

EMERGENCY MEDICINE HANDBOOK

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook establishes procedures for VHA Emergency Departments (EDs).
- 2. MAJOR CHANGES.** This is a new VHA Handbook establishing procedures for VHA EDs.
- 3. RELATED ISSUE.** None.
- 4. RESPONSIBLE OFFICE.** The Office of Patient Care Services (11), Specialty Care Services (111), is responsible for the contents of this VHA Handbook. Questions may be referred to the National Director for Emergency Medicine at (202) 461-7120.
- 5. RESCISSIONS.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of May 2015.

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EMERGENCY MEDICINE HANDBOOK

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures for VHA Emergency Departments (EDs).

2. BACKGROUND

Universal access to appropriate emergency services is the cornerstone of basic health care in the United States. VHA is committed to providing timely and high-quality emergency care to the Department of Veterans Affairs (VA) patient population. While it is recognized that a wide spectrum of emergency services may exist among facilities, emergency care must be uniformly available in all VHA EDs. The level of emergency care available is always congruent with the capability, capacity, and function of the local facility. The provision of emergency care includes detailed plans for the management of patients whose care needs may exceed the facility's capabilities, e.g., acute myocardial infarction (AMI) needing emergent cardiac catheterization, major trauma, obstetrics and gynecology, pediatrics, and surgical subspecialty care. This Handbook describes and delineates the resources and planning necessary to provide access to appropriate emergency medical and nursing care.

3. DEFINITIONS

a. **Emergency Department (ED)**. An ED is a unit that is dedicated to providing resuscitative therapy and stabilization in life threatening situations. It 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. Care is provided in a clearly defined area dedicated to the ED and operates 24 hours a day, 7 days a week (24/7).

b. **Urgent Care Clinic (UCC)**. An UCC is designed to provide 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, they are not designed to provide the full spectrum of emergency care. VA UCCs do not provide emergency medical care, pediatric, or maternity care and do not accept emergency cases from the Emergency Medical Services (EMS) System.

c. **Intensive Care Unit (ICU)**. An ICU is a special care unit dedicated to the management of acute illnesses, injuries, or post-operative care in which life or organ function may be in jeopardy. An ICU provides a higher level of medical services, medical technology, and staffing than other facility medical or surgical units.

d. **Observation Status**. Observation status describes a patient who presents with a medical condition showing a significant degree of instability or disability, and who needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. A patient admitted to observation status can occupy a special bed set aside for this purpose, or may occupy a bed in any unit of a hospital, e.g., a hospital medical unit. If the

ED has beds designated for use by observation patients, these beds are not designed to be a holding area in the ED. The length-of-stay (LOS) in an observation bed is not to exceed 23 hours and 59 minutes. *NOTE: Routine post-procedure recovery from ambulatory surgery is not observation. See current VHA policy standards for ED, UCC, and facility observation beds and recording observation patients for further details.*

e. **Emergency Medicine Field Advisory Committee (EMFAC)-sponsored Veterans Integrated Service Network (VISN) Emergency Medicine Committees.** The EMFAC has sponsored committees that are formed at the VISN level to augment the flow of information to and from the practicing providers to the Field Advisory Committee and the VA National Director for Emergency Medicine. The EMFAC is composed of eight or nine members from the emergency medicine community, each having responsibility for providing information to, and receiving information from, the two or three VISNs assigned to them. *NOTE: It is expected that all VISNs will have some facilities willing to participate, however, participation is not mandatory.* Each VISN Emergency Medicine Committee selects a Chairperson who summarizes committee discussions and reports a summary of these discussions to their respective EMFAC member on a monthly basis.

f. **Diversion.** Diversion is defined as a situation in which a selected group of, or all patients who would normally be treated by the facility, cannot be accepted for admission and evaluation because the appropriate beds are not available; needed services cannot be provided; staffing is inadequate; and acceptance of another patient would jeopardize the ability to properly care for those already at the facility, or disaster has disrupted normal operations (see subpar. 14d).

4. SCOPE

The practice of VHA emergency medicine includes:

- a. Unrestricted access to appropriate and timely emergency medical and nursing care 24/7.
- b. Evaluation, management, and treatment provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care.
- c. Emergency care provided by an emergency physician and emergency nursing staff physically present in the ED and continuously available 24-hours a day. *NOTE: VHA policy requires that all VHA EDs have mental health coverage during all hours of operation either on-site or on-call 24/7. 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). Psychiatric residents or post-doctoral psychologists may also be used with appropriate supervision.*
- d. An evaluation and emergency care provided to individual patients presenting to the ED that is consistent with all applicable standards and regulations, including compliance with all Emergency Medicine Treatment and Active Labor Act (EMTALA) statute, 42 U.S.C. §1395dd.
- e. Policies and procedures that allow for a smooth transition from the ED to the inpatient setting for definitive care.

- f. Support and participation in the existing EMS system and provision of medical direction for the patients in the pre-hospital setting, where appropriate.
- g. Supervision, teaching, and evaluation of the performance of medical and paramedical personnel including students, residents and fellows in the ED.
- h. Participation in research and collaboration in research efforts at the clinical and basic science level, if possible, to identify and address gaps in evidenced based practice. *NOTE: All research efforts must be in compliance with all applicable VA requirements (see VHA 1200 and 1050 series Directives and Handbooks).* The Office of Research and Development may be consulted as needed.
- i. Administrative involvement in hospitals, medical schools, and outpatient facilities.
- j. Emergent care that is congruent with the facility's capabilities in and around all medical centers, Community-based Outpatient Clinics (CBOCs), Domiciliaries, and administrative offices.
- k. A facility plan that includes the provision of Basic Life Support (BLS), activation of 911, and use of an Automated External Defibrillator (AED), when appropriate.

5. EMERGENCY MEDICINE FIELD ADVISORY COMMITTEE (EMFAC)

a. The EMFAC is the principle advisory body for emergency medicine in Patient Care Services. This Committee is made up of four to eight field-based representatives from across the country each serving a 3-year term. All EMFAC members must be VA employees.

(1) The EMFAC Manager (the National Director for Emergency Medicine) is responsible for appointing the EMFAC Chairperson and Vice Chairperson with the concurrence of the Chief Consultant, Medical-Surgical Services (MSS). These two appointments come from the active committee members of the EMFAC and may serve an additional 3 years.

(2) The EMFAC Manager and Chairperson are responsible for selecting and appointing the general committee membership.

(3) Approximately one third of the EMFAC membership is replaced each year after the first 3-year cycle.

(4) Appointments may be terminated and replacements added by the EMFAC Manager or Chief Consultant, MSS at any time. EMFAC members may be reappointed at the end of their term.

b. Efficient and timely information exchange with the persons developing new policies, procedures, and directives is enhanced by the VISN Emergency Medicine Committee structure. This structure is depicted in the Information Flow Diagram (see Appendix F) and is centered at the VISN level providing integration between the policy advisors and developers and the field-

based providers of care. This diagram outlines the national Emergency Medicine information flow process. The field-based emergency services staff and medical center Emergency Medicine Directors have access to the policy developers through the EMFAC representative for their VISN. *NOTE: Appendix F is not an organizational chart for a formal reporting process. It is a representation of the opportunities for sharing information between policy developers and the practicing providers.*

6. EMERGENCY MEDICINE DEPARTMENT ADMINISTRATION

a. Whenever and wherever possible, a facility Emergency Medicine Department is designated to manage and oversee the ED and associated teaching, research, and other administrative programs and activities.

b. VHA sites with EDs, that have an Emergency Medicine academic affiliation in place, or in the planning phase, need to have a designated department to parallel the medical school organization and to comply with Residency Review Committee (RRC) requirements.

c. Facilities whose mission, staffing, and resources limit the ability to support the ED in this manner should establish as much ED autonomy and authority as possible. For example, if a well organized ED is currently administered by Medicine-Ambulatory Care Services, an ED Medical Director must be designated and given primary authority to manage the ED operation and related programs. In addition, this ED Medical Director must be given membership on the Medical Staff Executive Committee (or equivalent committee). *NOTE: As available resources and capabilities improve in these facilities, evolution towards implementation of the full Emergency Medicine model is expected.*

d. The EMFAC and the VISN Emergency Medicine Committees serve as a resource to facilities as they develop and evolve these emergency medicine and ED initiatives.

7. RESPONSIBILITIES OF THE VISN DIRECTOR

The VISN Director, or designee (normally the Chief Medical Officer), is responsible for ensuring that each facility in the VISN is appropriately designated as one having or not having an ED.

8. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The Facility Director, or designee (Chief of Staff, Associate Director Patient Care for Nursing Services), is responsible for ensuring:

a. Appropriate competencies are completed for all nursing staff.

b. Equipment, supplies, and support services are provided to the Department of Emergency Medicine so that necessary space and resources are available in order for appropriate care to be consistently delivered in a timely fashion 24/7.

c. The ED is designed as a safe environment for patients.

- d. Appropriate signage at all entrances directs patients to the ED.
- e. A plan is established for the provision of additional nursing, provider, and support staff in times of acute overload or disaster.
- f. A diversion policy is in force that provides clear indications for the use of diversion and limitations for the length of time spent on diversion without a re-evaluation of the situation (see subpar. 14d).
- g. The credentialing and privileging process for ED physicians includes an assessment of airway management and management of hypotension prior to approval for use of anesthetic drugs (see subparagraph 15c).
- h. Protocols are established identifying procedures for assessing suspected alcohol intoxication. Breathalyzer or blood alcohol testing may be used with the patient's informed consent to aid in making this determination in the non-acute setting such as a CBOC or substance abuse clinic. Title 38, CFR 17.32(d) provides that signature consent would not be required
- i. Procedures and plans are established, with VA Regional Counsel review, to contact VA police or local law enforcement officials for patients leaving against medical advice if patients are considered a danger to themselves or others. These plans must take into consideration the laws governing the release of information about the Veteran's medical condition. No information that is protected by title 38 U.S.C. § 7332 (i.e., information related to the condition of sickle cell anemia or Human immunodeficiency virus (HIV), or the condition and treatment of drug or alcohol abuse) may be disclosed. *NOTE: VA policy regarding disclosing patient alcohol information to police is found in VHA Handbook 1605.1.*

9. RESPONSIBILITIES AND CREDENTIALS OF THE ED MEDICAL DIRECTOR

The ED Medical Director is responsible for directing the medical care provided in the ED and must:

- a. Be certified by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or possess comparable qualifications as established by the facility credentialing and privileging policy.
- b. Have experience and possess competence in management and administration of clinical services in an ED.
- c. Ensure that quality, safety, and appropriateness of emergency care are continually monitored and evaluated.
- d. Be a voting member of the hospital Medical Staff Executive Committee (MSEC) or equivalent committee.
- e. Be knowledgeable about EMS operations and the local and regional EMS network.

- f. Represent the VA facility on community EMS committees whenever possible, including participation in emergency preparedness activities.
- g. Assume responsibility for assessing and making recommendations to the facility's credentialing body related to the qualifications and clinical privileges of ED physicians.
- h. Ensure the operation of the ED is guided by well-established national guidelines and local policies and procedures, as needed.
- i. Provide all new staff members working in the ED with a formal orientation to ED operating policy and procedures and to the responsibilities of each ED staff member.
- j. Recruit and retain well-qualified ED physicians.
- k. Encourage the pursuit of academic affiliations with emergency medicine and other training programs wherever possible.
- l. Oversee all academic affiliation agreements for emergency medicine and the ED to ensure the quality of teaching and supervision of all trainees in the ED. *NOTE: In facilities with academic activities, the ED Medical Director is expected to provide academic and research opportunities to VA ED physicians qualified to teach and participate in other academic activities.*

10. RESPONSIBILITIES AND CREDENTIALS OF THE ED NURSE MANAGER

The ED Nurse Manager is responsible for overseeing the nursing care provided in the ED and must:

- a. Be a registered nurse and demonstrate evidence of substantial education, experience, and competence in emergency nursing. *NOTE: The Certified Emergency Nurse (CEN) credential is an excellent benchmark.*
- b. Show evidence of experience and competence in management and administration of ED clinical services.
- c. Ensure that the nursing and support staff are appropriately educated and qualified to perform the assigned duties in the ED.
- d. Collaborate with the ED Director on policy and procedure development.
- e. Monitor ED nursing staff competence and the nursing care that is delivered.
- f. Work in concert with the ED Director to ensure adequate tools are present to deliver quality patient care.

11. ED STAFFING

Appropriately educated and qualified emergency care professionals staff the ED during all hours of operation. This includes, at a minimum, a registered nurse and a licensed physician credentialed and privileged to work in the ED. ED volume, complexity, and flow rate are important information needed to determine the number of staff members required. A plan established and supported by the medical center must exist for additional nursing, provider, and support staff in times of acute overload or disaster.

a. Physician Staffing

(1) Each physician must be individually credentialed and privileged by the medical facility in accordance with criteria contained in the facility policy on physician credentialing.

(2) All physicians who practice in an ED must possess 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 clinical privileges. **NOTE:** *Physicians board certified in emergency medicine are preferred.*

(3) Residents may be appointed to serve as ED physicians (sometimes referred to as Medical Officer of the Day (MOD) in accordance with the provisions of VA guidelines on Pay Administration and VHA Handbook 1400.1). Residents who are appointed, outside of their training program, to work on a fee basis as an ED physician or MOD must be licensed, credentialed, and privileged in order to qualify for such an appointment. If appointed as an independent "admitting physician" for nights or weekend duty, the resident is not working under the auspices of a training program, and must meet the same requirements as all staff physicians and dentists appointed for ED duties at the facility. However, the hours worked count towards the duty week maximum under accreditation standards. Such residents must have completed their primary specialty training, as required to apply for board certification (see VHA Handbook 1400.1). **NOTE:** *The provision for residents to serve as fee-basis "admitting physicians" (if specified criteria are met) is allowable under an exemption to dual compensation restrictions governing VA employment. No other exemptions are allowed for trainees (as specified in VA guidance on Pay Administration).*

(4) As a general rule, residents who have not completed the preceding requirements are not eligible to practice independently in the ED. In a critical staffing emergency situation, permission to use a post-graduate year (PGY)-3 and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the respective VISN Director. When such an emergency exists, the VISN Director may approve the use of a PGY-3 and above, non-board-eligible resident on a short-term, time-limited basis, when truly exceptional circumstances exist. In these rare instances, the resident must be appropriately credentialed and privileged and be an approved provider of Advanced Cardiac Life Support (ACLS) (see VHA Handbook 1100.19). Normally, residents who have not satisfied their primary training requirements may only be eligible to serve as non-independent practitioners in the ED and if used under routine (non-emergent) conditions, must be credentialed and privileged as "dependent" practitioners, who must be supervised (see VHA Handbook 1400.1).

(5) As a reminder of the medical education aspects of ED internal moonlighting, ED duty can only occur on nights that the resident was not already on-call for the residents training program and unless as a rotation assigned by the program, must be outside the scope of the training program, i.e., the resident must not be assigned to provide coverage within VA or elsewhere during times working as an ED physician. In addition, any moonlighting hours at VA are required to be reported to the Program Director, are logged as part of the work week, and need to comply with training program restrictions as outlined by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) (see Appendix A and VHA Handbook 1400.1).

b. **Nursing Staff.** Each nurse working in the ED is to:

(1) Provide evidence of adequate previous ED or critical care experience, or have completed an emergency care education program. *NOTE: The CEN credential is an excellent benchmark.*

(2) Demonstrate evidence of the knowledge and skills necessary to deliver nursing care in accordance with the Standards of Emergency Nursing Practice. The Web site for the Emergency Nurse Association (ENA) Scope of Emergency Nursing Practice is: <http://www.ena.org/IQSIP/scopes/Pages/Default.aspx> (see subpar. 18f).

c. **Ancillary Staff**

(1) The use of ancillary staff, such as paramedics, ED health care technicians, and transporters is encouraged to assist the nursing and provider staff. Utilization of these types of staff members as nurse extenders have been successful in assisting ED staff with non-nursing duties, freeing up valuable time for nurses to provide the care needed for the patients being evaluated and treated. *NOTE: It is not intended that these additional staff members replace nursing or provider staff.*

(2) The use of Nurse Practitioners (NPs) and Physician Assistants (PAs) as additional staff is acceptable, as long as they work within their scope of practice and a physician is present at all times in the department.

12. RESIDENCY SUPERVISION IN THE ED

All residents seeing patients in the ED must be properly supervised.

a. The ED attending physician must be physically present in the ED and is the Attending of record for all patients. The ED attending physician must also be involved in the disposition of all ED patients.

b. Four types of documentation of resident supervision are allowed. These include:

(1) An attending physician progress note or other entry into the medical record.

(2) An attending physician addendum to the resident's note.

(3) A co-signature by the attending physician; this implies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. **NOTE:** *Use of the Computerized Patient Record System (CPRS) function "Additional Signer" is not acceptable for documenting supervision.*

(4) Resident documentation of supervision by the attending physician. A resident progress note, or other chart entry, that includes a description of the involvement of the Attending, (for example, "I have seen and discussed the patient with my supervising practitioner Dr. X, and Dr. X agrees with my assessment and plan."). At a minimum, the responsible attending physician is to be identified, e.g., "The attending physician of record for this patient encounter is Dr. X."

c. Residents who are called to the ED as part of their assignment to a consulting service are supervised by the attending physician on the consulting service (not the ED attending physician). These residents are expected to be in contact with their supervising attending physician (who does not need to be physically present), as appropriate. However, the ED attending physician is still responsible for the disposition of the patient and may request input from the consultation service attending physician, if necessary.

13. ED REQUIREMENTS

a. **Safety and Access.** The ED must be designed to provide a safe environment for patients and staff while making access convenient and protecting visual and auditory privacy to the greatest extent possible. Appropriate signage must be displayed indicating convenient access for all individuals presenting for care. These signs need to be placed in areas serving as major points of entrance into the facility and need to clearly indicate directions to access the ED.

b. **Equipment and Supplies.** The equipment and supplies necessary to care for patients expected to be seen in the ED must be readily available in the facility at all times (see App. B). A process for inspection and documentation of the proper functioning of all equipment must be in force (see VHA Handbook 1761.1).

c. **Support Services.** The specific services available at each facility need to be reviewed and determined by the on site Medical Director in cooperation with the Chief of Staff, the Associate Director Patient Care and Nursing Services, and any other directors of the departments providing services. Policies must be in place outlining access to support services during regular hours, off hours, weekends, and holidays. When these services are provided by on-call staff, 30 minutes is an acceptable time period to expect arrival of staff at the facility to perform the duties requested. Support services include, but are not limited to:

(1) **Laboratory.** All tests indicated in Appendix C need to be available 24/7 to all EDs. There is to be onsite staff capable of performing critical tests 24/7, such as glucose and troponin studies. The rest can be performed by on-call laboratory staff.

(2) **Pharmacy.** Medications need to be available 24/7 either through an in-house pharmacist, use of a stocked pharmacy in the ED, or a virtual pharmacy with the nursing

supervisor or other clinical provider as the access person. Dedicated Clinical Pharmacists have been proven to improve access, increase patient safety, and be cost-effective members of ED teams (see App. D). **NOTE:** *They are strongly recommended.*

(3) **Radiology.** Doppler ultrasound studies, computer tomography (CT) scanning, dye contrast studies, nuclear studies, and interventional radiology must be available on an urgent basis. MRI must be available directly on site or by contract (see Appendix E for the list of radiological procedures that need to be readily available 24/7 by in house or on-call staff).

(4) **Consultative Services.** The ED must be provided with a list of appropriate on-call specialty physicians, including radiologists, who are required to respond to assist the ED in caring for the patients seen.

(5) **Admission**

(a) Appropriately qualified physicians must be available and identified in advance to care for patients requiring admission. Controversies that may arise concerning which service is appropriate for admitting and treating patients need to be decided by the ED attending physician after consideration of all of the factors in the case. **NOTE:** *Cases involving disputes such as these can be referred to the Emergency Medicine Director for review on the next business day.*

(b) ED physicians are not responsible for managing admitted patients on the inpatient services. The Emergency Physician is not to write any orders that extend control and responsibility for the patient beyond the treatment given in the ED.

(6) **Follow-up Care.** A means of providing appropriate follow-up for patients seen and treated in the ED must be available. This can be provided by publishing, in advance, a comprehensive list of appropriately qualified primary care and specialty physicians available for follow-up visits, or by identifying the procedure for the utilization of primary care and specialty care clinics.

14. GENERAL OPERATIONS REQUIREMENTS

Operations in the ED need to be governed by an organizational plan that is consistent with the medical facility bylaws and is guided by national and local practice guidelines, policies, and procedures necessary for efficient and safe emergency care. In accordance with applicable laws, regulations, and standards, the medical screening examination (MSE) on each patient who enters the facility seeking care must be performed by a physician, NP, or PA, in accordance with the EMTALA and local policies delineated in the medical staff bylaws.

a. **Triage.** The VHA requires RN triage in all EDs, consistent with the Emergency Nurses Association position statement dated July 1996, and the use of the Emergency Severity Index (ESI) as the sole triage tool. The ESI triage algorithm yields rapid, reproducible, and clinically relevant stratification of patients into five groups and provides a method for categorizing ED patients by both acuity and resource needs (see <http://www.ahrq.gov/research/esi>).

b. Transfer Process

(1) Facilities must have a written policy and procedure for transfer when the ability to care for the patient exceeds the capabilities of the ED or when transfer is indicated for some other reason. This policy needs to outline the specific requirements for the vehicle and services that must be available during transfer. Copies of all medical records needed for ongoing care must accompany the patient or be provided by expeditious means as soon as possible, e.g., by fax transmission, etc. (see current VHA policy regarding Inter-facility Transfer).

(2) All patients require a MSE and are to be appropriately stabilized, if possible, prior to transfer. All transfers must comply with local, state, and Federal laws. VA has made a commitment to comply with all EMTALA requirements when transferring patients to another VA or non-VA site.

c. **Discharge (Instructions)**. All patients transferred or discharged from the ED must be given specific written or printed follow-up care instructions. These instructions must be legible and be reviewed with the patient prior to discharge; this must include medication instructions.

d. **Diversion**. It is recognized that circumstances may dictate the need to go on diversion status from time to time in the ED (see subpar. 3f). A diversion policy needs to be in force that provides clear indications for the use of diversion and limitations for the length of time spent on diversion without a re-evaluation of the situation. Local EMS policies and agreements may dictate some of the parameters for ED and medical facility diversion status. A VA patient being transported by ambulance has the right to request to go to a VA ED unless the assessment by a certified EMS provider (in direct radio or telephone contact with the VA ED provider) indicates that complying with the patient's request could result in further harm to the patient from a delay in obtaining appropriate treatment, or the facility is on Internal Disaster; for example, trauma patients should go to the nearest trauma center in the area designated by local EMS protocol.

(1) **Advanced Life Support (ALS) Diversion**. ALS Diversion is the diversion of ambulances caring for patients that require advanced life support or advanced monitoring. An example is the diversion of patients with acute myocardial infarction or unstable vital signs because of insufficient ICU or monitored beds in the facility and the ED.

(a) The ED may close to ALS ambulances only under one of the following circumstances:

1. When all but one of the available inpatient monitored beds are occupied and only one monitored bed remains in the ED.

2. The safe limits of treatment capacity have been reached. This means the ED is overcrowded with patients or there is not enough qualified staff to care for the patients currently in the department and the addition of any more patients would constitute an immediate danger to that patient or those already in the ED.

(b) While on ALS diversion, the ED can still receive ambulances under the following conditions:

1. The patient does not meet the criteria for ALS diversion, (i.e., the patient is a BLS patient).
2. All EDs in the community or local region are on diversion status.
3. The patient refuses to be transported to any other facility, i.e., the patient demands to be transported to VA.
4. A patient has an immediate life-threatening emergency and the VA is the closest medical facility capable of providing emergency care. *NOTE: This applies to all patients including those not eligible for VA care.*

(2) **ALS and BLS Diversion.** ALS and BLS Diversion is the diversion of all ambulances regardless of the need for monitoring; for example; the diversion of patients regardless of the level of care needed for treatment because facility beds are unavailable or there is an insufficient number of staff to care for additional patients. Patient demands are accepted.

(a) The ED may close to ALS or BLS ambulances under either of the following conditions:

1. When all but one of the available monitored hospital beds are occupied, all other inpatient beds are occupied, and only one unoccupied monitored bed remains in the ED.
2. The safe limits of treatment capacity have been reached. This means the ED is overcrowded with patients, or there are not enough qualified staff to care for the patients currently in the department and the addition of any more patients would constitute an immediate danger to that patient or to those already in the ED.

(b) While on ALS and BLS diversion, the ED can still receive ambulances under the following conditions:

1. All EDs in the community or local region are on diversion status.
2. The patient refuses to be transported to any other facility; i.e., the patient demands to be transported to VA.
3. A patient has an immediate life-threatening emergency and VA is the closest hospital capable of providing emergency care. *NOTE: This applies to all patients including those not eligible for VA care.*

(3) **Internal Disaster Diversion.** Internal Disaster Diversion is the diversion of all patients regardless of the level of care needed for treatment. The facility may have lost electricity or water, may have sustained physical damage to its structure, or be overwhelmed by current patient load. Patient demands are not accepted.

NOTE: The ED must never turn away an ambulatory patient or a patient who has arrived by ambulance; a medical screening must always be performed in accordance with the provisions of

title 42 CFR 489.24, 489.20. Patients, after being medically screened, may be referred to a clinic for further evaluation and treatment, if it is deemed appropriate.

15. MISCELLANEOUS POLICIES

Several specific issues are addressed in this paragraph that have been identified as critical issues at several VA medical facilities across the country; they are:

a. **Pediatric Resuscitation.** Pediatric resuscitation equipment must be available for BLS in pediatric emergencies, and all medical staff trained in its use.

(1) It is not a mandate that VA EDs provide training in Pediatric Advanced Life Support (PALS) to their employees unless they have pediatric resuscitation equipment in the ED.

(2) It is necessary to have a plan in place for calling 911 immediately to summon EMS after recognition of a pediatric code situation and for the provision of BLS by VA staff until EMS arrival on the scene.

b. **Use of Anesthetic Agents for Procedural Sedation in the ED.** VHA policy for moderate sedation by non-anesthesia providers requires that local policy contain "a statement that for the purposes of moderate sedation, drugs that are anesthetic agents (e.g., propofol, thiopental, methohexital, ketamine, etomidate, etc.) must be administered by an anesthesiologist, nurse anesthetist, or a Licensed Independent Practitioner (LIP) with the training and ability to rescue a patient from general anesthesia."

(1) It must be clear that the person administering the drugs cannot also be doing the procedure. Providers who want to use these drugs for procedural sedation in the ED must be appropriately credentialed to use anesthetic agents and have completed the training requirements as outlined in current VHA policy.

(2) Use of benzodiazepines, such as versed and narcotics, is permitted as long as the local policy for moderate sedation is followed and the providers are credentialed and privileged appropriately at their site. Additionally, local policy must designate the ED as a procedural sedation location in order for ED providers with appropriate privileging to administer drugs for procedural sedation.

c. **Rapid Sequence Intubation (RSI).** Emergency medicine providers may continue to use anesthetic agents for RSI, as long as they have documentation of appropriate training in airway management and management of hypotension due to these drugs. The credentialing and privileging process must include an assessment of airway management and management of hypotension prior to approval to use these drugs. Individuals performing emergency airway management within the VA must meet the requirements found in current VHA policy on airway management, which includes required demonstrated competencies and knowledge base, and a facility process for confirming such competencies.

d. Treatment of Intoxicated Patients

(1) Breathalyzer or blood alcohol testing may be used with the patient's informed consent to aid in making a determination of intoxication in the non-acute setting such as a CBOC or substance abuse clinic. Title 38, CFR 17.32(d) provides that signature consent is not required. The breathalyzer and blood alcohol test results must be made a part of the patient's electronic medical record.

(2) In medical emergencies, the patient's consent is implied by law. The practitioner may provide necessary medical care, including testing for blood alcohol levels without the consent of the patient, or a surrogate's express consent, when the following conditions are met:

(a) Immediate medical care is necessary to preserve life or avert serious impairment of the health of the patient and;

(b) The patient is unable to consent and the patient has no surrogate; or the practitioner determines that waiting for the patient's surrogate would increase the hazard to the life or health of the patient (see VHA Handbook 1004.01).

(3) When an intoxicated patient (breath alcohol or blood alcohol greater than the local legal limit (typically .08) or showing clinically significant behavioral signs of intoxication) verbally or nonverbally demonstrates an intent to operate a motor vehicle, attempts need to be made to persuade (or assist) the patient to arrange other transportation or to remain for extended observation until additional testing shows the level has dropped below the local legal limit and the patient is not showing signs of impairment.

(4) If the patient refuses the breathalyzer or blood test or is unwilling to remain for extended observation, the patient may not be held against his or her will by clinical staff. This must be documented in the medical record, with a witness if possible, i.e., that the patient was informed of any safety concerns and advised not to operate a motor vehicle. If the patient refuses to make other arrangements or to remain for observation until no longer intoxicated, the patient needs to be informed that facility police will be contacted due to concerns related to public safety.

16. STOP CODES

a. New stop codes 130 for ED and 131 for Urgent Care were developed to solve the problem related to capture of workload in the ED and UCCs.

b. All patients seen in an ED for treatment regardless of the severity of their illness or triage level must be coded as a 130. The intent is not to fragment the billing process for patients with differing acuities in the ED. It doesn't matter if they are seen in a fast track included as part of the ED or in the regular ED area. The reason for the visit has no bearing on the stop code used, only on the level of service provided for billing purposes. Patients that are seen in the ED are coded as a 130.

c. The Urgent Care code 131 was developed to capture the workload in UCCs (see http://vaww.dss.med.va.gov/programdocs/pd_oident.asp). *NOTE: This is an internal web site and is not available to the public.*

17. LOCAL AND REGIONAL EMS PARTICIPATION

a. All VHA facilities with an ED must:

(1) Establish a collaborative partnership with local emergency services and officials.

(2) Participate in the community's emergency resources continuum. This includes a discussion with local and regional EMS services about the capabilities of the VHA facilities in the service area and arrangements for emergency transportations services when needed.

b. VHA medical centers with an ED must also understand the responsibility to provide emergency care to Veterans, staff, and other non-Veterans who experience a medical emergency while in or near a VA facility. This includes acceptance of requests by EMS for transport of unstable Veteran or non-Veteran patients to VHA EDs when the VA medical center is the closest capable facility.

18. REFERENCES

a. VHA Handbook 1400.1, Resident Supervision.

b. VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures.

c. Gilboy N, Tanabe P, Travers DA, Rosenau AM Eitel DR. Emergency Severity Index, Version 4: Implementation Handbook. AHRQ Publication No., 05-0046-2. Rockville, MD: Agency for Health care Research and Quality. May 2005.

d. American College of Emergency Physicians (ACEP) Policy Statement, June 2004, Emergency Department Planning and Resource Guidelines.”

e. VHA Handbook 1100.19.

f. Emergency Nursing Scope of Practice found at:
<http://www.ena.org/practice/scopes/documents/scopeEmNP.pdf> .

g. VHA Handbook 1004.01.

h. VHA Handbook 1605.1.

SUPERVISION OF PHYSICIAN RESIDENTS PROVIDING EMERGENCY CARE COVERAGE

1. Emergency Department (ED) Physician (sometimes called the Admitting Officer of the Day). Physicians providing independent ED coverage must be credentialed, privileged, and fully licensed. *NOTE: Post-graduate year (PGY)-3 and above residents are normally subject to the same supervisory requirements as specified in paragraph 12.* However, in a critical staffing emergency situation, permission to use a PGY-3 and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the respective Veterans Integrated Service Network (VISN) Director. When such an emergency exists, the VISN Director may approve the use of a PGY-3 and above, non-board-eligible resident on a short-term, time-limited basis, when truly exceptional circumstances exist. In these rare instances, the resident must be appropriately credentialed and privileged and be an approved provider of Advanced Cardiac Life Support (ACLS) (see VHA Handbook 1100.19).

2. Supervision of PGY-4 and above Board-Certified or Board-Eligible Residents

a. Physician residents who are board-certified or board-eligible may be privileged as independent practitioners for purposes of ED coverage. Privileges sought and granted may only be those delineated within the general category for which the resident is board-certified or board-eligible.

b. Residents who are appointed as such, outside the scope of their training program (i.e., fee basis), must be fully licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for appointment, and they are subject to the provisions contained in VHA Handbook 1100.19, Credentialing and Privileging. Specialty privileges, which are within the scope of the resident's training program, may not be granted.

c. Regarding documentation of attending supervision for ED care:

(1) **Physical Presence.** The supervising practitioner for the ED must be physically present in the ED.

(2) **ED Visits.** Each new patient to the ED must be seen by or discussed with the supervising practitioner. *NOTE: Documentation of supervising practitioner involvement must be according to subparagraphs 12a, 12b(1)-(4), and 12c.*

(3) **Discharge from the ED.** The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the ED is appropriate. *NOTE: Any of the four types of documentation referenced in subparagraphs 12b(1)-(4).*

RECOMMENDED EQUIPMENT FOR THE ENTIRE EMERGENCY DEPARTMENT

Recommended equipment for the entire Emergency Department includes:

1. Central station monitoring capability;
2. Physiological monitors;
3. Defibrillator with monitor and battery;
4. Thermometers;
5. Pulse oximetry, peak flow meters;
6. Nurse-call system for patient use;
7. Portable suction regulator;
8. Infusion pumps to include blood pumps;
9. Intravenous (IV) poles;
10. Bag-valve-mask respiratory and adult and pediatric size masks;
11. Portable oxygen tanks;
12. Blood and fluid warmer and tubing;
13. Nasogastric suction supplies;
14. Nebulizer;
15. Gastric lavage supplies;
16. Urinary catheters, including straight catheters, foley catheters, coude catheters, filiforms followers, and appropriate collection equipment;
17. Intraosseous needles;
18. Lumbar puncture sets;
19. Splints;
20. Blanket warmer;

21. Tonometer;
22. Slit lamp, if applicable;
23. Wheelchairs;
24. Medication dispensing system with locking capabilities;
25. Separately wrapped instruments (specifics vary by department or service);
26. Weight scales;
27. Tape measure;
28. Ear irrigation and cerumen removal equipment;
29. Vascular Doppler;
30. Anoscope;
31. Adult “code” cart including carbon dioxide (CO₂) detectors or other esophageal detection devices;
32. Suture or minor surgical procedure sets (generic);
33. Portable sonogram equipment, if applicable;
34. Electrocardiogram (EKG) machine;
35. Point of care testing, if applicable;
36. X-ray view box and hot light;
37. Film boxes for holding x-rays;
38. Chart rack;
39. Ring cutters;
40. Computer system with internet capabilities;
41. Patient tracking system;
42. Radio or other device for communication with ambulances;

43. Patient discharge instruction system;
44. Patient registration system and information services;
45. Intradepartmental staff communication system, e.g., pagers, mobile phones, etc.;
46. ED charting system for physician, nursing, and attending physician documentation equipment;
47. Reference materials, including toxicology resource information;
48. Personal protective equipment, e.g., gloves, eye goggles, face masks, gowns, head and foot covers, etc.;
49. Linens, e.g., pillows, towels, wash cloths, gowns, blankets, etc.;
50. Patient belongings or clothing bag;
51. Security needs, including restraints and wand-type or free-standing metal detectors, as indicated;
52. Equipment for adequate housekeeping; and
53. Fetal monitoring, if appropriate.

RECOMMENDED LABORATORY CAPABILITIES

The facility Medical Director of the Emergency Department (ED) and the Director, Laboratory Services need to develop guidelines for availability and timeliness of services for an individual hospital's ED. The following laboratory capabilities are suggested for medical facilities with 24-hour EDs. *NOTE: This list may not be comprehensive or complete.*

1. Blood Bank

- a. Bank products availability.
- b. Type and cross-matching capabilities.

2. Chemistry

- a. Ammonia;
- b. Amylase;
- c. Anticonvulsant and other therapeutic drug levels;
- d. Arterial blood gases;
- e. Bilirubin (total and direct);
- f. Calcium;
- g. Carboxyhemoglobin;
- h. Cardiac isoenzymes;
- i. Chloride (blood and cerebrospinal fluid (CSF));
- j. Creatinine;
- k. Electrolytes;
- l. Ethanol;
- m. Glucose (blood and CSF);
- n. Hepatic panel;
- o. Lipase;

- p. Methemoglobin;
- q. Osmolality;
- r. Protein (CSF);
- s. Serum magnesium;
- t. Troponin; and
- u. Urea nitrogen.

3. Hematology

- a. Cell count and differential (blood, CSF, and joint fluid analysis);
- b. Coagulation studies;
- c. C-reactive protein (CRP);
- d. Erythrocyte sedimentation rate;
- e. Platelet count;
- f. Reticulocyte count; and
- g. Sickle cell preparation.

4. Microbiology

- a. Acid fast smear or staining;
- b. Chlamydia testing;
- c. Counter immune electrophoresis for bacterial identification;
- d. Gram staining and culture or sensitivities;
- e. Strep screening;
- f. Viral culture; and
- g. Wright stain.

5. Other

- a. Hepatitis screening;
- b. Human Immunodeficiency Virus (HIV) screening;
- c. Joint fluid and CSF analysis;
- d. Toxicology screening and drug levels;
- e. Urinalysis;
- f. Mononucleosis spot;
- g. Serology (syphilis, recombinant immunoassay);
- h. Pregnancy testing (qualitative and quantitative); and
- i. Herpes testing.

**SUGGESTED PHARMACOLOGICAL AND THERAPEUTIC DRUGS FOR
EMERGENCY DEPARTMENTS (EDs)**

The facility Medical Director of the Emergency Department (ED), representatives of the medical staff, and the facility Director, Pharmacy Service, need to develop a formulary of specific agents for use in an individual medical facility ED. These include:

1. Analgesics, both narcotic and non-narcotic;
2. Anesthetics including topical, infiltrative, and general;
3. Anticonvulsant;
4. Antidiabetic agents;
5. Antidotes including antivenins, if applicable;
6. Antihistamines;
7. Anti-infective agents (systemic and topical);
8. Anti-inflammatories both steroidal and non-steroidal;
9. Bicarbonates;
10. Blood modifiers such as anticoagulants to include fibrinolytics, anti-platelet and anti-thrombus agents, and hemostatic, i.e., systemic, topical, plasma expanders, or extenders;
11. Burn Preparations;
12. Cardiovascular agents as: ace inhibitors, adrenergic blockers, adrenergic stimulants, Alpha and Beta blockers, antiarrhythmic agents, calcium channel blockers, digoxin antagonist, diuretics, vasodilators, and vasopressors;
13. Cholinesterase inhibitors;
14. Diagnostic agents such as blood contents, stool contents, testing for myasthenia gravis, and urine contents;
15. Electrolytes, such as cation exchange resin, electrolyte replacements, and parenteral and oral fluid replacement solutions;
16. Gastrointestinal agents such as antacids, anti-diarrheals, emetics and anti-emetics, anti-flatulent, anti-spasmodics, bowel evacuants and laxatives, histamine receptor antagonists, and proton pump inhibitors;

17. Glucose elevating agents;
18. Hormonal agents such as oral contraceptives, steroid preparations, and thyroid preparations;
19. Hypocalcemia and hypercalcemia management agents;
20. Lubricants;
21. Migraine preparations;
22. Muscle relaxants;
23. Narcotic antagonist;
24. Nasal preparation;
25. Ophthalmologic preparations;
26. Otic preparations;
27. Oxytocics;
28. Psychotherapeutic agents.
29. Respiratory agents such as antitussives, bronchodilators, decongestants, leukotriene antagonist;
30. Rh₀ (D) immune globulin;
31. Salicylates;
32. Sedatives and hypnotics;
33. Vaccinations; and
34. Vitamins and minerals.

RADIOLOGIC, IMAGING, AND OTHER DIAGNOSTIC SERVICES

NOTE: The specific services available for emergency patients in an individual facility Emergency Department (ED) needs to be determined by the Medical Director of the ED in collaboration with the directors of the diagnostic services and other appropriate individuals.

1. The following are to be readily available 24-hours a day for emergency patients:

- a. Standard radiologic studies of bony and soft-tissue structures including, but not limited to cross-table lateral views of spine with full series to follow.
- b. Portable chest radiographs for acutely ill patients and for verification of placement of endotracheal tube, central line, or chest tube.
- c. Soft-tissue views of the neck.
- d. Soft-tissue views of subcutaneous tissues to rule out the presence of foreign bodies.
- e. Standard chest radio graphs, abdominal series, etc.
- f. Doppler studies.
- g. Emergency ultrasound services for the diagnosis of obstetric or gynecologic, cardiac, and hemodynamic problems and other urgent conditions.

2. The following services are to be available on an urgent basis. They are to be provided by staff in the medical facility, or by staff to be called in to respond within a reasonable period of time, or by facility agreement:

- a. Ventilation-perfusion lung scans.
- b. Other scintigraphy for trauma and other conditions.
- c. Computed tomography.
- d. Dye-contrast studies as: intravenous pyelography, gastro-intestinal contrast, etc.
- e. Vascular and flow studies, including impedance plethysmography.
- f. Interventional radiology (IR).
- g. Magnetic resonance imaging (MRI).

EMERGENCY DEPARTMENT INFORMATION FLOW DIAGRAM

Efficient and timely information exchange with the persons developing new policies, procedures and directives is enhanced by the newly created Veterans Integrated Service Network (VISN) emergency medicine committee structure. This structure is depicted in the following Information Flow diagram and is centered at the VISN level providing integration between the policy advisors, developers, and the field-based providers of care. The following chart outlines the national Emergency Medicine information flow process. The field-based emergency services staff and medical center Emergency Medicine Directors would have access to the policy developers through the Emergency Medicine Field Advisory Committee (EMFAC) representative for their VISN. **NOTE:** This is not an organizational chart for a formal reporting process. It is a representation of the opportunities for sharing information between policy developers and the practicing providers.

Emergency Medicine Information Flow Diagram

