§157.125. Requirements for Trauma Facility Designation.

(a) General Provisions. The goal of the trauma system is to reduce the morbidity and mortality of the trauma patient. The objective of the trauma system is to get the right patient, to the right place, at the right time, to receive the right care. The purpose of this section is to set forth the requirements for a healthcare facility to become a designated trauma facility.

(1) The Department of State Health Services (department) shall determine the designation level for each health care facility by physical location, based on, but not limited to, the location's own resources and levels of care capabilities, and compliance with the essential criteria and standard requirements outlined in this section.

(2) The Emergency Medical Services (EMS)/Trauma Systems Section shall recommend to the Commissioner of the Department of State Health Services (commissioner) the trauma designation of a facility at the level it deems appropriate.

(3) Facilities eligible for trauma designation include:

(A) a hospital in the state of Texas, licensed or otherwise meeting the description in accordance with Texas Administrative Code (TAC) Chapter 133 Hospital Licensing;

(B) a hospital owned and operated by the state of Texas; or

(C) a hospital owned and operated by the federal government; and

(D) all facilities shall have the capability to provide stabilization, and transfer or treatment for the major and severe trauma patient.

(4) Facilities with multiple locations under one state license applying for designation at one location, shall be required to apply for designation at each of its individual locations where inpatients receive hospital services. Each individual location shall be considered separately for designation.

(5) Designation does not extend to provider-based departments of the designated facility, which are not contiguous with the designated facility.
(6) Departments or services within a facility shall not be designated separately.

(7) A trauma facility designation is issued for the physical location and to the legal owner of the operations of the facility. If a designated facility has a change of ownership or a change of the physical location of the facility, the designation shall not be transferred or assigned.

(8) The four levels of trauma designation and the requirements for each are as follows:

(A) Comprehensive (Level I). The facility shall meet the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center.

(B) Major (Level II). The facility shall meet the current ACS essential criteria for a verified Level II trauma center.

(C) Advanced (Level III). The facility shall meet TAC §157.125 (j) and (n) requirements in this section.

(D) Basic (Level IV). The facility shall meet TAC §157.125 (j) and (o) requirements in this section.

(b) Survey Process. A facility seeking designation shall undergo an onsite survey as outlined in this section.

(1) The facility shall be responsible for scheduling a trauma verification or designation survey as follows:

(A) Level I and II facilities shall request a trauma verification survey through the ACS trauma verification program.

(B) Level III and IV facilities shall request a trauma designation survey through a department recognized organization.

(2) The facility shall notify the department of the date of the scheduled survey no later than 30 days prior to the survey.

(3) The facility shall be responsible for any expenses associated with the survey.
(4) The surveying organization shall notify the department of the date of the scheduled survey and the members of the survey team no later than 30 days prior to the survey.

(5) The department, at its discretion, may appoint an observer(s) to accompany the survey team. In this event, the department is responsible for any expenses associated with the observer(s) attending the survey.

(6) The survey team shall evaluate the facility's compliance with ACS or TAC §157.125 requirements by:

(A) reviewing facility documents;

(B) performing patient case reviews on closed medical records;

(C) tour of the physical plant;

(D) conduct staff interviews to include these roles:

(i) the chief executive officer;

(ii) the chief nursing officer;

(iii) the current Trauma Medical Director(TMD);

(iv) the current Trauma Program Manager(TPM);

(v) the current executive sponsor of the trauma program;

and

(vi) general staff.

(7) The facility must provide documented evidence of performance improvement activities to validate compliance with TAC §157.125. Failure to provide this evidence may result in denial of designation.

(8) The surveyor(s) shall provide the facility with a complete written, and signed survey report regarding their evaluation of the facility's compliance and noncompliance with ACS or TAC §157.125 requirements.

(9) Survey organizations evaluating facility compliance to TAC §157.125 shall forward the survey report to the facility within 30 calendar days of the date of the survey.
(10) The facility is responsible for forwarding a copy of the complete survey report to the department in the application packet if it intends to continue the designation process.

(c) Designation Process.

(1) In Active Pursuit of Designation(IAP) applies only to an undesignated facility that applies for trauma designation and is in active pursuit of designation in accordance with Texas Health and Safety Code, Chapter 780 Trauma Facilities and Emergency Medical Services, §780.004(2)(i). In Active Pursuit is defined by the State for funding purposes only. It is not to be used by other organizations regarding designation status.

(2) Initial designation is intended for facilities that are designating for the first time, those designating following a hiatus from the system, following a change of ownership or a change in physical location, or changing designation levels.

(A) An initial application for a higher or lower level designation may be submitted to the department at any time.

(B) A designated trauma facility that is increasing its trauma capabilities may choose to apply for a higher level of trauma designation at any time. It shall be necessary to repeat the designation process for the higher level.

(C) A designated trauma facility unable to maintain compliance with its current level of designation may choose to apply for a lower level of designation. It shall be necessary to repeat the designation process for the lower level. There shall be a desk review by the department to determine if a full survey shall be required.

(3) Renewal of designation occurs every three years and includes facilities that are renewing an existing designation.

(4) It shall be necessary to repeat the designation process as described in this section prior to expiration of a facility's designation, or the designation expires.

(5) Facility Conferences.
(A) Application for an initial designation by a facility will require a pre-survey conference. An executive officer, TMD and TPM of the facility shall participate in the pre-survey conference conducted by department staff. The purpose of the pre-survey conference is to review and discuss the designation requirements for the applicable level prior to the initial onsite designation survey. The department may waive the pre-survey conference requirement.

(B) Application for renewal of designation, determined to be a designation with contingencies, or denial of designation, will necessitate a conference. An executive officer, TMD and TPM of the facility shall participate in a conference conducted by department staff. The purpose of the conference is to review and discuss the corrective action plan (CAP) for the facility to achieve compliance with the rules. The department may waive the conference requirement.

(6) Application Packet. A facility seeking designation, shall submit a completed application packet to include:

(A) an accurate and complete designation application form for the appropriate level of designation requested;

(B) Full payment of the non-refundable, non-transferrable, designation fee as listed.

   (i) Level I and Level II applicants, the fee will be no more than $10 per licensed bed with an upper limit of $5,000 and a lower limit of $4,000.

   (ii) Level III applicants, the fee will be no more than $10 per licensed bed with an upper limit of $2,500 and a lower limit of $1,500.

   (iii) Level IV applicants, the fee will be no more than $10 per licensed bed with an upper limit of $1,000 and a lower limit of $500.

(C) a complete trauma designation survey report, which includes patient case reviews, submitted no later than 120 days from the date of the survey;
(D) If deficiencies or findings of not met are identified on the
survey report, the facility shall develop and implement a plan of
correction (POC). The POC shall include:

(i) a statement of the cited deficiency;
(ii) details of the corrective action to ensure compliance
with the requirement;
(iii) the title of the individual(s) responsible for ensuring
the correction action(s) is implemented;
(iv) the date by which the corrective action will be
implemented, within 120 days from the date of the survey;
(v) how the corrective action will be monitored; and
(vi) supporting documentation of corrective actions.

(E) Evidence of participation in the applicable Regional
Advisory Council (RAC);

(F) Evidence of submission of data to the department trauma
registry; and

(G) Any subsequent documents requested by the department
within the timeframe determined by the department.

(7) If a facility seeking initial designation fails to meet the
requirements in subsections (c)(6)(A) – (G) above, the application will
not be processed.

(8) Renewal of designation. The facility shall submit the documents
described in subsection (c)(6)(A) – (G) above, to the department no
later than 90 days prior to the designation expiration date.

(9) If a facility seeking renewal of designation fails to meet the
requirements in subsection (c)(6)(A) – (G) above, the application will not be
processed, and the original designation will expire on the expiration date.

(10) The facility shall have the right to withdraw its application at any
time prior to being recommended for trauma designation by the department.
(11) The trauma designation application packet in its entirety shall be part of a facility's multidisciplinary trauma performance improvement program, pursuant to confidentiality in the Health and Safety Code, §773.095.

(12) Approval Process.

(A) The department shall review the findings of the survey report, and POC (if required), submitted by the facility to determine compliance with the requirements.

(B) A recommendation for designation will be made to the commissioner if the facility meets the requirements for designation defined in this section.

(C) If a facility does not meet the requirements for the level of designation requested, the department shall notify the facility of the deficiencies and may take the following action:

(i) develop and require a CAP to include the specific requirements not met by the facility, supporting evidence of non-compliance, and required corrective action(s) to be completed by the facility;

(ii) designate the facility at the appropriate level for which requirements are met;

(iii) deny designation of the facility; and/or

(iv) require a second survey to ensure compliance with the requirements.

(13) If the commissioner concurs with the recommendation to designate, the facility shall receive a letter of designation valid for three years and a certificate of designation as appropriate.

(14) Display: the hospital shall display the trauma designation certificate and the current letter awarding designation from the commissioner, in a public area of the designated facility that is readily visible to patients, employees, and visitors.

(15) The trauma designation certificate shall be valid only when displayed with the current letter awarding designation.
(16) If the facility closes or loses trauma designation, the certificate shall be returned to the department.

(17) Alteration: the trauma designation certificate and the award letter shall not be altered. Any alteration to either document voids trauma designation for the remainder of that cycle.

(18) The department shall post the current designation status of each facility on the department website.

(19) If a facility disagrees with the department's decision regarding its designation status, the facility has a right to a hearing, in accordance with the department's rules for contested cases, and Government Code, Chapter 2001.

(d) Exceptions and Notifications

(1) Notification of an event or decision impacting the ability of a trauma facility to comply with designation criteria to maintain the current designation status, or to increase the trauma facility's capabilities that impact patient care, and regional plans or guidelines, shall be documented and provided to the following:

(A) EMS providers within a time period appropriate for the change in capabilities;

(B) all healthcare facilities that may be impacted by a change in the facility's trauma services, including but not limited to facilities to which it customarily transfers-out and/or transfers-in trauma patients, within a time period appropriate for the change in capabilities;

(C) applicable RAC(s) within a time period appropriate for the change in capabilities; and

(D) the department within a time period appropriate for the change in capabilities.

(2) If the facility is unable to comply with program requirements to maintain the current designation status, it shall submit to the department a POC as described in (c)(6)(D) of this section, and a request for a temporary exception to criteria. Any request for an exception shall be submitted in writing from an executive officer of the facility. The department shall review the request and POC, and either grant or deny the exception. If the facility
has not come into compliance at the end of the exception period, the department may at its discretion:

(A) allow the facility to request designation at the level appropriate to its revised capabilities;

(B) allow the facility to relinquish designation status; or

(C) designate the facility at the level appropriate to its revised capabilities.

(e) Relinquishment of designation. If the facility chooses to relinquish its trauma designation, it shall provide at least a 30-day notice to the department, applicable RAC(s), EMS providers, and all healthcare facilities that may be impacted, including but not limited to, healthcare facilities which it customarily transfers-out and/or transfers-in trauma patients, if it no longer provides trauma services.

(f) A facility may not use the terms "trauma facility", "trauma hospital", "trauma center", or similar terminology in its signs, advertisements, or in printed materials and information it provides to the public unless the facility is currently designated as a trauma facility according to the process described in this section.

(g) The department shall have the right to review, inspect, evaluate, and audit all trauma patient records, multidisciplinary trauma performance improvement and peer review committee meeting minutes, and other documents relevant to trauma care in any designated trauma facility or applicant facility, at any time to verify compliance with Health and Safety Code, Chapter 773 Emergency Medical Services, §773.111 and TAC §157.125, including the designation requirements. The department shall maintain confidentiality of such records to the extent authorized by the Texas Public Information Act, Government Code, Chapter 552, and consistent with current laws and regulations related to the Health Insurance Portability and Accountability Act of 1996, and/or any other relevant confidentiality law or regulation.

(h) Onsite reviews conducted by the department shall be scheduled as appropriate. The department shall provide a report with findings to the facility for these onsite reviews.

(i) If a designated trauma facility ceases to provide services to meet and/or maintain compliance with the requirements of this section, or if it violates TAC Chapter 133 Hospital Licensing requirements, resulting in enforcement
action, or under an agreed order, the department may deny, suspend, or
revoke the designation.

(j) The department may grant an exception to this section if it finds that
compliance with this section would not be in the best interest of the persons
served in the affected local system.

(k) Program Requirements.

(1) Program Plan. The facility shall develop a written plan of the
trauma program that includes, a detailed description of the scope of services
available to all trauma patients, defines the trauma patient population
evaluated and/or treated by the facility, transferred, or transported by the
facility, that is consistent with accepted professional standards of practice for
trauma care, and ensures the health and safety of patients.

(A) The written plan and the program policies and procedures
shall be reviewed and approved by the facility’s governing body at
least every 3 years. The governing body shall ensure that the
requirements of this chapter are implemented and enforced.

(B) The written program plan shall include, at a minimum:

(i) policies and procedures based on national evidence-
based standards of practice of trauma care, that are
adopted, implemented, and enforced for compliance by the
facility, that governs the trauma program through all
phases of care for all patient populations;

(ii) a periodic review and revision schedule for all trauma
care policies and procedures;

(iii) written triage, stabilization and transfer guidelines for
the trauma patient that include consultation and transport
services;

(iv) written assessment, treatment, referral and transfer
guidelines for patients with the following:

(I) burn injuries, to include a plan to expedite the
transfer of acute major and severe burn patients for
specialized care;
(II) identified spinal cord injury and/or moderate to severe head injuries, to include a plan to expedite the transfer of acute spinal cord/head injury patients for specialized care; and

(III) suspected and/or confirmed maltreatment injuries of all patient populations.

(v) provisions for the availability of all necessary equipment and services to administer the appropriate level of care and support of the patient population served;

(vi) telemedicine utilization in Emergency Services;

(vii) requirements for minimal credentials for all medical and healthcare staff participating in the care of trauma patients;

(viii) provisions for medical and healthcare staff education, including annual competency and skills assessment appropriate for the patient population served, and team-based training at frequent intervals for high-risk events;

(viii) describe the role of the hospitalist/intensivist physicians in the care of the trauma patient;

(ix) identification of a program sponsor who is a member of the executive leadership at the facility;

(x) provisions for consistent participation by the TMD, TPM, Trauma Registrar, and/or other members of the trauma program in the RAC;

(xi) contingency plans to ensure the immediate continuation of an active trauma program in the event that the TMD and/or TPM position(s) becomes vacant; and

(xii) a trauma staff registered nurse as a representative on the nurse staffing committee as established in accordance with TAC §§133.41(o)(2)(F).

(2) Medical Records. Maintain medical records that contain information to justify and support the immediate evaluation, activation, resuscitation, diagnosis, treatment, and describe the patient’s progress and response to
medication(s) and intervention(s) from arrival in the Emergency Department through hospital discharge. Records include patient care reports provided by EMS to the facility receiving the trauma patient.

(3) Trauma Performance Improvement Plan. The facility shall develop, implement, maintain, and evaluate an effective, ongoing, facility-wide, data-driven, outcome-based, trauma performance improvement (PI) plan. The plan shall be individualized to the facility and meet the requirements described in this section.

(A) The trauma PI plan shall be reviewed and approved by the facility’s governing body. The governing body and facility administration shall ensure that the requirements of this section are implemented and enforced.

(B) The trauma PI plan shall include, at a minimum:

(i) A description of the facility’s trauma program and the services provided. All facility services (including those services furnished under contract or arrangement) shall focus on decreasing deviations from the trauma standards of care to ensure achievement of optimal trauma patient outcomes, patient safety standards, and cost-effective care.

(ii) How the program evaluates the standards of practice, provision of trauma care and patient services, identifies opportunities for improvement, develops and implements improvement plans, and evaluates the plans’ outcomes until resolution is achieved.

(iii) Evidence to support that aggregate patient data, including identification and tracking of trauma patient complications, variances from standards of care, and the tiered levels of review, is continuously evaluated for opportunities by the multidisciplinary trauma PI and peer review committee.

(iv) Required members of the multidisciplinary trauma PI and peer review committee(s) shall include, at a minimum:

(I) the TMD,

(II) the TPM,

(III) the Trauma Registrar (TR),
(IV) an executive officer of the facility,

(V) a trauma nurse(s) active in the management of adult and/or pediatric trauma patients as applicable,

(VI) physicians and surgeons that provide care to trauma patients, and

(VII) other healthcare professionals participating in the care of major or severe trauma patients.

(v) provisions to document the attendance, activities, actions, and follow-up of outcomes by the multidisciplinary trauma PI and peer review committee;

(vi) provisions to document evidence of ongoing monthly review of trauma facility regulatory compliance, trauma patient outcomes, and trauma system performance from multidisciplinary trauma PI and peer review committee meetings; and

(vii) documentation that a 12-month summary, of the Trauma PI program activities, was provided to the governing body for review.

(4) Texas EMS/Trauma Registry Requirements. Any designated trauma facility must submit accurate, timely, and complete trauma registry data to the Texas EMS/Trauma Registry at least quarterly.

(A) For initial designation, six months of data must be submitted to and received by the Texas EMS/Trauma Registry prior to the initial designation survey.

(B) For renewal of designation, data shall be submitted to and received by the Texas EMS/Trauma Registry continuously throughout the designation cycle.

(C) Trauma data shall be submitted as defined in Chapter 103, Injury Prevention and Control.

(D) Trauma data shall be submitted within 60 days of patient discharge, with an 80% accuracy rate.
(E) The Trauma Registrar and/or TPM must ensure ongoing internal data validation and accuracy for data submissions to the state registry.

(F) Trauma patients, received at a provider-based department not contiguous with the designated facility, that meet trauma registry inclusion criteria must be included in the trauma registry and trauma performance improvement program.

(5) Outreach and Healthcare Provider Education.

(A) There shall be an identified individual to coordinate the facility’s outreach and education programs.

(B) The facility shall provide training programs in trauma-related continuing education, for staff and community members involved in trauma care, based on needs identified from the trauma PI program including:

(i) staff, specialty and community physicians;

(ii) nurses;

(iii) advanced practice clinicians including, Physician Assistants, Advanced Nurse Practitioners, and Certified Registered Nurse Anesthetists;

(iv) allied health personnel;

(v) EMS personnel; and

(vi) other appropriate personnel.

(6) Injury Prevention and Public Education.

(A) There shall be an identified individual to coordinate the injury prevention and public education programs.

(B) The facility shall provide evidence of coordination and/or participation, in community and/or RAC injury prevention and public education activities, including common major injury incidents identified within the facility’s service area.

(7) Disaster Response Plan.
(A) All trauma facilities shall have a comprehensive hospital disaster plan including department specific policies and procedures.

(B) The trauma facility shall have documented evidence of training all facility staff to respond to a mass casualty event and a no-notice event.

(C) The facility shall have documentation of the response, with an after-action review, and performance improvement action plan.

(D) The facility response can be through simulation training, a planned exercise, or response to an actual event.

(8) EMS Communication.

(A) There shall be two-way communication between the facility and all EMS personnel and/or vehicles.

(B) The facility will share patient health outcome information with EMS Providers for quality improvement as long as both entities have (or have had in the past) a relationship with the patient(s) in question in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.

(9) Medical Staff. The facility must have an organized, effective trauma program that is recognized in the medical staff bylaws and approved by the governing body. Medical staff credentialing shall include a process for requesting and granting delineation of privileges for trauma care.

(10) Trauma Medical Director. There shall be an identified Trauma Medical Director (TMD) responsible for the provision of trauma care who is credentialed and privileged by the facility for the treatment of trauma patients. The TMD shall be a physician who:

(A) is a trauma/general surgeon that demonstrates knowledge, experience, and expertise in caring for trauma patients;
(B) regularly and actively participates in trauma care at the hospital where trauma medical director services are provided;

(C) holds current completion status of ATLS or a department recognized equivalent course;

(D) demonstrates effective administrative skills and oversight of the trauma performance improvement program;

(E) completes an average of 16 hours of trauma-related continuing medical education annually;

(F) has evidence of disaster response education; and

(G) maintains active staff privileges as defined in the facility’s medical staff bylaws.

(H) The TMD shall be a member of the Medical Executive Committee (MEC).

(I) The TMD shall have responsibility for the overall clinical direction and oversight of the trauma service.

(J) The responsibilities and authority of the TMD shall include, but are not limited to:

(i) reviewing credentials of medical staff requesting privileges for trauma call coverage and to participate in trauma patient care;

(ii) making recommendations to the MEC for either approval or denial of trauma privileges;

(iii) ensuring a written, on-call schedule, and a backup on-call schedule/plan is readily available to relevant staff in the emergency department, for obtaining surgical care for all surgical specialties;

(iv) excluding those physicians from trauma call coverage and patient care who do not maintain trauma program requirements;
(v) ensuring the use of medical staff peer case review outcomes, including deviations from trauma standards of care trending, when considering re-credentialing physicians providing trauma care;

(vi) developing and providing ongoing management of treatment protocols based on current standards of trauma care;

(vii) participating in the ongoing education of the medical, nursing, and ancillary staff in the care of the trauma patient;

(viii) serving as chair/co-chair of the trauma PI and peer review committee(s);

(ix) ensuring the multidisciplinary trauma PI and peer review committee meeting(s) are specific to trauma care, ongoing, data-driven and effective;

(x) participating in the applicable RAC(s) and reviewing the RAC(s) trauma system plan;

(xi) participating in the facility, community, and regional disaster preparedness activities; and

(xii) providing evidence that he/she is aware of the multidisciplinary team findings on all trauma patients.

(11) Trauma Program Manager (TPM). There shall be an identified Trauma Program Manager responsible for monitoring trauma patient care throughout the continuum of care and through discharge.

(A) The Trauma Program Manager will have the equivalent authority and responsibility as granted to other department or nurse managers, and:

(i) shall be a registered nurse;

(ii) demonstrates knowledge, experience, and expertise in caring for trauma patients;
regularly and actively participates in trauma care at the facility where trauma program manager services are provided;

(iii) is current in appropriate adult and pediatric trauma nursing courses or department recognized equivalent courses;

(iv) has completed a department recognized course designed for his/her role which provides essential information on the structure, process, organization and administrative responsibilities of a trauma program;

(v) has completed a course designed for his/her role which provides essential information of a trauma PI program to include trauma outcomes and performance improvement or a department recognized equivalent course;

(vi) has completed a department recognized injury scoring and/or coding course, within 18 months of becoming the trauma program manager;

(vii) has evidence of disaster response education;

(viii) has evidence of disaster response education;

(B) The Trauma Program Manager has the authority and oversight in collaboration with the TMD to:

(i) be responsible for the integration and monitoring of compliance of the trauma nursing standards of care;

(ii) monitor trauma patient care, from prehospital and arrival, through Emergency Department (ED), surgical intervention(s), Intensive Care Unit (ICU), rehabilitation, and discharge, through the trauma performance improvement (PI) program; and

(iii) monitor the clinical outcomes and system performance of the trauma program.

(iv) participates in a leadership role in the facility through committee participation, facility-wide PI initiatives, and emergency management and disaster response committee;
(v) participates in RAC activities through committee membership, and regional emergency preparedness.

(l) Trauma Designation Level I (Comprehensive). The facility shall meet the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center.

(m) Trauma Designation Level II (Major). The facility shall meet the current ACS essential criteria for a verified Level II trauma center.

(n) Trauma Designation Level III (Advanced). The facility shall meet TAC §157.125 (j) in this section; and the following requirements:

1. Trauma Medical Director shall be a physician who:
   (A) is a currently board-certified or board-eligible trauma/general surgeon according to current requirements; or
   (B) is a trauma/general surgeon that demonstrates knowledge, experience and expertise in caring for trauma patients.

2. All trauma/general surgeons who provide trauma care and participate in continuous 24 hours a day trauma call coverage shall:
   (A) be present at the patient bedside upon arrival for a full trauma team activation, with a maximum response time of 30 minutes from activation notification;
   (B) be present at the patient bedside for a limited trauma team activation with a maximum response time of 60 minutes from activation notification; and
   (C) be the admitting physician on all multi-system trauma patients requiring the consultation of one or more specialty services;
   (D) be board-certified or board-eligible according to current requirements, and have completed ATLS successfully; or
   (E) if not board-certified or board-eligible:
(i) demonstrates significant knowledge, experience, and expertise in caring for trauma patients;

(ii) holds current completion status of ATLS, or a department recognized equivalent course; and

(iii) averages at least 9 hours of trauma-related continuing medical education annually.

(G) maintain compliance with trauma treatment protocols as evidenced through the trauma PI program;

(H) participate in the trauma PI program and attend at least 50% of the multidisciplinary trauma PI and peer review committee meetings;

(I) be approved by the TMD; and

(J) be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.

(K) Surgical Residency Program. If a facility has a residency program:

(i) the team of surgical residents that start the evaluation and treatment of the trauma patient, shall have at a minimum, a postgraduate year 4 (PGY-4) or more senior surgical resident who is a member of the facility’s residency program;

(ii) the attending surgeon must be compliant with all response times. The presence of a surgical resident does not take the place of the attending physician; and

(iii) the attending surgeon shall participate in all major therapeutic decisions, be present in the emergency department for major resuscitations, and be present during all phases of operative procedures.

(3) In addition to continuous trauma/general surgery coverage, the facility shall have continuous 24 hours a day orthopedic surgical coverage.

(4) All orthopedic and neurosurgeons who provide trauma care or participate in continuous trauma call coverage shall:
(A) be present at the patient bedside for a full trauma team activation within 30 minutes from activation notification;

(B) be present at the patient bedside for a limited trauma team activation within 60 minutes from activation notification;

(C) be board-certified or board-eligible according to current requirements; or

(D) if not board-certified or board eligible, demonstrates significant knowledge, experience, and expertise in caring for trauma patients;

(E) maintain compliance with trauma treatment protocols as evidenced through the trauma PI program;

(F) participate in the trauma PI program;

(G) at a minimum, orthopedic surgeons and neurosurgeons, participate in the published, on-call schedule and backup on-call schedule or plan, readily available to all relevant staff to obtain specialty surgical care;

(H) be approved by the TMD; and

(I) be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.

(J) Designated liaisons, or predetermined alternates, for orthopedic surgery, and neurosurgery, shall attend at least 50% of the multidisciplinary trauma PI and peer review committee meetings, and average at least 16 hours of trauma related continuing medical education annually, if not current with board maintenance of certification or board eligibility.

(5) Emergency Medicine. The Emergency Medicine physicians providing trauma call coverage shall:

(A) be in-house 24 hours a day and arrive at the patient bedside appropriately upon trauma activations;

(B) be board-certified or board-eligible in Emergency Medicine and have successfully completed ATLS; or
(C) if not board-certified or board-eligible:

(i) demonstrate significant knowledge, experience, and expertise in caring for trauma patients;

(ii) hold current completion status of ATLS, or a department recognized equivalent course; and

(iii) average at least 9 hours of trauma-related continuing medical education annually.

(D) maintain compliance with trauma treatment protocols as evidenced through the trauma PI program;

(E) participate in the multi-disciplinary trauma PI program;

(F) be approved by the TMD; and

(G) be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.

(H) A designated liaison, or predetermined alternate liaison, shall attend at least 50% of the multidisciplinary trauma PI and peer review committee meetings.

(6) Advanced Practice Providers. Physician Assistants (PA), and Nurse Practitioners (NP), shall not be a substitute for the required physician response, in patient care planning, nor in trauma PI activities. Advanced Practice Providers who participate in the care of major and severe trauma patients shall:

(A) demonstrate knowledge, experience, and expertise in caring for major and severe trauma patients;

(B) hold current completion status of ATLS or a department recognized equivalent course;

(C) average at least 9 hours of trauma-related continuing medical education annually;

(D) maintain compliance with trauma treatment protocols as evidenced through the trauma PI program;
(E) participates in the multi-disciplinary trauma PI program;

(F) be approved by the TMD; and

(G) be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.

(7) Anesthesia services shall be in compliance with 25 TAC §133.41 Hospital Functions and Services.

(A) An anesthesiologist providing trauma care shall:

   (i) be board-certified or board-eligible in specialty;

   (ii) if not current with board maintenance of certification or board eligibility, average at least 9 hours of continuing medical education annually;

   (iii) maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;

   (iv) be approved by the TMD; and

   (v) be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.

(B) A designated liaison, or predetermined alternate, shall attend at least 50% of the multidisciplinary trauma PI and peer review committee meetings.

(C) Certified Registered Nurse Anesthetist (CRNA) providing trauma care shall:

   (i) average at least 9 hours of continuing education annually;

   (ii) maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;

   (iii) participate in the multi-disciplinary trauma PI program;
(iv) be approved by the TMD; and

(v) be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma patients.

(8) Radiology.

(A) A radiologist shall be on-call 24 hours a day and promptly available within 30 minutes of request. The radiologists' response times shall be continuously monitored by the trauma PI program.

(B) Changes in preliminary and final interpretations of radiologic studies shall be routinely monitored and reviewed with the radiology department. Identified cases shall be evaluated to determine the reason for misinterpretation, adverse outcomes, and opportunities for improvement.

(9) Nursing Services. Nursing administration shall:

(A) ensure the trauma nursing positions, including the TPM and TR, have adequate time dedicated to the trauma program to ensure compliance with TAC §157.125 requirements;

(B) commit to advancing the education and understanding of trauma standards of care for all nursing staff caring for the trauma patient;

(C) approve and utilize an acuity-based patient classification system to define workload and number of nursing staff to provide safe patient care for all trauma patients throughout their hospitalization; and

(D) develop a written facility plan for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, volume, multiple emergency procedures, and admissions.

(10) Emergency nursing staff who participate in the care of the major and severe trauma patients shall have:

(A) at least two members of the registered nursing staff, responding to and participating in initial resuscitations for full and limited trauma activations, have current credentials in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses;
(B) documentation that 100% of emergency nursing staff responding to trauma activations or caring for trauma patients, have current credentials in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses, within 12 months of date of assignment in the ED; and

(C) emergency nursing documentation for trauma patients that is systematic, meets the trauma registry guidelines, and includes at a minimum: trauma activation times, primary and secondary surveys with interventions, sequence of care, diagnostic evaluation(s), serial vital signs, neurologic assessment(s), outcomes, plan of care with disposition, and the response times of all trauma team members.

(11) All Nursing Staff who participate in the care of trauma patients throughout the continuum of care shall:

(A) have ongoing documented knowledge and skills in trauma nursing for patients of all ages including trauma specific orientation, annual clinical competencies, and continuing education;

(B) have written standards of trauma nursing care for all units (i.e. Emergency Department (ED), Intensive Care Unit (ICU), Surgery, Post Anesthesia Care Unit (PACU), and general inpatient) with evidence of appropriate implementation for all trauma patients; and

(C) document nursing care for trauma patients that is systematic, meets the trauma registry guidelines, and includes at a minimum: patient assessments with interventions, sequence of care, serial vital signs, neurologic assessment(s), diagnostic evaluations, outcomes, and plan of care with disposition.

(12) Trauma Registrar. There shall be an identified Trauma Registrar, separate from but supervised by the TPM, who has:

(A) completed appropriate education and training within 18 months of hire into the position of trauma registrar which includes:

   (i) a department recognized injury scoring and/or coding course;

   (ii) a comprehensive trauma registry training course or a department recognized equivalent course; and
(13) Emergency Services. Equipment and services for critically or seriously injured patients, complex neurosurgical patients, or orthopedic injured patients, of all ages shall be available for:

(A) evaluation;
(B) resuscitation and life support;
(C) hemodynamic monitoring
(D) temperature management;
(E) hemorrhage control;
(F) orthopedic splinting; and
(G) burn care.

(14) Surgical Services. Equipment and services to provide care for trauma patients requiring operative interventions shall be available, including resuscitation, hemodynamic monitoring, temperature management, hemorrhage control, orthopedic splinting, and burn care.

(A) Operating rooms and appropriate personnel shall be available 24 hours a day.
(B) An operating room shall be ready to accept an acute trauma patient within 45 minutes of notification.
(C) Post-anesthesia care shall be provided by registered nurses and other essential personnel available 24 hours a day in PACU or ICU.

(15) Intensive Care Services. Intensive care services shall be available for trauma critical care patients, to include:

(A) A designated physician surgical director or surgical co-director who is:
(i) a board-certified or board-eligible surgeon;
(ii) responsible for developing, implementing, and enforcing policies, protocols, and management guidelines related to trauma ICU patients;

(iii) maintains compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;

(iv) participates in the multi-disciplinary trauma PI program;

(v) approved by the TMD; and

(vi) be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma critical care patients.

(B) Physicians providing intensive care shall:

(i) be immediately available 24 hours a day onsite or on-call if not in-house, to promptly arrive at the patient bedside within 30 minutes of request/ notification;

(ii) be privileged in surgical critical care; or

(iii) have trauma/general surgeon on-call to provide surgical coverage of surgical emergencies, and routine care for trauma patients, if a non-surgically trained intensivist is present or on-call;

(iv) maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;

(v) participate in the multi-disciplinary trauma PI program;

(vi) be approved by the TMD; and

(vii) be credentialed and privileged by the facility to participate in the resuscitation and treatment of trauma critical care patients.

(C) The on-call physician coverage and response times shall be monitored through the trauma performance improvement program.

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(D) Intensive care equipment and services for critically or seriously injured patients, complex neurosurgical patients, or orthopedic injured patients, of all ages shall be available for:

(i) evaluation;
(ii) resuscitation and life support;
(iii) hemodynamic monitoring
(iv) temperature management;
(v) hemorrhage control;
(vi) orthopedic splinting; and
(vii) burn care.

(16) Clinical Support Services.

(A) Cardiopulmonary Services. Cardiopulmonary personnel appropriate for the patient population served shall be in-house and available 24 hours a day.

(B) Clinical Laboratory Service. Laboratory services and personnel shall be onsite and available 24 hours a day. The laboratory shall have current policies and procedures developed and implemented collaboratively between the trauma service and the blood bank to include emergent blood release and a massive transfusion process.

(C) Standard Radiological Services. Radiological services and appropriately trained personnel shall be onsite and available 24 hours a day.

(D) Special Radiological Services. Special radiological services and appropriately trained personnel shall be available as defined by the facility’s trauma plan to include:

(i) Computerized Tomography (CT). Appropriate equipment and trained personnel shall be available onsite or on-call 24 hours a day.
(I) Personnel shall arrive on-site promptly within 30 minutes of request/notification.

(II) On-call personnel response times and CT availability shall be documented and continuously monitored through the trauma performance improvement program.

(ii) sonography; and

(iii) angiography.

(17) The facility shall have the following services available for all trauma patients:

(A) Physical therapy;

(B) Occupational therapy;

(C) Speech therapy;

(D) Social services; and

(E) Pastoral Care.

(18) Specialized Services.

(A) Acute hemodialysis. A written transfer plan which shall be implemented if the facility does not have the capability for this standard.

(B) Rehabilitation Medicine.

(i) A physician-directed rehabilitation service, staffed by personnel trained in rehabilitation care and equipped properly for care of the critically injured patient; or

(ii) a written transfer plan to expedite the transfer of rehabilitation patients when medically feasible to a rehabilitation facility.

(o) Trauma Designation Level IV (Basic). The Level IV trauma designated facility shall meet the following requirements:
(1) The Trauma Medical Director shall be a physician who:

(A) is a currently board-certified or board-eligible general surgeon according to current requirements if surgical procedures are regularly performed on trauma patients; or

(B) is currently board-certified or board-eligible in emergency medicine, if no surgical procedures are regularly performed on trauma patients; or

(C) demonstrates knowledge, experience, and expertise in the stabilization and transfer of trauma patients, if all major and severe trauma patients are immediately transferred and not admitted.

(2) The Emergency Medicine physicians providing trauma care in a Level IV facility not utilizing telemedicine medical services shall:

(A) be available 24 hours a day onsite or on-call if not in house, to promptly arrive at the patient bedside within 30 minutes of request/notification.

(B) be currently board-certified or board-eligible in emergency medicine and has completed ATLS successfully; or

(C) if not board-certified or board-eligible in Emergency Medicine shall;

(i) demonstrate knowledge, experience, and expertise in caring for major and severe trauma patients appropriate for the population served; and

(ii) holds current completion status of ATLS or a department recognized equivalent course.

(D) if not current with board maintenance of certification or board eligibility, average at least 9 hours of trauma-related continuing medical education annually;

(E) maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;

(F) participate in the multi-disciplinary trauma PI program;

(G) be approved by the TMD; and
(H) be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.

(I) Designate a liaison, and one pre-determined alternate liaison who shall attend at least 50% of the multi-disciplinary trauma PI and peer case review committee meetings.

(3) The Emergency Medicine physicians consulting for trauma care, in a Level IV facility located in a county with a population of less than 30,000 utilizing telemedicine medical services to collaborate care with a physician or an advanced practice provider onsite, shall:

(A) be available 24 hours a day to promptly respond via telemedicine medical services within 30 minutes of request/notification;

(B) be board-certified or board-eligible in Emergency Medicine;

(C) have completed ATLS successfully;

(D) if not current with board maintenance of certification or board eligibility, average at least 9 hours of trauma-related continuing medical education annually;

(E) maintain compliance with trauma treatment protocols as evidenced through the trauma PI program;

(F) be approved by the TMD; and

(G) be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.

(4) Advanced Practice Providers including Physician Assistants (PA), and Nurse Practitioners (NP), who participate in the care of major and severe trauma patients shall:

(A) be available 24 hours a day and on-call if not in house, to promptly arrive at the patient bedside within 30 minutes of request/notification;

(B) demonstrate knowledge, experience, and expertise in caring for major and severe trauma patients;
(C) holds current completion status of ATLS or a department approved equivalent course;

(D) average at least 9 hours of trauma-related continuing medical or nursing education annually as appropriate;

(E) maintain compliance with trauma treatment protocols as evidenced through the trauma performance improvement program;

(F) participate in the trauma multi-disciplinary PI program;

(G) be approved by the TMD; and

(H) be credentialed and privileged by the hospital to participate in the resuscitation and treatment of trauma patients.

(I) If advanced practice providers’ supervision is conducted through a physician and telemedicine technology, specific treatment protocols and performance improvement measures must be documented and monitored.

(5) Radiologist Services.

(A) A radiologist shall be on-call and promptly available within 30 minutes of request. The radiologist call-back response times shall be continuously monitored through the trauma PI program.

(B) Changes in preliminary and final interpretations of radiologic studies shall be routinely monitored and reviewed with the radiology department. Identified cases shall be reviewed to determine the reason for misinterpretation, adverse outcomes, and opportunities for improvement.

(6) Nursing Services. Nursing administration shall:

(A) ensure the trauma nursing positions, including the TPM and TR, have adequate time dedicated to the trauma program to ensure compliance with TAC §157.125 requirements;

(B) commit to advancing the education and understanding of trauma standards of care for all nursing staff caring for the trauma patient;
(C) approve and utilize an acuity-based patient classification system to define workload and number of nursing staff to provide safe patient care for all trauma patients throughout their hospitalization; and

(D) Develop a written facility plan for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, volume, multiple emergency procedures, and admissions.

(7) Emergency Nursing Staff who participate in the care of the major and severe trauma patient shall have:

(A) at least one member of the registered nursing staff responding to and participating in initial resuscitations for full and limited trauma activations, has current credentials in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses;

(B) documentation that 100% of emergency nursing staff responding to trauma activations or caring for trauma patients, have current credentials in appropriate adult and pediatric trauma nursing courses, or department recognized equivalent courses, within 12 months of date of assignment in the ED; and

(C) emergency nursing documentation for trauma patients that is systematic, meets the trauma registry guidelines, and includes at a minimum: trauma activation times, primary and secondary surveys with interventions, sequence of care, diagnostic evaluation(s), serial vital signs, neurologic assessment(s), outcomes, plan of care with disposition, and the response times of all trauma team members.

(8) Nursing Staff who participate in the care of all trauma patients throughout the continuum of care shall:

(A) have ongoing documented knowledge and skills in trauma nursing for patients of all ages including trauma specific orientation, annual clinical competencies, and continuing education;

(B) have written standards of trauma nursing care for all units (i.e. ED, ICU, Surgery, PACU, general inpatient) with evidence of appropriate implementation for all trauma patients; and

(C) document nursing care for trauma patients that is systematic, meets the trauma registry guidelines, and includes at a
minimum: patient assessments with interventions, sequence of care, diagnostic evaluations, serial vital signs, neurologic assessment(s), outcomes, and plan of care with disposition.

(9) Trauma Registrar. There shall be an identified Trauma Registrar who has:

(A) completed appropriate education and training within 24 months of hire into the position of trauma registrar which includes:

(B) a department recognized injury scoring, and/or coding course; and

(C) four hours of continuing education annually specific to trauma data quality.

(10) Emergency Services. Equipment and services for critically or seriously injured patients, complex neurosurgical patients, or orthopedic injured patients, of all ages shall be available for:

(A) evaluation;

(B) resuscitation and life support;

(C) hemodynamic monitoring

(D) temperature management;

(E) hemorrhage control;

(F) orthopedic splinting; and

(G) burn care.

(11) Clinical Support Services.

(A) Respiratory Services. Respiratory services shall be available 24 hours a day onsite and appropriate for the trauma patient population served.

(B) Clinical Laboratory Service.
(i) Laboratory services shall be available 24 hours a day onsite, with the emergency release of blood products, and a plan to obtain additional blood products.

(ii) Laboratory personnel shall be available onsite or on-call 24 hours a day, and promptly arrive on-site within 30 minutes of request. On-call response times will be documented and monitored through the trauma performance improvement program.

(C) Standard Radiological Services. Services and appropriate trained personnel shall be available onsite or on-call 24 hours a day, and promptly arrive onsite within 30 minutes of request. On-call response times will be documented and monitored through the trauma performance improvement program.

(D) Special Radiological Services. Computerized tomography scanner (CT) abilities appropriate for the trauma population served shall be available onsite 24 hours a day. Appropriate trained personnel shall be available onsite or on-call 24 hours a day, and promptly arrive onsite within 30 minutes of request. On-call personnel response times will be documented and monitored through the trauma performance improvement program.

(12) Social Services and Pastoral Care shall be available 24 hours a day.

(13) If the facility performs surgery and/or provides inpatient trauma care, the facility shall provide the same level of care that the patient would receive at a higher level designated facility and shall review the care provided through the trauma PI Program.

(p) Survey Team.

(1) The American College of Surgeons (ACS) multi-disciplinary survey team for Level I or Level II facilities shall include at a minimum: two trauma/general surgeons and a registered nurse, who are currently active in the management of trauma patients. Stand-alone pediatric facilities shall be surveyed by an ACS multi-disciplinary team that includes at a minimum: two pediatric trauma/general surgeons and a pediatric registered nurse, who are currently active in the management of pediatric trauma patients.
(2) Multi-disciplinary survey teams evaluating compliance with the Texas Administrative Code §157.125 requirements shall include at a minimum:

(A) Level III facilities shall be surveyed by a department recognized organization with a multi-disciplinary team that includes at a minimum: a trauma/general surgeon and a registered nurse who are currently active in the management of trauma patients, and have the knowledge, experience, and expertise in the oversight of a trauma program. Stand-alone pediatric facilities shall be surveyed by a department-recognized organization, with a multi-disciplinary team that includes at a minimum: a trauma/general surgeon and a registered nurse who are currently active in the management of pediatric trauma patients and have the knowledge, experience, and expertise in the oversight of a trauma program. An additional surveyor may be requested by the facility or required by the department.

(B) Level IV facilities shall be surveyed by a representative of a department-recognized organization that is a trauma/general surgeon and/or a registered nurse who is currently active in the management of trauma patients and has the knowledge, experience, and expertise in the oversight of a trauma program. Stand-alone pediatric facilities shall be surveyed by a representative of a department-recognized organization that is a trauma/general surgeon and/or a registered nurse who is currently active in the management of pediatric trauma patients and has the knowledge, experience, and expertise in the oversight of a trauma program. An additional surveyor may be requested by the facility or required by the department.

(3) Each member of the survey team described above shall:

(A) be currently employed at a designated trauma facility that is greater than 100 miles from the requesting facility;

(B) not be employed or practicing in the same TSA as the designating facility;

(C) not be a current employee or former employee within the last 5 years of the facility or of an affiliated facility that is the subject of the survey;

(D) not be employed at a facility that is a primary transfer facility with the facility being surveyed, except for a burn facility;
(E) not survey the facility program and physical location on consecutive designation cycles;

(F) not be requested by the facility; and

(G) not possess other potential conflict(s) of interest.

(4) Each member of the survey team shall:

(A) have at least 5 years of experience in the care of trauma patients;

(B) be currently coordinating care for trauma patients;

(C) have knowledge, direct experience, and expertise in the preparation for and successful completion of trauma facility designation for no fewer than 2 successful cycles;

(D) have successfully completed a department-approved trauma facility site surveyor course and any additional training required by the department;

(E) have successfully completed a trauma designation surveyor internship;

(F) be successfully re-credentialed every 4 years; and

(G) have current credentials as follows:

(i) Registered Nurses: current in appropriate adult and pediatric trauma nursing courses or department recognized equivalent courses; and

(ii) Physicians: current completion status of ATLS or a department approved equivalent course.

Email Comments To: