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

CHAPTER 1200-8-30
STANDARDS FOR PEDIATRIC EMERGENCY CARE FACILITIES

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1200-8-30-.01 DEFINITIONS.

(1) ACLS. Advance Cardiac Life Support.

(2) APLS. Advanced Pediatric Life Support.

(3) 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.

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

(5) 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.

(6) CPR. Cardiopulmonary Resuscitation.

(7) E. Essential.

(8) ECG. Electrocardiogram.

(9) ED. Emergency Department.

(10) EED. Essential in emergency department.

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

(12) EH. Essential in hospital.

(13) EMS. Emergency medical service.

(14) EMSC. Emergency medical service for children.

(15) ENPC. Emergency Nursing Pediatric Course.

(16) EP. Promptly available.

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

(Rule 1200-8-30-.01, continued)

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

(19) 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.

(20) ICP. Intracranial Pressure.

(21) IM. Intramuscular.

(22) IV. Intravenous.

(23) OR. Operating Room.

(24) PA. Physician's Assistant.

(25) PALS. Pediatric Advanced Life Support.

(26) 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.

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

(28) 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.

(29) QA. Quality Assurance.

(30) QI. Quality Intervention.

(31) RN. Registered Nurse.

(32) RRT. Registered Respiratory Therapist.

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

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

(35) 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.

(36) 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.*

1200-8-30-.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.*

1200-8-30-.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;

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;

(Rule 1200-8-30-.03, continued)

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;

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;

(Rule 1200-8-30-.03, continued)

(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.

(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;

(Rule 1200-8-30-.03, continued)

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 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;

(Rule 1200-8-30-.03, continued)

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;

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.

(Rule 1200-8-30-.03, continued)

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.*

1200-8-30-.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.

(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:

(Rule 1200-8-30-.04, continued)

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.*

1200-8-30-.05 BASIC FUNCTIONS.

(1) Medical Services.

(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

(Rule 1200-8-30-.05, continued)

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 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.

(Rule 1200-8-30-.05, continued)

(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.

(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.

(Rule 1200-8-30-.05, continued)

(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.

(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

(Rule 1200-8-30-.05, continued)

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.

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			

(Rule 1200-8-30-Table 1, continued)

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
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

(Rule 1200-8-30-Table 1, continued)

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 (shiley 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
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	

(Rule 1200-8-30-Table 1, continued)

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	

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

(Rule 1200-8-30-Table 1, continued)

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		
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			

(Rule 1200-8-30-Table 1, continued)

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	
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	

(Rule 1200-8-30-Table 1, continued)

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: 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
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

(Rule 1200-8-30-Table 1, continued)

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: 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			