Neurosurgeon | EP | SE | | |
| Orthopedic surgeon | EP | SE | SE | |
| Otolaryngologist | EP | | | |
| Urologist | EP | | | |
| Plastic surgeon | EP | | | |
| Oral/maxillofacial surgeon | EP | | | |
| Gynecologist | EP | | | |
| Microvascular surgeon | EP | | | |
| Hand surgeon | EP | | | |
| Ophthalmologist | EP | | | |
| Cardiac surgeon | EP | | | |
| Pathologist | EP | | | |
| Pediondontist | EP | | | |
| Physical Medicine/Rehabilitation physician | E | | | |
| **Trauma Rehabilitation Program** | | | | |
| Physical Therapy | E | | | |
| Occupational Therapy | E | | | |
| Speech Therapy | SE | | | |
| Special Education | E | | | |

TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES

| Part 2/7 | FACILITY DESIGNATION/LEVEL | | | |
|---|---|---|---|---|
| **2. EQUIPMENT** | CRPC | General | Primary | Basic |
| EMS communication equipment* | E | E | E | E |

(Rule 1200-08-30-Table 1, continued)

| | | | | |
|---|---|---|---|---|
| Organized emergency cart* | EED&EPI | EED | EED | EED |
| Printed drug doses/tape | EED&EPI | EED | EED | EED |
| **Monitoring devices** | | | | |
| ECG monitor/defibrillator with pediatric paddles or pads 0-400 joules and hard copy capabilities | EED&EPI | EED | EH | EH |
| Pulse oximeter (adult/pediatric probes) | EED&EPI | EED | EH | EH |
| Blood pressure cuffs (infant, child, adult, thigh) | EED&EPI | EED | EED | EED |
| Rectal thermometer probe (28 deg. – 42 deg. C) | EED&EPI | EED | EH | EH |
| Otoscope, ophthalmoscope, stethoscope | EED&EPI | EED | EED | EED |
| Cardiopulmonary monitor with pediatric and hard copy capability, visible/audible alarms, routine testing and maintenance | EED&EPI | EED | EED | EH |
| Doppler and noninvasive blood pressure monitoring (infant, child, adult) | EED&EPI | EED | EH | |
| End tidal CO2 detector | EED | EED | EED | EED |
| End tidal CO2 monitor | EED&EPI | EH | SE | |
| Monitor for central venous pressure, arterial lines, temperature | EH&EPI | EH | SE | |
| Monitor for pulmonary arterial pressure and intracranial pressure | EPI | | | |
| Transportable monitor | EED&EPI | EED | EH | EH |
| **Airway control/ventilation equipment** | | | | |
| Bag-valve-mask device: pediatric (450 mL), and adult (1000 mL) with oxygen reservoir and without pop-off valve. Infant, child, and adult masks | EED&EPI | EED | EED | EED |
| Oxygen delivery device with flow meter | EED&EPI | EED | EED | EED |
| Clear oxygen masks, standard and non-rebreathing (neonatal to adult size) | EED&EPI | EED | EED | EED |
| Nasal cannula (infant, child, adult) | EED&EPI | EED | EED | EED |
| PEEP valve | EED&EPI | EED | | |
| Suction devices-catheters 6-14 fr, yankauer-tip/suction equipment | EED&EPI | EED | EED | EED |
| Nasal airways (infant, child, adult) | EED&EPI | EED | EED | EED |
| Nasogastric tubes (sizes 6-16 fr) | EED&EPI | EED | EED | EED |
| Laryngoscope handle and blades: | | | | |
| - curved 2,3 | EED&EPI | EED | EED | EED |
| - straight or Miller 0,1,1-1/2, 2,3 | EED&EPI | EED | EED | EED |
| Endotracheal tubes: | | | | |
| - uncuffed (2.5-5.5) | EED&EPI | EED | EED | EED |
| - cuffed (6.0-9.0) [all pediatric sizes EPI] | EED&EPI | EED | EED | EED |
| Stylets for endotracheal tubes (pediatric, adult) | EED&EPI | EED | EED | EED |
| Lubricant, water soluble | EED | EED | EED | EED |
| Magill forceps (pediatric, adult) | EED | EED | EED | EED |
| Spirometers, chest physiotherapy and suctioning equipment | EPI | | | |
| Continuous oxygen analyzers with alarms | EPI | | | |
| Inhalation therapy equipment | EPI | | | |
| Tracheostomy tubes (sizes 0-6) | EED | EH | EH | |
| Oxygen blender | EED&EPI | EED | EED | EED |
| Pediatric endoscopes and bronchoscopes available | EH | EH | | |
| Respired gas humidifiers and bronchoscopes available | EPI | | | |
| Pediatric ventilators | EPI | EH | | |
| Difficult airway kit | EED&EPI | EED | SE | SE |
| **Vascular access supplies** | | | | |
| Arm boards (infant, child, and adult sizes) | EED&EPI | EED | EED | EED |
| Butterflies (19-25 gauge) | EED&EPI | EED | EED | EED |
| Catheters for intravenous lines (16-24 gauge) | EED&EPI | EED | EED | EED |
| Needles (18-27 gauge) | EED&EPI | EED | EED | EED |
| Intraosseous needles | EED&EPI | EED | EED | EED |
| Umbilical vessel catheters (3,5 fr) and cannulation tray | EED | EED | EH | EH |
| IV administration sets and extension tubing with calibrated chambers | EED&EPI | EED | EED | EED |
| Extension tubing, stopcocks, T-connectors | EED&EPI | EED | EED | EED |

(Rule 1200-08-30-Table 1, continued)

| | | | | |
|---|---|---|---|---|
| Infusion device able to regulate rate and volume of infusate | EED&EPI | EED | EED | EED |
| Isotonic balanced salt solution and D[5[ 0.5 normal saline | EED | EED | EED | EED |
| Central venous access utilizing Seldinger technique (4-7 fr) | EED&EPI | EED | EED | |
| IV fluid/blood warmer | EED&EPI | EED | EH | |
| Blood gas kit | EED | EED | EH | |
| Rapid infusion pumps | EED&EPI | EH | | |

| TABLE 1. PEDIATRIC EMERGENCYCARE FACILITIES | | | | |
|---|---|---|---|---|
| Part 3/7 | FACILITY DESIGNATION/LEVEL | | | |
| **2. EQUIPMENT AND SUPPLIES (Cont.)** | CRPC | General | Primary | Basic |
| **Specialized pediatric trays** | | | | |
| Lumbar puncture | EED&EPI | EED | EED | EH |
| Urinary catheterization: Foley 6-14 fr | EED&EPI | EED | EED | EED |
| Venous cutdown | EED&EPI | EED | EH | EH |
| Thoracostomy tray with chest tube sizes 10-28 fr | EED&EPI | EED | SE | |
| Peritoneal lavage tray | EED&EPI | EED | SE | |
| Needle cricothyrotomy set | EED&EPI | EED | EED | |
| Intracranial pressure monitor tray | EED&EPI | SE | | |
| Obstetrical Kit | EED | EED | EED | EED |
| Oral Airway (1 in 0-5) | EED&EPI | EED | EED | EED |
| Tracheostomy tray | EED&EPI | EED | SE | |
| **Fracture management devices** | | | | |
| Cervical immobilization equipment suitable for ped. patients | EED | EED | EED | EED |
| Spine board (child/adult) | EED | EED | EED | EED |
| Extremity splints | EED | EED | EED | EED |
| Femur splint; child, adult | EED | EED | EED | EED |
| Activated charcoal | EED | EED | EED | EH |
| Beta-agonist for inhalation | EED&EPI | EED | EED | EH |
| Bretylium | EED&EPI | EED | EH | EH |
| Calcium chloride | EED&EPI | EED | EH | EH |
| Corticosteroids (dexamethasone, methylprednisolone) | EED | EED | EED | EH |
| Cyanide kit and pediatric doses | EED | | | |
| Dextrose-25% and 50% | EED&EPI | EED | EED | EH |
| Digitalis antibody | EH | EH | EH | |
| Diphenhydramine | EED | EED | EED | EH |
| Epinephrine (1:1000, 1:10,000) | EED&EPI | EED | EED | EH |
| Factor VIII, IX concentrates, DDAVP | EH | EH | EH | |
| Flumazenil | EH | EH | EH | EH |
| Furosemide | EED&EPI | EED | EED | EH |
| Glucagon | EED | EED | EED | |
| Insulin | EH | EH | EH | |
| Ipecac | EED | EED | EED | EH |
| Kayexalate | EH | EH | EH | |
| Ketamine | EED | EH | ED | |
| Magnesium sulfate | EED&EPI | EED | EH | |
| Mannitol-20% | EED&EPI | EH | EH | |
| Methylene blue | EH | EH | EH | EH |
| N-acetyl cysteine | EH | EH | EH | |
| Naloxone | EED | EED | EED | EH |
| Potassium chloride | EED | EED | EED | |
| Prostaglandin | EH | EH | EH | |
| Sodium bicarbonate 4.2%, 7.5% and 8.4% | EED&EPI | EED | EED | EH |
| Succinylcholine | EED | EED | EH | |
| Whole bowel irrigation solution | EH | EH | EH | |

(Rule 1200-08-30-Table 1, continued)

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

(Rule 1200-08-30-Table 1, continued)

| | | | | |
|---|---|---|---|---|
| Defibrillator, monitor, including internal and external paddles | E | E | | |
| Laparotomy tray | 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 | | |

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

(Rule 1200-08-30-Table 1, continued)

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

TABLE 1. PEDIATRIC EMERGENCY CARE FACILITIES

| Part 6/7 | FACILITY DESIGNATION/LEVEL | | | |
|---|---|---|---|---|
| **3. FACILITIES (Cont.)** | CRPC | General | Primary | Basic |
| **OTHER** | | | | |
| Pediatric Echocardiography | E | | | |
| Pediatric Cardiac Catheterization | E | | | |
| Electroencephalography | E | | | |
| Access to: | | | | |
| Regional poison control center | E | E | E | E |
| Hemodialysis capability/transfer agreement | E | E | E | |
| Rehabilitation medicine/transfer agreement | E | E | SE | |
| Acute spinal cord injury management capability/transfer agreement | E | E | SE | |
| Hyperbaric oxygen chamber availability/transfer agreement when appropriate | E | | | |
| **4. Access, Triage, Transfer, and Transport** | | | | |
| Support of medical control* | E | E | SE | SE |
| Accept call-ahead ambulance information | E | E | E | E |
| Transfer agreements for:<br>In-patient pediatric care | | | E | E |
| ICU pediatric care | | E | E | E |
| Major trauma care | ES | E | E | E |
| Burn care | ES | E | E | E |
| Hemodialysis | ES | E | E | E |
| Spinal injury care | ES | E | E | E |
| Rehabilitation care | ES | E | E | E |
| Accept all critically ill patients from lower-level hospitals within a region | E | SE | | |
| Access to transport services appropriate for pediatrics | E | E | E | E |
| Provide 24-hour consultation to lower-level facilities | E | | | |
| Consultation agreements with CRPC | | E | E | E |
| **5. Education, Training, Research, and Quality Assessment and Improvement*** | | | | |
| **Education and Training** | | | | |
| Public education, injury prevention | E | E | SE | SE |
| Assure staff training in resuscitation and stabilization | E | E | E | E |
| Assist with pre-hospital education | E | SE | SE | SE |
| CPR certification for PICU nurses and respiratory therapists | E | | | |
| CPR certification for ED nurses and RRTs | E | E | E | E |
| Resuscitation practice sessions | E | SE | SE | SE |
| Ongoing CME for RNs and RRTs from the PICU | E | | | |
| Ongoing CME for RNs and RRTs from the ED | E | E | E | E |

(Rule 1200-08-30-Table 1, continued)

| | | | | |
|---|---|---|---|---|
| Network educational resources for training all levels of health professionals | E | SE | | |
| **RESEARCH** | | | | |
| Support state EMSC and CRPC research efforts and data collection | E | E | E | E |
| Participate in and/or maintain trauma registry | 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 | Primary | Basic |
| **QUALITY ASSESSMENT AND IMPROVEMENT** | | | | |
| Structured QA/QI program with indicators and periodic review | E | E | E | E |
| Participate in regional quality review by CRPC and/or local EMS authority | E | E | E | E |
| **6. ADMINISTRATIVE SUPPORT AND HOSPITAL COMMITMENT** | | | | |
| Make available clinical resources for training pre-hospital personnel | E | SE | SE | |
| Assure properly trained ED staff | E | E | E | E |
| Assure availability of all necessary equipment/supplies/protocols/agreements/policies | E | E | E | E |
| Provide emergency care and stabilization for all pediatric patients | E | E | E | E |
| Support networking education/training for health care professionals | E | E | E | E |
| Assure appropriate medical control and input to ED management and pediatric care | E | SE | SE | SE |
| Participate in network pediatric emergency care | E | E | E | E |
| Assure conformity with building and federal codes for PICU | E | | | |
| Assure transport services and agreements are available | E | E | E | E |
| Assure resources available for data collection | E | E | E | E |
| Assure availability of:<br>Social services | E | E | E | |
| Child abuse support services | EP | EP | EP | |
| Child life support | E | | | |
| On-line pre-hospital control | E | SE | SE | SE |
| Respiratory care | EED | EH | EH | SE |
| Pediatric Critical Care Committee | 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.*