

March 2, 2010

## STANDARDS FOR EMERGENCY DEPARTMENT AND URGENT CARE CLINIC STAFFING NEEDS IN VHA FACILITIES

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides policy for Emergency Departments (EDs) and Urgent Care Clinics (UCCs) in VHA for use in determining the appropriate staffing levels for physicians, nurses, and ancillary personnel.

### 2. BACKGROUND

a. EDs must have adequate staff and resources available to evaluate all individuals presenting to the ED or UCC. Because of the unscheduled and episodic nature of health emergencies and acute illnesses, experienced and qualified physician, nursing, and ancillary personnel must be available during all hours of operation.

b. The Department of Veterans Affairs (VA) recognizes the importance of providing quality emergency and urgent care to Veterans and subscribes to the following principles as outlined by the American College of Emergency Physicians (ACEP):

- (1) Emergency medical care must be available to all members of the public.
- (2) Access to appropriate emergency and urgent care must be unrestricted.
- (3) Evaluation, management, and treatment of patients must be appropriate and expedient.
- (4) Resources need to exist in the ED and UCC to accommodate each patient from the time of arrival through evaluation, decision making, treatment, and disposition.
- (5) EDs and UCCs need to have policies and plans to provide effective administration, staffing, facility design, equipment, medication, and ancillary services.

c. The emergency or urgent care physician, emergency or urgent care nurse, and additional medical team members are the core components of the emergency or urgent care medical system. Effective working relationships need to be established with other health care providers and entities with whom they must interact. Timely emergency care by an ED physician and ED nursing staff, physically present in the ED, must be continuously available 24 hours a day, 7 days a week (24/7). *NOTE: The Emergency Nurses Association has endorsed the concept of adequate staffing to support the delivery of optimum patient care, achieve an operationally efficient department, and maintain a qualified and satisfied nursing staff.*

**THIS VHA DIRECTIVE EXPIRES MARCH 31, 2015**

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### d. Definitions

(1) **Emergency Care.** Emergency care is the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition that poses a threat of serious jeopardy to life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

(2) **Emergency Department (ED).** The primary responsibility of the ED is to provide resuscitative therapy and stabilization in life-threatening situations. The ED is staffed and equipped to provide initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and psychiatric disorders, regardless of the level of severity. Emergency care is provided in a clearly defined area dedicated to this function, and operates 24/7.

(3) **Urgent Care.** Urgent care is unscheduled ambulatory care for an acute medical or psychiatric illness or minor injuries for which there is a pressing need for treatment to prevent deterioration of the condition or impairing possible recovery.

(4) **Urgent Care Clinic (UCC).** An UCC provides ambulatory medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or psychiatric illness, or minor injuries. UCCs can exist in facilities with or without an ED. In either case, UCCs are not designed to provide the full spectrum of emergency medical care. Hours of operation are based on facility need and policy.

(5) **Veterans Rural Access Hospital (VRAH).** A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to health care is limited. The facility is limited to not more than 25 acute medical or surgical beds. Such facilities must be part of a network of health care that provides an established referral system for tertiary or other specialized care not available at the rural facility.

**3. POLICY:** It is VHA policy that facilities with EDs and UCCs have a written policy designating minimum staffing requirements for EDs and UCCs during all hours of operation.

### 4. ACTION

a. **National Director for Emergency Medicine.** The National Director for Emergency Medicine is responsible for providing national guidance to ensure a standardized approach for the provision of safe, quality care within VHA's EDs and UCCs. This Directive includes policy and direction used to determine the appropriate staffing levels for physicians, nurses, and ancillary personnel.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring that all facilities with EDs and UCCs within the VISN provide appropriate numbers of qualified staff to care for patients presenting for evaluation and treatment.

c. **Facility Director.** The Facility Director is responsible for ensuring that:

- (1) The ED Medical Director, ED Nurse Manager, and ED and UCC staff have the appropriate qualifications (see Attachment A).
- (2) Local policy is in effect designating the appropriate numbers of qualified staff to provide timely care to patients presenting to the ED and UCC for evaluation and treatment (see Attachment B).
- (3) EDs and UCCs are appropriately equipped and supplied to provide care for the types of patients expected to be seen and treated, to include adequate administrative staff and provider staffing (see Attachment B). In addition, ED and UCC "on call" mental health providers must be equipped with reliable cell phones or pagers.
- (4) All Veterans who are homeless, or at risk for homelessness, who do not meet admission criteria, are offered shelter through collaborative relationships with providers in the community.
- (5) A qualified physician is present in the ED at all times and on site at facilities with UCCs during all hours of operation.

e. **Facility Level Chief of Staff and Nurse Executive.** The Chief of Staff and Nurse Executive are responsible for:

- (1) Ensuring that ED and UCC care is provided by properly trained, experienced, credentialed, and privileged physicians, physician's assistants, nurse practitioners, and nurses during all hours of operation.
- (2) Ensuring that each VHA ED and UCC has mental health coverage available during all hours of operation either on-site or on-call (since behavioral health services provide a critical supportive role to the ED and UCC). This coverage is to be provided by an independent licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, physician assistant, or advanced practice nurse). *NOTE: With appropriate supervision, psychiatric residents or post-doctoral psychologists may also be used.* If the UCC is not open 24/7, the person answering telephone calls is to direct patients to the ED where they can receive emergency service.
  - (a) Ensuring that for VHA complexity Level 1a facilities (those facilities that have higher utilization, higher risk patients, specialized intensive care units, and research, educational, and clinical missions), mental health coverage, at a minimum, be on-site (based in the ED) from 7:00 a.m. to 11:00 p.m. At other times, it may be on-site or on-call. Mental health providers covering on-site from 7:00 a.m. to 11:00 p.m. may participate in activities throughout the medical facility; however, they must not undertake any medical facility activities that would prevent them from coming immediately to the ED if called. Psychiatric residents and psychology post-doctoral fellows, where available, may provide ED coverage. If that coverage is on site, the psychiatry or psychology supervising attending must also be present in the ED. For other facilities, coverage may be either on-site or on-call at all times. These mental health providers need to be equipped with reliable cell phones or pagers.

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(b) Ensuring that VHA EDs have “on-call” coverage for mental health, this requires a telephone response within 20 minutes and the ability to implement on-site evaluations within a period of time established by facility policy. Psychiatric residents and psychology post-doctoral fellows, where available, may provide ED coverage. *NOTE: Psychiatry residents or psychology fellows who are on call and respond to requests for ED consultation are expected to contact their supervising practitioners while the patient is still in the ED in order to discuss the case and to develop and recommend a plan of management.*

(3) Ensuring, since social work services provide a critical service function to the ED, each ED has ready access on-site or on-call 24/7 to social work services to assist in facilitating access to Veterans' benefits and referral to any non-clinical services needed by the Veteran.

(4) Ensuring, VA police are utilized as key staff members of the ED to ensure the safety of staff and patients and to assist in potentially volatile situations. In most facilities, VA police provide a key role in promptly responding to behavioral health emergencies, in helping to manage assaultive patients, and in intervening when potential contraband, weapons, and illicit substances are either detected or suspected to be on a patient.

(5) Providing sufficient support services to the ED and UCC to ensure that necessary and appropriate care can be consistently delivered to patients in a timely fashion. It is recognized that additional staff, such as health care technicians, paramedics, licensed practical nurses (LPNs), nurses' aides, patient support assistants (PSA), pharmacists, and clerical staff, provide important supportive roles in the ED. *NOTE: The use of such additional staff is supported and encouraged.*

(6) Addressing the need for support staff members and ensuring their duties, capabilities, and limitations are delineated.

(7) Providing sufficient provider staff and support services to cover the inpatient units so the ED providers do not have to leave the ED. Only on off-tours of duty and weekends, in facilities that meet the requirements for a VRAH and facilities that have a Level 4 Intensive Care Unit (ICU) and no more than five ICU beds, the ED physician may be allowed to respond to cardiopulmonary and respiratory emergencies in any inpatient unit. These facilities must monitor this activity closely to ensure patient care in the ED is not being compromised because of this practice.

(8) Having the appropriate number of providers, nurses, nurse extenders, and ancillary providers available based on collected data.

(9) Ensuring policies and procedures are implemented to:

(a) Meet the standards required by The Joint Commission; and

(b) Monitor the patient volumes and complexity, including patient visits per hour.

(10) Ensuring that ED staff is aware of the medical facility's services made available to assist homeless Veterans through the assigned Healthcare for Homeless Veterans (HCHV) outreach worker(s) and refers the Veteran (and family) to these staff members for assistance.

d. **ED Medical Director.** The ED Medical Director is responsible for:

(1) Oversight over all aspects of the practice of emergency medicine in the ED.

(2) Assessing and making recommendations to the hospital's credentialing body related to the qualifications and clinical privileges of prospective emergency physicians.

(3) Ensuring the physician staff is adequately educated and qualified.

e. **ED Medical Director and ED Nurse Manager.** The ED Medical Director and the ED Nurse Manager are responsible for ensuring the quality, safety, and appropriateness of emergency care are continually monitored and evaluated. They must have appropriate qualifications for their responsibilities and ensure there is adequate staffing for ED and UCC.

f. **ED Nurse Manager or Nursing Director.** The ED Nurse Manager or Nursing Director is responsible for:

(1) Ensuring that the nursing staff and support staff are appropriately educated and qualified.

(2) Working in conjunction with the ED Medical Director and all ancillary services to ensure the timely delivery of emergency nursing care in accordance with the Standards of Emergency Nursing Practice.

## 5. REFERENCES

a. 2008 Hospital Accreditation Standards, The Joint Commission.

b. American College of Emergency Physicians Policy Statement: Emergency Department Planning and Resource Guidelines October 2007.

c. Emergency Nurses Association (ENA). (2003). ENA position statement: Staffing and productivity in the emergency care setting. Des Plaines, IL.

d. Berliner, H., Kovner, C., and Zhu, C. (2002, December). Nurse staffing ratios in California hospitals: A critique of the final report on hospital nursing staff ratios and quality of care. SEIU Nurse Alliance of California, [www.nurseallianceca.org](http://www.nurseallianceca.org).

**6. FOLLOW-UP RESPONSIBILITY:** Office of Patient Care Services (11), Medical-Surgical Services (111) is responsible for the contents of this Directive. Questions may be referred to the National Director for Emergency Medicine at (202) 461-7120.

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**7. RESCISSIONS:** None. This VHA Directive expires March 31, 2015

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**DISTRIBUTION:** E-mailed to the VHA Publications Distribution List 3/3/2010

ATTACHMENT A

PROVIDER QUALIFICATIONS

1. **Emergency Department (ED) Medical Director.** The ED Medical Director must be board certified in Emergency Medicine, Internal Medicine, Surgery, or Family Practice and have significant Emergency Medicine experience.” In addition, the ED Director must:

- a. Possess competence in management and administration of the clinical services of the ED.
- b. Be knowledgeable about the Emergency Medical Services (EMS) operations and the EMS regional network.

2. **ED Physician Staff.** ED Physician Staff must:

- a. Possess the training, experience, and competence in emergency medicine sufficient to evaluate and initially manage and treat all patients who seek emergency care, consistent with the physician’s delineated privileges. *NOTE: This does not require a Board Certification in Emergency Medicine.*
- b. Be subject to the customary credentialing process and must be members of the facility staff with clinical privileges in emergency medicine.

3. **Urgent Care Clinic (UCC) Physician Staff.** UCC Physician Staff must:

- a. Possess the training, experience, and competence sufficient to evaluate and manage patients seeking urgent care, consistent with the physicians’ delineated privileges.
- b. Be subject to the customary credentialing process and must be members of the facility staff.

4. **Physician Assistants and Nurse Practitioners (Mid-Level Providers).** Physician Assistants and Nurse Practitioners must:

- a. Have or acquire specific experience or specialty training in emergency care.
- b. Participate in a supervised orientation program.
- c. Receive appropriate training and continuing education in providing emergency care.
- d. Possess knowledge of specific ED policies and procedures and participate in performance improvement activities in the ED.
- e. Be trained to supplement or assist physicians in clinical and administrative duties.

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f. Have role and responsibilities clearly delineated in the appropriate privileges or scope of practice that is congruent with the VA facility medical staff by-laws, rules, and regulations, and is within the scope of the practitioner's credentials and licensure.

**5. ED Nurse Manager or ED Nursing Director.** The ED Nurse Manager or ED Nursing Director, must possess evidence of significant experience in emergency medicine and competence in the management and administration of the clinical services in the ED.

**6. ED Registered Nurse (RN).** Each RN working in the ED must have:

a. The knowledge and skills necessary to deliver nursing care in accordance with the Standards of Emergency Nursing Practice.

b. Previous ED or critical care experience, or have completed a critical care or emergency care education program. *NOTE: For EDs employing graduate nurses, an opportunity for the individual to complete a course must be provided.*

**ATTACHMENT B**

**PROVIDER STAFFING**

1. Physician staffing guidelines must take into account physician abilities in terms of the number of patients that can be seen and effectively managed per hour as well as the number of hourly patient visits to the Emergency Department (ED). A number of studies have looked at patient visits per hour and the range appears to be somewhere between 1.8 and 2.5 patients per hour. Mid-level providers can be expected to see anywhere from 50 percent to 75 percent of the physician work load. Because of the complexity of the patient population in Veterans Health Administration (VHA), it is recommended using 2.0 patients per hour as the baseline for VHA practicing emergency medicine physicians.

2. ED patient volumes and hourly visits must be monitored to determine the ideal staffing pattern throughout the day. Periods when patient hourly visits exceed the recommended patient per hour load must be staffed with additional providers to minimize delays in evaluation, treatment, and appropriate disposition. Additional providers may include physicians, physician assistants, or nurse practitioners. Failure to provide additional providers will result in a compounding of the problem as the day progresses and additional factors come into play, such as lack of beds for admissions and delays in moving admitted patients to inpatient units.

3. A properly trained, experienced, credentialed, and privileged emergency physician must be:

a. Present in the ED at all times and must not be expected to cover the inpatient unit or respond to emergencies outside of the ED.

(1) Only on off-tours of duty and weekends, in facilities that meet the requirements for a Veterans Rural Access Hospital (VRAH) and facilities that have a Level 4 Intensive Care Unit (ICU) and no more than five ICU beds, the ED physician may be allowed to respond to cardiopulmonary and respiratory emergencies in any inpatient unit.

(2) Furthermore, medical facilities must have contingency plans in place to rapidly mobilize additional staff in cases where patient care demands exceed the available physician staffing resources.

b. On site to provide care to patients in each UCC. The appropriate number of staff needed to manage the UCC is to be based on the upper limit of recommended patients seen per hour for the ED. In this case, hourly visits exceeding 2.5 patients per hour would require additional staff. Physician's assistants and Nurse Practitioners may be used as additional staff, as long as they work within their scope of practice. *NOTE: All VHA ED and UCC facilities must have written provider staffing contingency plans that include a back-up call schedule to address situations where expedient mobilization of provider resources are needed. These plans need to empower ED nursing personnel to contact the ED Director, or designee, to discuss the need for implementation of the policy when provider staffing is deemed insufficient to handle patient demands.*

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4. Registered Nurse (RN) staffing for EDs and UCCs must be based upon, but not limited to common workload indicators, such as volume, acuity level, resource intensity; scope of services; ancillary support; skill mix and staff replacement calculations; as well as unit-specific workload indicators, such as complexity of services to include holding beds and the need for specific validated competencies.
5. Highly complex and high volume EDs must have at a minimum two RNs available at all times that have designated direct care responsibilities. Veterans Rural Access Hospitals (VRAHs) must have a written and approved contingency plan that allows for safe staffing levels during high volume periods.
6. UCCs minimum staffing needs to include one RN and one additional support staff member during all hours of operation. Additional staff is needed during periods of increased patient volume and a plan needs to be in place to rapidly augment staff if needed based on acuity and volume.