



Society *for* Academic Emergency Medicine

**EMERGENCY CENTER  
CATEGORIZATION STANDARDS**

**FIRST EDITION**

**Last Revised: January, 1999**

**SOCIETY FOR ACADEMIC EMERGENCY MEDICINE**

**EMERGENCY CENTER CATEGORIZATION  
STANDARDS**

**FIRST EDITION**

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**I. STAFFING**  
**A. MEDICAL**

**1. Department Head/Chief/Chair**

**CRITICAL CRITERIA**

A Director must be designated for the EC. Should the position be vacated, an acting Director may be appointed for a period not to exceed one (1) year. This individual should have the same qualifications as the director.

a. Qualifications:

- 1) Board certified (ABEM, ABOEM) physician in Emergency Medicine (or board prepared with one year Emergency Department experience). Board certification must be obtained within five (5) years of admissibility. Evidence of administrative/leadership experience.

b. Responsibilities:

**RELATIVE CRITERIA**

- 1) To provide 24-hour responsibility for the Center.
- 2) To possess the administrative authority to admit patients to any service as appropriate.
- 3) Ongoing clinical supervision of attending physicians, residents, physician's assistants, nurse practitioners and other house staff members working in the EC
- 4) Sign out rounds with the staff. This responsibility may be designated to the physician clinically assigned to the EC.
- 5) Establish policies and procedures for all patient populations (e.g. pediatric, adult, geriatric, trauma, etc.) with yearly review and update.
- 6) Ensure continuing education for attendings and house staff.
- 7) Provide Continuous Quality Improvement (CQI) through a structured departmental program which is implemented by the Emergency Center on an ongoing and retrospective basis. Emergency Center CQI is linked with hospital wide multidisciplinary CQI.
- 8) Have in place a staff development program.
- 9) Work collaboratively with EC Nurse Manager for overall EC management.
- 10) Chair or designee is a member of key hospital committees (e.g. Critical Care, Pharmacy, Laboratory, CQI, etc.). Should have representation on the hospital executive committee.

c. Continuing Education:

Continuing Education (C.E.) of 50 hours per year.

**I. STAFFING**  
**A. MEDICAL**

**2. Attending Physicians**

**CRITICAL CRITERIA**

At least one attending assigned to the Emergency Center exclusively, 24 hours a day, 7 days a week, at a ratio of 1:10 - 1:20 patients per 8 hours as primary provider or 1:21 - 1:30 patients per 8 hours as a supervisor. If the director is to be included in the physician/patient ratio, he/she must be physically present and seeing patients for that shift. Staffing should be adjusted up to meet activity.

- a. Qualifications of at least one attending assigned to the Emergency Center exclusively, 24 hours a day, seven days a week:  
Board certified (ABEM, ABOEM) or admissible (completed required amount of training) in Emergency Medicine. Board certification must be obtained within 5 years of admissibility.

**RELATIVE CRITERIA**

- b. Qualifications of additional attending physicians assigned to the emergency center:

Board certified (ABEM, ABOEM) or admissible (completed required amount of training) in emergency medicine. Board certification must be obtained within five years of admissibility. In the case of physicians covering a designated pediatric area of the emergency center, Board certification or admissibility in pediatric emergency medicine also meets this standard.

- c. Responsibilities:

- 1) Clinical assignment exclusively to the Emergency Center during an assigned shift.
- 2) Supervise and provide direct patient care during clinical shift.
- 3) Care of all Emergency Center patients where emergency intervention is required, including assessment, intervention, and evaluation, in consultation with specialty services.

- d. Continuing Education:

Continuing Education (C.E.) of 50 hours per year.

- e. All physicians must be credentialed in the core curricular procedures of Emergency Medicine.

I. **STAFFING**  
A. **MEDICAL**

3. *On-call Specialty Attending Physicians*

**CRITICAL CRITERIA**

a. Qualifications:

- 1) The hospital must provide attending physicians who are board certified/board admissible in their respective specialties.
- 2) Member of hospital staff.

b. Responsibilities:

**RELATIVE CRITERIA**

- 1) Available 24 hours a day, 7 days a week, via a schedule available in the Emergency Center.
- 2) Available by telephone within ten (10) minutes and in the Emergency Center for consultation within thirty (30) minutes of being called.
- 3) Specialty Attendings are:
  - \* Anesthesiology
  - Angiography
  - Cardiology
  - Cardiothoracic Surgery
  - Gastroenterology
  - \* General Surgery/Trauma
  - Genito-Urologic Surgery
  - Hematology
  - Infectious Disease
  - \* Internal Medicine/Critical Care
  - Interventional Radiology
  - Maxillo-Facial Surgery (ENT, Plastic or Oral Surgery)
  - Nephrology
  - Neurological Surgery
  - Neurology
  - \* Obstetric-Gynecologic Surgery
  - Ophthalmic Surgery
  - Orthopedic Surgery
  - Pathology (Anatomic)
  - Pathology (Clinical)
  - Pediatrics
  - Pediatric Surgery
  - Psychiatry
  - Pulmonary Diseases
  - Radiology, e.g., routine diagnostic
  - Vascular Surgery

\*Must be in-house 24 hours/day.

**I. STAFFING**  
**A. MEDICAL**

**4. Resident Physicians On-call**

If there is no in house attending physician, a resident at the specified level, with hospital privileges, is an acceptable substitute.

a. Qualifications:

**CRITICAL CRITERIA**

- 1) General Surgery at PGY 4 level, minimum. This person should be accorded independent privileges to initiate and perform emergency surgery.
- 2) Anesthesiology at PGY 3 level, or certified Registered Nurse Anesthetists.

**RELATIVE CRITERIA**

- 3) Radiology at PGY 4 level, minimum. If hospital does not have a Radiology training/residency program, this requirement can be met with the Radiology attending requirement as described on the previous page.
- 4) Internal Medicine/Critical Care at PGY 3 level, minimum.

b. Responsibilities:

- 1) House staff physician to be within the hospital and available in the Emergency Center within five (5) minutes. The house staff physician must be available only in the absence of an attending physician in the respective specialty.
- 5) Available 24 hours a day, 7 days a week, via an available Emergency Center printed schedule.

**I. STAFFING**  
**A. MEDICAL**

**5. Rotating House Staff**

**CRITICAL CRITERIA**

a. Responsibilities:

House staff rotating to the Emergency Center are assigned to examine and treat patients under the supervision of the Emergency Center Attending staff.

b. Qualifications:

**RELATIVE CRITERIA**

House staff rotating to the Emergency Center from other services should have instruction and training in Basic and Advanced Cardiac Life Support (BCLS, ACLS). They should complete BCLS and ACLS refresher courses (or equivalent courses) or successfully challenge the exams every two (2) years. House staff rotating to the Pediatric Emergency Center should have instruction and training in Basic Cardiac Life Support (BCLS) and Pediatric Advanced Life Support (PALS). They should complete BCLS and PALS refresher courses (or equivalent courses) or successfully challenge the exams every two (2) years.

**I. STAFFING**  
**B. NURSING**

***1. Nurse Manager/Patient Care Coordinator***

**CRITICAL CRITERIA**

a. Qualifications:

- 1) State R.N. Licensure.
- 2) Full-time R.N., assigned to the Emergency Center exclusively.
- 3) Certified Emergency Nurse (CEN) certification must be achieved within two (2) years of hire.
- 4) Three (3) years experience as a clinical R.N., two (2) years of which must be in the ED/EC.
- 5) One year administrative or leadership experience.

**RELATIVE CRITERIA**

- 6) A Masters in Nursing, Healthcare Administration, or Business Administration.
- 7) Successful completion of Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS), Trauma Nurse Core Course (TNCC) and Pediatric Advance Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC) or equivalent courses. Must demonstrate competency in BCLS, ACLS and PALS or ENPC every two (2) years. Must repeat the courses within one (1) year of national guidelines changes.

b. Responsibilities:

- 1) Responsible for Emergency Center supervision and patient care coordination on a 24-hour, 7-day/week basis.
- 2) Supervises, directs and selects all members of the Emergency Center nursing staff.
- 3) Provides clinical and administrative guidance to all members of the nursing team.
- 4) Responsible for inservice and continuing education of all nursing personnel.
- 5) In collaboration with the Emergency Center management team, establishes, recommends and updates clinical/administrative policies and procedures pertaining to all aspects of operations.
- 6) Participates in performance improvement program of Emergency Center.
- 7) Maintains responsibility for staffing of nursing staff.
- 8) Works collaboratively with the EC medical director for overall clinical management and staff supervision.

c. Continuing Education:

Continuing Education (C.E.) of 50 hours per year.

**I. STAFFING**  
**B. NURSING**

**2. Charge Nurse**

**CRITICAL CRITERIA**

A charge nurse is assigned to the Emergency Center 24 hours/day, 7 days/week. The charge nurse cannot have primary patient care responsibilities except in an Emergency Center where the average census on a particular 8 hour shift is 25 or less.

a. Qualifications

- 1) State R.N. Licensure.
- 2) Two years of ED/EC experience.
- 3) Successful completion of charge nurse orientation.

**RELATIVE CRITERIA**

- 4) Certified Emergency Nurse (CEN) certification must be achieved within two (2) years of hire.
- 5) Successful completion of Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS) , Trauma Nurse Core Course (TNCC) and Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC) or equivalent courses. Must demonstrate competency in BCLS, ACLS and PALS or ENPC every two (2) years. Must repeat the courses within one (1) year of national guidelines changes.

b. Responsibilities:

- 1) Responsible for the nursing care of patients on a specific shift.
- 2) Enforces and implements policies and procedures.
- 3) Supervises, directs and evaluates the effectiveness of patient care on a specific shift.
- 4) Provides consistent leadership to the staff on a specific shift.
- 5) Monitors and directs patient flow.
- 6) Participates in emergency nursing management decisions.

c. Continuing Education:

Continuing Education (C.E.) of 50 hours per year.

**I. STAFFING**  
**B. NURSING**

**3. Nurse Educator**

**CRITICAL CRITERIA**

- a. Qualifications:
- 1) State R.N. Licensure.
  - 2) A masters degree or current enrollment in a masters program in Nursing, Nursing Education or equivalent.
  - 3) Two years of ED/EC experience, or one year of critical care and one year of ED/EC experience.

**RELATIVE CRITERIA**

- 4) Certified Emergency Nurse (CEN) certification must be achieved within two (2) years of hire.
  - 5) Successful completion of Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS), Trauma Nurse Core Course (TNCC) and Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC) or equivalent courses. Must demonstrate competency in BCLS, ACLS and PALS or ENPC every two (2) years. Must repeat the courses within one (1) year of national guidelines changes.
- b. Responsibilities:
- 1) R.N. responsible for inservice education in the Emergency Center.
  - 2) Plans and implements inservice and continuing education programs for all levels of nursing personnel on a 24-hour basis, including orientation, BCLS and other technical skills necessary for the care of all patients in the Emergency Center.
  - 3) In collaboration with the nurse manager evaluates the clinical performance of all nursing personnel on an ongoing basis.
  - 4) For Emergency Centers with an annual census equal to or greater than 40,000, the Nurse Educator is assigned exclusively to the Emergency Center and reports to the Emergency Center Nursing Leadership.
- c. Continuing Education:
- Continuing Education (C.E.) of 50 hours per year.

**I. STAFFING**  
**B. NURSING**

**4. Staff Nurse - including part-time/per diem staff** **CRITICAL CRITERIA**

At the following ratio per 8 hours (RN:Bed):

Monitored beds	1:4	
	Unmonitored beds	1:6
Observation beds	1:8	
	Resuscitation beds	2:1

- a. Qualifications:
- 1) State R.N. Licensure.
  - 2) One year of clinical R.N. experience.
  - 3) Successful completion of an Emergency Center orientation course based upon ENA core curriculum, in the first year of Emergency Center employment.
  - 4) Documents knowledge and understanding of EC policies and procedures.

**RELATIVE CRITERIA**

- 5) Successful completion of Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support ACLS, Trauma Nurse Core Course (TNCC) and Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC) or equivalent courses. Must demonstrate competency in BCLS, ACLS and PALS or ENPC every two (2) years. Must repeat the courses within one (1) year of national guideline changes.
  - 6) Current Certified Emergency Nurse (CEN) certification is recommended.
- b. Responsibilities:
- 1) R.N. assigned exclusively to the Emergency Center for the entire shift.
  - 2) Communicates difficulties to the charge nurse.
  - 3) Supervises the performance of ancillary nursing personnel.
  - 4) Performs triage, direct care and education to patients.
- c. Continuing Education:
- 1) Continuing Education (C.E.) of 50 hours per year.
  - 2) For part-time/per diem R.N.s - C.E. programs of 25 hours per year.

**I. STAFFING**  
**B. NURSING**

**5. Triage Staff**

Triage of patients will be performed by specifically trained professional staff using defined and approved protocols.

a. Qualifications:

**CRITICAL CRITERIA**

- 1) State R.N. Licensure.
- 2) 1 year EC clinical experience.

b. Responsibilities:

**RELATIVE CRITERIA**

- 1) A Registered Nurse assigned to triage 24 hours a day, 7 days a week, is required. There will be a specific R.N. assigned exclusively to triage, at a ratio of 1:50 per 8-hour shift, in addition to the above-established ratios of professional staff.
- 2) This person will have high visibility in the Emergency Center and be able to perform initial patient assessment prior to registration, as well as ongoing monitoring of the waiting room.

**6. Agency Staff/Float - Registered Nurses**

**CRITICAL CRITERIA**

Qualifications:

- 1) State R.N. Licensure.
- 2) Oriented to the Emergency Center.
- 3) Performance evaluation after orientation to the Emergency Center, and annually thereafter.

**RELATIVE CRITERIA**

- 4) Demonstrated knowledge in Emergency Center nursing.
- 5) Current successful completion of Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS), Trauma Nurse Core Course (TNCC) and Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC) or equivalent courses.

**7. Licensed Practical Nurse - L.P.N.s**

**CRITICAL CRITERIA**

L.P.N.s may not be substituted for R.N.'s to augment an insufficient R.N./patient ratio.

a. Qualifications:

- 1) State L.P.N. Licensure.
- 2) Successful completion of an Emergency Center orientation course (based on assignment) and successful completion of a Basic Cardiac Life Support (BCLS) or equivalent course. Must demonstrate competency in BCLS every two (2) years and must repeat the course within one (1) year of national guidelines changes.

**I. STAFFING**  
**B. NURSING**

**7. Licensed Practical Nurse - L.P.N.s (Cont'd)**

**CRITICAL CRITERIA**

- 3) One year of clinical experience.

**RELATIVE CRITERIA**

b. Responsibilities:

Assist the R.N. in all aspects of Emergency Center care and perform all designated functions under his/her supervision.

c. Continuing Education

Continuing Education (C.E.) of 50 hours per year.

## I. STAFFING

### C.

### OTHER STAFF

#### 1. *Inpatient Admitting Staff*

#### CRITICAL CRITERIA

##### a. Additional Physician Staffing

The facility shall have a written policy that inpatient admitting physician(s) shall assume the responsibility for the clinical management of patients who have been admitted from the Emergency Center and are awaiting transfer to inpatient beds. If there is an admitting team, this team must be supervised by an attending physician and must consist of staffing not assigned to any other Emergency Center responsibilities. Physician(s) assigned to the care of such boarder patients may not be concomitantly assigned to the care of Emergency Center patients. This policy must be signed by the Chief Executive Officer (or by a comparable senior executive) and by the appropriate Clinical Chairs.

##### b. Additional R.N. Staffing

#### CRITICAL CRITERIA

This policy must specify that nursing staffing ratios for these patients must be maintained at the same level as the inpatient service(s), consistent with the acuity of the patients.

##### c. Ancillary Services

#### RELATIVE CRITERIA

Ancillary services (e.g., phlebotomy, nursing assistants, transport services) must be provided at the same level as the inpatient services.

#### 2. *Administrator/Administrative Assistant*

#### RELATIVE CRITERIA

##### a. Qualifications

- 1) One (1) year in hospital management of clinical division.
- 2) Graduate of an accredited program at least at a minimum of a baccalaureate (BS/BA) level.

##### b. Responsibilities:

Assigned to the Emergency Center, with 24-hour responsibility for the coordination and management of all ancillary and clerical functions, in collaboration with the Emergency Center Director and Nurse Manager.

##### c. Continuing Education:

Continuing Education (C.E.) of 50 hours per year related to healthcare administration.

**3. Clerical Staff**

**CRITICAL CRITERIA**

a. Registrar

With 24 hours/day, 7 days/week coverage, at a ratio of 1:25 patients per 8 hours. Full-time staff is required to provide registration, billing, logging and clinical appointments to expedite patient flow.

b. Unit Clerk

For Emergency Centers which register more than twelve (12) patients per 8 hour shift, there must be a Unit Clerk present, exclusive of personnel performing the registration and billing function. If the ratio exceeds 1:25 patients per 8 hours, an additional clerk must be provided.

**4. Technician**

**CRITICAL CRITERIA**

Works under the direct supervision of a licensed professional appropriate to the local standards in the performance of technical/laboratory duties exclusively in the Emergency Center. Performs additional related duties within Emergency Center policies and procedures and JCAHO/regulatory agency requirements. Demonstrates and promotes service excellence at all times.

**5. Interpreter**

**CRITICAL CRITERIA**

a. Language Translation

1. Fluent in the English language.
2. Language bank/interpreters available 24 hours a day, 7 days a week, for those who do not speak English in the community.

b. Hearing impaired

Available 24 hours a day, 7 days a week.

**6. Messenger**

**RELATIVE CRITERIA**

With 24 hours/day, 7 days/week coverage. A full-time messenger function for the Emergency Center, exclusive of the professional staff, for the acquisition of necessary supplies and equipment, delivery of lab specimens, acquisition of records and performance of other errands.

**I. STAFFING**  
**C. OTHER STAFF**

**7. Social Worker**

**CRITICAL CRITERIA**

a. Qualifications:

- 1) Graduate of M.S.W. program.
- 2) One year of social work experience.

b. Responsibilities:

**CRITICAL CRITERIA**

- 1) At least one full-time position assigned to assure that patients' social service needs are met on a 24 hour basis.
- 2) Provides required follow-up and referral based on community needs, including placement, clothing, home assistance, transportation means and shelter when needed.
- 3) Implements individual or group counseling for selected categories of patients or patients' family problems.
- 4) Provides for the coordination of assessment of all possible child abuse (physical and sexual) and neglect, elder abuse and neglect, domestic violence, sexual assault and victims of crime, crisis intervention, and bereavement counseling.

c. Resources Available:

**CRITICAL CRITERIA**

Twenty four hour accessibility by telephone to a Social Work Supervisor, Child Protection Coordinator, or senior member of the child protection team for consultation or referral agreements in place.

d. Continuing Education:

**RELATIVE CRITERIA**

Continuing Education (C.E.) of 50 hours per year should encompass the following topics:

- 1) Child Abuse and Neglect.
- 2) Sexual Assault.
- 3) Domestic Violence.
- 4) Elder Abuse/Neglect.
- 5) Crime Victims.

**I. STAFFING**  
**C. OTHER STAFF**

**8. Counselors**

**RELATIVE CRITERIA**

Alcoholism/Substance Abuse Counselor

It is recommended to have a counselor on alcoholism/substance abuse available for patients.

**9. Nurse Practitioner (N.P.)**

**CRITICAL CRITERIA**

a. Responsibilities:

Care of Emergency Center patients under the supervision and guidance of a licensed physician, based on collaborative agreements and protocols.

b. Qualifications:

- 1) State R.N. Licensure.
- 2) Graduate of a National League of Nursing (NLN) accredited N.P. program
- 3) Current certification from American Nurses Credentialing Center (ANCC) or other national certifying board.

**RELATIVE CRITERIA**

- 4) Successful completion of Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS), Trauma Nurse Core Course (TNCC), and Pediatric Advanced Life Support (PALS) or equivalent courses. For BCLS, ACLS and PALS, must demonstrate competency every two (2) years. Must repeat the courses within one (1) year of national guidelines changes. Nurse practitioner shall have training and experience in trauma management equivalent to Advanced Trauma Life Support (ATLS) (depending on role and responsibility in the Emergency Center).
  - 5) M.S. in Nursing.
- c. Continuing Education:  
Continuing Education (C.E.) of 50 hours per year.

**I. STAFFING**  
**C. OTHER STAFF**

**10. Physician's Assistant/Associate (P.A.)**

**CRITICAL CRITERIA**

- a. Responsibilities:  
Care of Emergency Center patients under the supervision and guidance of a licensed physician, based on written agreements and protocols.
- b. Qualifications:
  - 1) B.S./B.A. from a recognized P.A. program.
  - 5) Licensure and practice as required by State law.

**RELATIVE CRITERIA**

- 6) Successful completion of Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) or equivalent courses. For BCLS, ACLS and PALS, must demonstrate competency every two (2) years. Must repeat the courses within one (1) year of national guidelines changes. Physician's Assistant shall have training and experience in trauma management equivalent to Advanced Trauma Life Support (ATLS) (depending on role and responsibility in the Emergency Center).
- c. Continuing Education:  
Continuing Education (C.E.) of 50 hours per year.

## II. PROFESSIONAL TRAINING AND CONTINUING EDUCATION

### A. ORIENTATION:

### RELATIVE CRITERIA

A program for all full-time personnel should be implemented in a planned, formal and coordinated way, ideally as a joint effort of nurses, physicians, and administration.

Orientation Program - this should include:

- a. Recognition, recording and interpretation of signs and symptoms of emergent and non-emergent adult and pediatric patients.
- b. Initiation of BCLS and other life support procedures for both adult and pediatric patients.
- c. Parenteral administration of IV fluids, blood and blood components and emergency drugs and substances.
- d. Safe and effective use of all electronic equipment.
- e. recognition and intervention for life threatening arrhythmia's.
- f. Infection Control, including aseptic technique, hand washing, contact isolation, respiratory isolation, reverse isolation.
- g. Management of sepsis.
- h. Management of wounds.
- i. Initial management of burns.
- j. Initial management of general trauma, and spinal cord and head injuries.
- k. Emergency delivery and initial care of the newborn.
- l. Initial management of overdose (drugs and alcohol), and withdrawal syndromes.
- m. Initial management of psychiatric emergencies including:
  - 1) The violent, homicidal and suicidal patient.
  - 2) Management of grief reaction.
  - 3) Differentiation between organic and functional states.
- n. Recognition and initial intervention of psychological and social problems of patients and their families.
- o. Initial management of amputated parts.
- p. Knowledge of regional paramedic protocols.
- q. Recognition and management of the pediatric, geriatric, and adult abuse/neglect patient.
- r. Initial management of the sexually assaulted adult and pediatric patient.
- s. Knowledge of regional HAZMAT and disaster protocols.

## **II. PROFESSIONAL TRAINING AND CONTINUING EDUCATION**

### **B. CONTINUING EDUCATION**

### **RELATIVE CRITERIA**

A program for all personnel should be implemented in a planned, formal and coordinated way, as a joint effort of nurses, physicians and administration to reflect the current needs of the staff and patient population served.

The continuing education program should include at least the following:

- a. New diagnostic and therapeutic measures.
- b. Safety Control.
- c. Infection Control.
- d. BCLS review, at least yearly.
- e. Principles of treatment related to burn care.
- f. General and central nervous system trauma.
- g. Respiratory care.
- h. Participation in extramural educational programs related to Emergency Medicine or Emergency Nursing.
- i. Review and update of items listed in Orientation Program.
- j. Review and update on pediatric and adult abuse/neglect patients.
- k. Managing the violent patient.

### III. FACILITY

It is recommended that hospitals which treat a large number of non-urgent patients in their Emergency Center consider establishing a Walk-In Clinic/Fast Track Area for the non-acute patient population to prevent over-crowding in the Emergency Center.

#### A. EC DESIGN GENERAL - requirements include:

1. EC Signs - to include: **RELATIVE CRITERIA**
  - a. A prominent street entrance sign which is:
    - 1) Visible by day and night from approximately one block.
    - 2) Well lit at night.
    - 3) In English.
    - 4) In the major language(s) of the community.
  - b. Signs inside the hospital to indicate and direct patients to:
    - 1) EC location.
    - 2) Triage area.
    - 3) Registration area.
    - 4) "Prohibited to Enter" area(s) to prevent unauthorized personnel from entering the treatment and work areas of the EC.
    - 5) Patient's Bill of Rights.
2. A separate ambulance bay adjacent to the EC and within easy access of the EC treatment area. For all new EC treatment area construction after effective date of the First Edition Standards, the route from the ambulance bay to the EC treatment areas shall not transverse the EC waiting area.
3. A triage area with privacy during evaluation with triage nurse at the entrance to the EC with a telephone or intercom (before clerical registration.) The triage area must offer an unobstructed view of the waiting room.
4. A registration area (or bedside registration when applicable).
5. Separate utility rooms:
  - a. Clean.
  - b. Dirty.
6. Adequate storage area for back-up supplies and equipment.
7. Appropriate facilities for:
  - a. Hand washing.
  - b. Surgical scrub prior to sterile technique procedures.
8. Shower or bath facilities and a mechanism for decontamination of patients.
9. Family Grieving Room/Consultation Room.

### III. FACILITY

### RELATIVE CRITERIA

#### **B. DESIGN OF TREATMENT AREAS - requirements include:**

1. Separate treatment area for the emergent and urgent patients, to facilitate patient examination treatment.
2. An adequate space for adult and pediatric waiting and treatment areas, e.g.:
  - a. A waiting area with adequate telephones and lavatories and a section designated for children.
  - b. An adult treatment area.
  - c. A pediatric treatment area.
3. A separate area for cardiac arrest, multiple trauma and emergency surgery procedures. This area must have at least two treatment bays, preferable 200 square feet each. If a separate area is not available for Pediatrics, then this area must be equipped to handle pediatric respiratory arrest, cardiac arrest, multiple trauma and emergency surgery procedures.
4. A separate area for the care of psychiatric emergencies, e.g., a crisis intervention room. There should be a capability to adjust to additional circumstances by providing a safe environment when more than one room is needed for the psychiatric patients.
5. The treatment area should have capacity for:
  - a. Physical examination.
  - b. Suturing and other surgical procedures,
  - c. Cast and splint application.
  - d. Gynecological examination and treatment.
  - e. The treatment area should have the capacity to provide for emergencies of any variety including psychiatric, burn, poisoning, neonatal, trauma, as well as cardiac in addition to the initial management and stabilization of all critically ill patients.
  - f. Special emergency procedures, e.g., ear, eye, nose and throat, genito-urinary, etc.
6. Isolation **CRITICAL CRITERIA**  
The treatment area must have a negative pressure room.

### III. FACILITY

#### C. ADDITIONAL REQUIREMENTS - these include: **CRITICAL CRITERIA**

1. Critical care areas in the hospital for life threatening emergencies.
2. An Operating Room, within easy access to the EC. The OR must be available 24 hours/day, 7 days/week, and must be capable of initiating a case within 10 minutes.

##### OR Specifics

- a. Thermal control equipment:
    - 1) For the patient.
    - 2) For blood.
  - b. Monitoring equipment:
    - 1) ECG., cardiac monitoring, defibrillator with pacemaker capacity, pulse oximeter and CO<sub>2</sub> monitoring.
    - 2) Invasive arterial pressure monitoring capability.
    - 3) Mechanical ventilator.
    - 4) Image intensifier (fluoroscopy).
  - c. Bronchoscopes and endoscopes.
  - d. Appropriately trained PACU nursing staff, available 24 hours/day, as per a posted schedule.
  - e. Ancillary personnel physically available in the facility or within 30 minutes.
3. A PACU or ICU capability is to be available in or adjacent to the Operating Room (OR), for post-operative patients, 24 hours/day with capability to perform (or transfer to a specialty referral center\*):
    - a. Cardio-pulmonary bypass.
    - b. Peritoneal dialysis, hemoperfusion, hemodialysis.
    - c. Treatment of severe burns\*.
    - d. Neurosurgical procedures.
    - e. Angiography – CT scanning.
    - f. Replantations\*.
    - g. Hyperbaric oxygen therapy\*.
    - h. Trauma Center care\*.
    - i. Pediatric Intensive care.
    - j. Neonatal Intensive care (Level III nursery)\*.
    - k. Ultrasound.
    - l. V/Q scanning.

\*Officially designated as a specialty referral center. Patients should be delivered to above specialty treatment centers within 30 minutes from time of decision to transfer. Formal transfer policies and procedures must exist.

### **III. FACILITY**

#### **C. ADDITIONAL REQUIREMENTS cont'd: CRITICAL CRITERIA**

4. Medical, surgical and pediatric intensive care units capable of providing comprehensive critical care services 24 hours-a-day. Intensive care unit beds available within 2 hours on a consistent basis for the transfer of EC patients. Additionally, the Center must adhere to the requirements of EMTALA.

#### **IV. EQUIPMENT AND SUPPLIES**

#### **RELATIVE CRITERIA**

All emergency equipment and supplies necessary for acute treatment must be regularly maintained, and should be compliant with standard safety and minimal operating standards. Resuscitation equipment must be monitored for adequacy and function every shift, according to a formal mechanism with accountability.

##### **A. GENERAL**

#### **RELATIVE CRITERIA**

\* **In EC or immediately available from within the hospital.**

\*\* **Available to the EC within 5 minutes.**

1. Examination tables/stretchers to be stable, with a locking system, with side rails and safety straps, adjustable to a required position (Fowler or Trendelenburg) and preferably preventing any additional, unnecessary movement of the patient.
2. Gynecological exam table with stirrups.
3. A communication system between all areas in the EC (e.g., intercom, call bell, telephone).
4. Refrigerators for storage of perishable drugs and items.
5. Blood storage refrigerator in the EC or within easy access to it. There must be immediate access (within five minutes) to emergency transfusion blood. If there is no immediate access to blood, an emergency supply of at least two units of O-negative blood must be stored in the EC.
6. Mechanical or hand pump to administer blood under pressure as well as intravenous infusion pumps.
7. Blood warming equipment.
8. Temperature and blood pressure monitoring equipment including electronic non-invasive BP monitor with adult and pediatric cuffs (all sizes).
9. Capability for measuring temperature between 60<sup>0</sup> and 115<sup>0</sup> F.
10. Bag-valve mask, in adequate quantities. Infant (240cc) and child (500cc) bag-valve mask devices with clear face masks with a soft or inflatable collar for easy sealing capacity (size 0-4).
11. Ophthalmoscope(s) and otoscope(s) in adequate quantities with adult and pediatric specula.

A. GENERAL (Cont'd)

RELATIVE CRITERIA

\* **In EC or immediately available from within the hospital.**

\*\* **Available to the EC within 5 minutes.**

12. Sandbags or similar immobilization devices in adequate quantities. Infant, toddler, child, and adult size rigid cervical collars.
13. Physical restraints including papoose board.
14. Central venous pressure monitoring equipment.
15. Large bore orogastric tube and equipment for gastric lavage. Large bore NG and OG tubes and equipment for gastric lavage. pediatric range, #10 -#18 French; Adult range, #32 - #40 French. feeding tubes pediatric range, #5 - #10 French; Adult range, #16 - #18 French.
16. Doppler.
17. Radiant warmer for newborn resuscitation and Isolette for newborn transport available immediately upon request.
18. Infant scale.
19. Sterile equipment sets for:
  - a. Birth on Arrival (BOA).
  - b. Central line.
  - c. Cut down.
  - d. External and transvenous pacemaker.
  - e. Intubation.
  - f. Lumbar puncture - lumbar puncture tray (with 22 gauge 1.5" needles and manometer).
  - g. Minor surgical procedures and general suturing material, including cardiovascular and plastic suturing material.
  - h. Peritoneal lavage.
  - i. Pleural closed drainage system.
  - j. Phlebotomy - including 27, 25, 23, and 21 gauge butterflies.



A. GENERAL (Cont'd)

RELATIVE CRITERIA

\* **In EC or immediately available from within the hospital.**

\*\* **Available to the EC within 5 minutes.**

19. Sterile equipment sets for (cont'd):

k. Tracheostomy - cricothyroidotomy equipment (including pediatric size tracheostomy tubes: tube outside diameter in mm: premature 4.0, newborn 4.5-5.0, infant 5.5, 1-3 years 6.0, 3-6 years 7.0, 6-12 years 8.0, >12 years 10.0).

l. Thoracotomy.

m. Thoracostomy.

n. Arterial line catheter and equipment for intra-arterial pressure monitoring.\*

o. Pericardiocentesis.

p. Umbilical line placement tray with 3, 5 French catheters

20. Bronchoscopes and endoscopes.\*

21. Chest tubes including pediatric sizes: Newborn 10-12 Fr, infant 14-20 Fr, child 20-28 Fr, adolescent 28-42 Fr.

22. Volume ventilator.\*\*

23. Appropriate oxygen delivery devices in adult and pediatric sizes.

24. Peak flow meters in adult and pediatric sizes.

25. If the following optional items are available in the EC, operation of such must either be in compliance with regional and federal regulations or designated as strictly for educational purposes (e.g. STAT Lab).

a. Hematocrit/Hemoglobin analyzer.

b. Blood gas analyzer.

c. Microscope.

d. Centrifuge.

**A. GENERAL (Cont'd)**

**RELATIVE CRITERIA**

- \* **In EC or immediately available from within the hospital.**
  - \*\* **Available to the EC within 5 minutes.**
26. Indicator tests with appropriate CLIA licensing, competency certification and quality control.
    - a. Dipstick for urinalysis.
    - b. Urine pregnancy test.
    - c. Nitrazine paper.
    - d. Stool testing for occult blood.
    - e. Capillary blood glucose testing (CBGT).
  27. Pediatric Dose Chart for all Pediatric Advanced Life Support medications and equipment, e.g. Broselow Tape or similar system for accurate dosing.
  28. IV equipment to include both pediatric (18-24 gauge, short length) and adult size catheters.
  29. Standard solutions for both the adult and pediatric patient IV use.
  30. Several defibrillator/monitor units (with adult and pediatric paddles for external and internal use).
    - a. Several defibrillator/monitor units with a rate triggered alarm.
    - b. Several battery operated portable units for transport only.
    - c. At least one with a synchronization mode and external pacer capacity. Inter-changeable leads between all defibrillator/monitors preferred.
  31. Flow directed balloon catheters to be available within 30 minutes (e.g., in stock in the ICU).
  32. Cardiopulmonary resuscitation cart equipped for at least three arrests, based on American Heart Association Standards. Pediatric and adult sizes to be included.
  33. The following items are to be in the hospital and readily available:
    - a. Hypothermia and hyperthermia equipment, e.g., bath tub or its equivalent, cooling stretcher or high speed fan.
    - b. Peritoneal dialysis.



A. GENERAL (Cont'd)

RELATIVE CRITERIA

\* In EC or immediately available from within the hospital.

\*\* Available to the EC within 5 minutes.

34. Equipment for cervical traction, to include Vincke or Gardner-Wells tongs.\*

35. Slit lamp.

36. Pulse oximeter.

37. Pediatric oral rehydrating solution, milk, and soy-based infant formulas.

38. Ring cutter.

39. Emergency drugs and solutions to include:

- a. All drugs listed in current editions of AHA textbook of Advanced Cardiac Life Support, Pediatric Advanced Life Support and Neonatal Advanced Life Support.
- b. Antibiotics.
- c. Anticonvulsants.
- d. Antidotes for poisonings.
- e. Antihypertensive agents.
- f. Agents which are listed in blood/body fluid exposure protocols (which should be compliant with current CDC recommendations) including antiretroviral agents promptly available for dispensing.
- g. Cardiac medications.
- h. Corticosteroids.
- i. Diuretics.
- j. Inhaled  $\beta$ -agonists.
- k. Medications for intracranial hypertension.
- l. Medications for psychiatric emergencies.

A. GENERAL (Cont'd)

RELATIVE CRITERIA

\* **In EC or immediately available from within the hospital.**

\*\* **Available to the EC within 5 minutes.**

39. Emergency drugs and solutions to include (cont'd):

- m. Medications for rapid sequence intubation (including neuromuscular blocking agents).
- n. Medications for sedation and analgesia.
- o. Opiates.
- p. Tetanus and diphtheria prevention and prophylaxis specifically adult DT and pediatric DT and tetanus immune globulin, rabies immune globulin and vaccine, hepatitis immune globulin and vaccine and Rho immune globulin. Available from Pharmacy, or in the Emergency Center.
- q. Thrombolytics.
- r. Vasopressors.
- s. Volume expanders.

#### IV. EQUIPMENT & SUPPLIES

#### RELATIVE CRITERIA

##### **B. EQUIPMENT AND SUPPLIES IN ROOMS FOR LIFE THREATENING EMERGENCIES - e.g., CARDIAC ARREST, MULTIPLE TRAUMA** - requirements include:

1. Suction equipment (flexible and rigid).
2. Oxygen equipment (including simple and non-rebreathing face masks, pediatric oxygen hood and infant and child sized bag-valve-mask devices).
3. Endotracheal equipment:
  - a. Adult size endotracheal tubes, stylets, laryngoscope blades, Magill forceps.
  - b. Pediatric size endotracheal tubes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, uncuffed; 6.0, 6.5, 7.0, 7.5, 8.0 cuffed; pediatric stylets; laryngoscope blades 0, 1, 2, 3 straight Miller; 1, 2, 3, 4 curved MacIntosh and pediatric Magill forceps.
4. Airways, all sizes (including guide sizes: 00, 0, 1, 2, 3, 4).
5. Foley catheter equipment.
6. Nasogastric tube equipment, all sizes (including French 10, 12). Feeding tubes (5 & 8 French).
7. ECG machine: paper, paste, adult, pediatric and neonatal size electrodes.
8. Intraosseous - Jamshidi bone marrow needles (or equivalent) for intraosseous infusion (No. 15 & 18 gauge).
9. Intravenous access equipment, both central and peripheral.
10. Cardiac and oxygen saturation monitoring for neonates temperature monitoring and warming.
11. Fiberoptic bronchoscope for intubation.\*
12. CPAP and BIPAP equipment and available Heliox.\*
13. End tidal CO<sub>2</sub> detector.
14. Gloves/Gowns.
15. Protective eyewear.
16. Masks (TB protective).

\*Or immediately available in the hospital.

**IV. EQUIPMENT & SUPPLIES**

**RELATIVE CRITERIA**

**C . OTHER TREATMENT ROOMS**: the minimal requirements are:

1. Suction equipment.
2. Oxygen equipment.
3. Airways.
4. Privacy.

V. **ANCILLARY SERVICES**

A. **LABORATORY FOR STAT SPECIMENS** - requirements are: **CRITICAL CRITERIA**

Laboratory to analyze STAT specimens from the EC on a priority basis, 24 hours per day, 7 days per week, located within five minutes from the EC, for the following tests:

- a. Blood gases, Beta HCG blood/urine, hemoglobin, hematocrit, potassium, glucose, carboxyhemoglobin and methemoglobin - within 10 minutes.
- b. Calcium, SMA 7, or equivalent, serum ammonia, urinalysis, amylase, PT and/or PTT and INR - within 60 minutes.

B. **TOXICOLOGY SCREENING CAPABILITY** - Capability to obtain levels 24 hours/day, 7 days/week. **CRITICAL CRITERIA**

1. Requirements to include but not limited to serum levels for:
  - a. Acetaminophen, digoxin, diphenylhydantoin sodium, lithium, salicylates, theophylline, ethanol, and osmolality, determined by a freezing point depression osmometer - within 90 minutes.
  - b. Barbiturates, ethylene glycol, methanol - within 4 hours.
2. Specific toxicologic tests may be ordered for validation purposes if indicated.

C. **BLOOD BANK** - requirements are: **CRITICAL CRITERIA**

1. 2 units of packed cells of O-negative blood within five (5) minutes.
2. 2 units of type specific blood within 15 minutes.
3. Type and crossed matched blood within 45 minutes.

**D. RADIOLOGICAL** - requirements include: **CRITICAL CRITERIA**

Radiology capability for high priority EC patients on an individual basis 24 hours/day, 7 days/week as follows (time to initiate emergent study/time to result):

- a. standard radiographs - 5 minutes/10 minutes.
- b. ultrasonography - 5 minutes/30 minutes.
- c. computed tomography - 5 minutes/30 minutes.
- d. angiography - 1 hour/2 hours.
- e. MRI - magnetic resonance imaging (or acceptable alternative) - 30 min/1 hour (if not available on site, transfer policy which upholds above standards must be in place).
- f. nuclear medicine capability (or acceptable alternative).

**E. CENTRAL STERILE SUPPLY DEPARTMENT (C.S.S.D.)**

**CRITICAL CRITERIA**

Sterile supplies available to EC 24 hours/day, 7 days/week.

**F. SECURITY** - requirements include: **CRITICAL CRITERIA**

1. Security personnel support must maintain a safe and secure environment for both patients and staff across the entire range of departmental conditions.
2. Police and security facilities and/or special officers assigned to the EC 24 hours/day, 7 days/week. If personnel are not assigned please explain as to availability of and process for access to security force.

**G. HOUSEKEEPING** **CRITICAL CRITERIA**

Housekeeping and cleaning service assigned to the EC 24 hours/day, 7 days/week.

## VI. EC RECORDS

## CRITICAL CRITERIA

**MEDICAL RECORDS** - The creation of a medical record should be immediate and not delay patient care. It is required that:

1. All past record(s)
  - a. In-patient
  - b. Out-patient
  - c. Emergency Center

be easily retrievable and available 24 hours/day, 7 days/week. All records are to be incorporated into a patient unit medical record. A computerized alternative is acceptable. Pertinent records to the patient's immediate care should be available.

2. Each visit will have a separate EC record filled out, at least in duplicate (e.g. for admitting, QA, billing, etc.).
  - a. The original should be incorporated into the patient's unit medical record.
  - b. A copy is to be kept on file in the EC for quality assurance and statistical data collection purposes at least until the file is incorporated into the permanent medical record.
3. Each EC record is to include the following:
  - a. Current and updated patient identification data (if such is not available, the reason for it should be clearly documented in the record).
  - b. Time and means of arrival and departure.
  - c. Pertinent history, physical findings, including vital signs and appropriate assessment.
  - d. Emergency care given to the patient prior to arrival to the hospital; attach ambulance call report form to the original record after completing the bottom part of the form noting patient diagnosis, disposition and EC record number.
  - e. Diagnostic and therapeutic orders (indicate presence or absence of allergies).

**VI. EC RECORDS**

**CRITICAL CRITERIA**

**MEDICAL RECORDS (CONT'D)**

- f. Clinical observations, interventions, and reaction to treatment.
- g. Results of procedures, x-rays and tests, transcribed to EC record (all tests that are done on emergency basis, while the patient is in the EC).
- h. Diagnostic impression at the termination of EC visit, including final disposition, patient's condition at discharge and what instructions were given to patient and/or family when applicable, with the patient's and/or family's signature who received the instructions, as well as the signature of the person giving the instructions.
- i. When the patient leaves against medical advice (AMA), it will be clearly documented and signed by at least two (2) professional members of EC staff.
- j. The record will be signed by all the physicians treating the patient in a legible and identifiable manner.
- k. Notation of discharge time.
- l. Emergency Center data collection must be compliant with state and federal documentation requirements (for example - CDC DEEDS data elements).

## **VII. MANUALS AND REFERENCES**

### **A. WRITTEN POLICIES AND PROCEDURES    **RELATIVE CRITERIA****

1. It is required that there be written policies and procedures relating to the scope and conduct of patient care in the EC.
2. These policies and procedures are to be:
  - a. readily available to all the staff in the EC 24 hours/day, 7 days/week.
  - b. approved by medical, nursing and administrative leadership staff.
  - c. reviewed at least on a yearly basis with an authorizing signature and date of last review.

### **B CURRENT REFERENCE MATERIAL - requirements include:**

#### **CRITICAL CRITERIA**

1. Regional poison control telephone number available.

2. Current editions of references pertaining to the following are required:

#### **RELATIVE CRITERIA**

- a. Advanced Cardiac Life Support: American Heart Association.
- b. Advanced Trauma Life Support: American College of Surgeons.
- c. Emergency Medicine.
- d. Hospital Formulary.
- e. Internal Medicine.
- f. Orthopedics.
- g. Pediatric Emergency Medicine.
- h. Pediatric Advanced Life Support: American Heart Association or the American Academy of Pediatrics.
- i. Physicians Desk Reference (PDR) (or equivalent).
- j. Pharmacology.

**B CURRENT REFERENCE MATERIAL (CONT'D) - requirements include:**  
**RELATIVE CRITERIA**

- k. Radiology.
- l. Toxicology.

**C. CURRENT REFERENCE MATERIAL      **RELATIVE CRITERIA****

References for the acute management of the following emergencies are **recommended:**

- a. Dermatology.
- b. Environmental.
- c. Obstetrics/Gynecology.
- d. Pediatrics.
- e. Wilderness Medicine.

**D. CURRENT REFERRAL AND CONSULTATION SERVICES      **RELATIVE CRITERIA****

A list of referral consultative services should include:

- a. Ambulance transport and rescue services.
- b. Antivenom services.
- c. Medical Examiner.
- d. Police.
- e. Radiation exposure services.
- f. Special care services, not provided by the hospital.
- g. State and local health departments.
- h. Tissue and organ donation centers.

**D. CURRENT REFERRAL AND CONSULTATION SERVICES (CONT'D)**  
**RELATIVE CRITERIA**

A list of referral consultative services should include:

- i. Hyperbaric oxygen therapy services.
- j. Child Support Enforcement.
- k. Emergency Children's Service.
- l. Social Service.

**VIII. CONTINUOUS QUALITY IMPROVEMENT** - Areas include:

**A. PERFORMANCE IMPROVEMENT PROJECTS CRITICAL CRITERIA**

1. An active departmental strategy should demonstrate performance improvement in overall process, patient outcome, and administration.
2. Several specific projects should be made available to the surveyor to demonstrate the above with documentation of initial evaluation, Q.I. implementation, and endpoint improvement.

**B. EC RECORDS: CRITICAL CRITERIA**

1. Records will be randomly sampled for review by the Medical Director or his/her designee as to the adequacy of services rendered, adherence to protocols and adequacy of documentation.
2. There should be a set mechanism for the correction of identified deficiencies.
3. There should be an automatic audit of all records of patients dying within 24 hours of arrival to the EC whether admitted or not.

**C. SUPPORT SERVICES CRITICAL CRITERIA**

1. Review of:
  - a. All EC radiographs by a radiology attending with the official interpretation incorporated into the patient's medical record **within 24 hours.**
  - b. All abnormal EC laboratory tests by the Medical Director and/or his/her designee within the following time frame:
    - 1) STAT laboratory tests within **10 minutes.**
    - 2) Urgent laboratory tests within **60 minutes.**
    - 3) Demonstrate the mechanism by which all delayed tests results are reported, followed up and documented within **24 hours of time posted by laboratory.**
  - c. Compliance with the policy that surgical specimens removed from any patient in the EC be sent to the pathology department (except where otherwise required by law enforcement agents) and that the official report is a part of the EC record within 24 hours.
2. A recall procedure to be implemented for patients who require additional studies or treatment as determined by the review process.

**VIII. CONTINUOUS QUALITY IMPROVEMENT** - Areas include:

**D. ANTIBIOTICS**

**RELATIVE CRITERIA**

There will be a medical staff review of the clinical use of antibiotics on an ongoing basis.

**E. TRANSFERS**

**RELATIVE CRITERIA**

There will be a review mechanism for all transfers.

**F. OUT-PATIENT DEPARTMENT (OPD) REFERRAL**

**RELATIVE CRITERIA**

OPD referral from the EC will be reviewed for appropriateness and timeliness.

**IX. EDUCATION**  
**A. OVERVIEW**

**RELATIVE CRITERIA**

The Emergency Center should demonstrate an on-going commitment to education. The Center should serve as a local and regional educational resource, disseminating information and providing training to a variety of constituents both within and external to its institution. These include medical and nursing personnel, pre-hospital personnel, residents and students, and the general public.

The educational program should be integrated with approved residency training and graduate training programs. The educational program should address the needs of the Center's clinical enterprise, providing state of the art information on the practice of emergency medicine. The center should assess the unique educational needs of the community it serves and provide programs which enhance the delivery of emergency services.

There should be evidence of sustained funding for educational activities.

Traditional structured educational classes and courses should be available. The Center should also demonstrate its efforts at meeting educational needs through innovative programs and/or technology. The center should have a system in place to monitor the effectiveness of its programs and faculty.

Working relationships should exist between the Center's educational program and:

1. Office of Graduate Medical Education.
2. Office of Continuing Medical/Nursing Education.
3. Local/Regional/State Office of Emergency Medical Services.

**B. DESCRIPTION OF EDUCATIONAL ACTIVITIES**

**RELATIVE CRITERIA**

1. Provide an overview of the activities and scope of the Center's educational program. Describe faculty and staff commitments, support from your parent organization, as well as how your program is integrated with other educational programs at your institution.
2. Describe the funding support for your educational program.
3. Describe the process of how the Center assesses and meets community needs. This should include a description of public educational programs in injury and illness prevention, initial treatment, emergency access to care, and appropriate use of emergency system resources.

**B. DESCRIPTION OF EDUCATIONAL ACTIVITIES CONT'D**

**RELATIVE CRITERIA**

4. Describe the process used to measure educational program and faculty/teacher effectiveness.
5. Describe how the Center has met the unique educational challenges of pre-hospital personnel to include regional training in the response to disasters, mass casualties, terrorism, and exposure to hazardous materials.
6. Provide documentation for all of the above within the past 12 months.

**X. RESEARCH**

**A. OVERVIEW**

**RELATIVE CRITERIA**

The Emergency Center should demonstrate an on-going commitment to high quality biomedical, clinical, and health services research. The Center should actively support and encourage collaborative efforts with other academic departments and institutions through participation in research endeavors.

The Center's research program should be structured to work closely with residency training and graduate training programs. The research program should collaborate with the Departmental CQI/QA program in assessing the quality of care rendered through structured patient outcome and process evaluation, while adhering to institutional (IRB) and federal (DHHS/FDA) regulations.

There should be evidence of past and present grant acquisition from industry, private foundations and federal funding organizations.

Structured research didactic sessions and conferences should be available for attendings, residents, nurses, and medical students. Additionally the Center should have in place a system to monitor its research activities and progress, to review protocols for feasibility, address budgetary issues, allocate resources as well as to mentor faculty, attending physicians, residents and nurses in the research process.

Working relationships should exist between the Center's research program and local support and regulatory bodies such as the:

1. IRB (Institutional Review Board).
2. Animal Care Committee.
3. Office of Research Grants and Contracts.
4. Department/Division of Biostatistics or other biostatistical support.
5. Basic Science Investigators.

**XI. RESEARCH**

**B. RESEARCH PROGRAM DESCRIPTION    **RELATIVE CRITERIA****

1. Provide an overview of the activities and scope of your Center's research program. Describe faculty and staff commitments, support from your parent organization and areas of interest.
2. List and briefly describe research projects carried out by your center over the past 3 years.
3. List and briefly describe funding support for research projects over the past 3 years.
4. Describe your Center's efforts at disseminating research findings:
  - presentation of abstracts at scientific sessions.
  - publication of abstracts in meeting proceedings and peer-review journals.
  - publication of manuscripts in peer-review journals.
  - invited presentations.
5. List all peer-reviewed publications by Emergency Medicine faculty within the last 3 years.

## **XI. ADMINISTRATION**

### **A. OVERVIEW**

### **CRITICAL CRITERIA**

The Emergency Center should have the necessary administrative resources and structural organization to carry out its comprehensive mission. In addition to strong leadership and sound managerial practices, sufficient support personnel and dedicated administrative facilities are necessary to ensure stability and success. The Center should be capable of simultaneously addressing internal departmental issues, inter-departmental and hospital issues, as well as external issues of vital importance to the Center.

Internally, the Center's administrative unit should insure that the care delivered meets acceptable standards for quality and cost, that local and national regulations are adhered to, and that acceptable methods exist for communication and information exchange among all personnel. All services, research, and educational programs should be coordinated.

The administrative unit should maintain strong working relationships with hospital departments and other functional elements within the hospital. The Center's leaders should actively participate in governing bodies, clinical conferences, hospital forums, and leadership roles. The Center should be recognized for its contributions to the success of the parent organization.

An Emergency Center should demonstrate the ability to provide assistance, support, and leadership to individuals and organizations within its surrounding region. Effective communication and a community based needs assessment should direct the Center's efforts.

### **B. DESCRIPTION OF CENTER ADMINISTRATION**

### **CRITICAL CRITERIA**

1. Provide an overview of your Center's central administration and organization. Describe faculty and staff commitments, support from your parent organization, and the mission of your Center.
2. Provide an overview of the financial resources dedicated to the Center and its programs.
3. Describe how your Center coordinates its services, research and educational programs.
4. Describe how your Center maintains effective communication with its own personnel and with individuals/organizations that interact directly with the Center.

**XI. ADMINISTRATION**

**B. DESCRIPTION OF CENTER ADMINISTRATION**

**CRITICAL CRITERIA**

5. Describe how the Center evaluates its programs and services for effectiveness.
6. Describe the working relationships between the Center, hospital departments and academic units.
7. List the Center's current community outreach programs which focus on the following:
  - a. the general public.
  - b. community organizations.
  - c. pre-hospital personnel.
  - d. medical and nursing personnel.

**XII. PRE-HOSPITAL CARE**

**RELATIVE CRITERIA**

Pre-hospital care is an integral part of an Emergency Center.

Are you a pre-hospital base station?  yes  no

Do you have a pre-hospital care coordinator?  yes  no

Nurse:  yes  no

Physician:  yes  no

Other:  yes  no

Please describe: \_\_\_\_\_

How is pre-hospital care coordinated in your community? Please explain in a short paragraph.

How is medical direction provided to the pre-hospital personnel? Please explain in a short paragraph.

Do you provide training for pre-hospital care personnel?  yes  no

What aspects of pre-hospital care do you audit as part of your quality improvement? Please explain in one page or less with specific examples.

Have you performed any pre-hospital care research in the past 3 years?

yes Please list peer-reviewed publications in past 3 years.

no

**XIII. INFORMATION SYSTEMS**

**RELATIVE CRITERIA**

Being able to immediately obtain patient information is critical to the care of many patients. Emergency Centers should be able to obtain a hospital record within 10 minutes of request or to be able to immediately pull-up the following patient specific information from the hospital computer: problem list, medications, list of clinic dates and hospital admissions with discharge diagnoses, hospital discharge summaries, previous laboratory data, and final reports of radiographic studies. Please explain how patient information is obtained. If medical records are obtained within a median of ten minutes, please include a random audit of the timeliness of 100 consecutive requests for medical records from the Emergency Center.

What aspects of emergency care in your Emergency Center are computerized? Please explain in 1-2 paragraphs.

What are your one year, five year and ten year plans for information systems in your Emergency Center? Please explain in a one page letter cosigned by your hospital's chief information officer.

Do you have internet capability within the Emergency Center?

\_\_\_\_\_ yes      \_\_\_\_\_ no

Do Emergency Center nursing management staff have:

Voice mail:    \_\_\_\_\_ yes      \_\_\_\_\_ no

E-mail        \_\_\_\_\_ yes      \_\_\_\_\_ no

Do Emergency Center physician staff have:

Voice mail:    \_\_\_\_\_ yes      \_\_\_\_\_ no

E-mail        \_\_\_\_\_ yes      \_\_\_\_\_ no

Do Emergency Center administrative, educational and research leadership staff have:

Voice mail:    \_\_\_\_\_ yes      \_\_\_\_\_ no

E-mail        \_\_\_\_\_ yes      \_\_\_\_\_ no

Does the Emergency Center have a web site? If so, please list the address and briefly describe in one paragraph what is listed on the site.

**XIV. DISASTER PLANNING**

Emergency Centers will be well prepared for local disasters.

**A. THE EC MUST BE INTEGRATED AS A KEY ELEMENT IN REGIONAL DISASTER PLANS. RELATIVE CRITERIA**

Describe the EC integration as a key element in regional disaster plans.

Does your hospital have a disaster committee?

yes  no

Does the Emergency Center have a representative on this committee?

yes  no

Please include your hospital's and Emergency Center's disaster policy/plan. The disaster plan must be consistent with JCAHO policy requirements.

Please describe the specific disaster drills the EC has participated in the past 3 years. (Utilize one page or less.)

**B. DEVELOPMENT OF AND COMPLIANCE WITH HAZMAT PROTOCOLS. RELATIVE CRITERIA**

Describe the development of and compliance with HAZMAT protocols.

## **XV. BENCHMARKING**

## **RELATIVE CRITERIA**

### **A. OVERALL PROCESS INDICATORS:**

1. For outpatients, time from arrival to discharge.
2. Time from arrival to admission and subsequent arrival on floor, in unit, or in O.R.
3. Describe any observation units in use in the EC.

### **B. PATIENT SATISFACTION.**

## **RELATIVE CRITERIA**

### **C. PATIENT RATE OF UNSCHEDULED RETURNS TO EC WITHIN 72 HOURS.**

## **RELATIVE CRITERIA**

### **D. TIME FROM ARRIVAL TO TREATMENT: **RELATIVE CRITERIA****

Please select 2 to 3 indicators to demonstrate your current process for timely treatment of the following emergencies:

1. Acute Myocardial Infarction.
  - a. Arrival to ECG time.
  - b. Arrival to Emergency Physician evaluation.
  - c. Arrival to thrombolytic therapy and/or arrival to angioplasty times.
2. Acute Ischemic Stroke.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to head CT result.
  - c. Arrival to head CT review by neuroradiologist.
  - d. Arrival to completion of initial consultation by neurologist.
  - e. Arrival to thrombolytic therapy (if applicable).
3. Multiple Trauma Notification.
  - a. Number of staff routinely involved, describe: nurse, technician, resident physician, attending physician, surgical staff roles and responsibilities.
  - b. Time from arrival to Emergency Physician evaluation.
  - c. Arrival to O.R. in the subset of patients requiring emergency operative intervention.
4. Neurosurgical Operative Emergency.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to completed neurosurgical consultation.
  - c. Arrival to O.R.

**XV. BENCHMARKING**

**D. TIME FROM ARRIVAL TO TREATMENT (CONT'D):**

**RELATIVE CRITERIA**

Please select 2 to 3 indicators to demonstrate your current process for timely treatment of the following emergencies:

5. Septic Shock.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to antibiotic therapy initiation.
  
6. Open Fracture.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to splinting.
  - c. Arrival to completed orthopedic consultation.
  - d. Arrival to O.R.
  
7. Traumatic Spinal Cord Injury.
  - a. Arrival to Emergency Physician evaluation.
  - b. Time to high dose steroid therapy.
  - c. Arrival to completed subspecialty (i.e. orthopedics or neurosurgery) consultation.
  
8. Acute Arterial Occlusion.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to completed vascular surgical consultation.
  - c. Arrival to O.R.
  
9. Cardiac Arrest.
  - a. Number of staff routinely involved, describe: nurse, technician, resident physicians, emergency physicians roles and responsibilities.
  - b. Time to intubation.
  
10. Acute Respiratory Failure.
  - a. Time to intubation.
  - b. Time to Intensive Care Unit.
  
11. Carbon Monoxide Poisoning.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to oxygen therapy.
  - c. Arrival to hyperbaric chamber, for those patients requiring HBO Therapy.
  
12. Bacterial Meningitis.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to antibiotic therapy initiation.

**XV. BENCHMARKING**

**D. TIME FROM ARRIVAL TO TREATMENT (CONT'D):**

**RELATIVE CRITERIA**

Please select 2 to 3 indicators to demonstrate your current process for timely treatment of the following emergencies:

13. Neutropenic Fever.
  - a. Arrival to Emergency Physician evaluation.
  - b. Arrival to antibiotic therapy initiation.

**XVI. HOSPITAL ACCREDITATIONS**

**CRITICAL CRITERIA**

**General: Institutions applying must be JCAHO accredited.**

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**

The mission of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is to improve the quality of care provided to the public through the provision of Healthcare accreditation and related services that support performance improvement in Healthcare organizations.

Please list your most recent JCAHO site survey for the EC:

Date: \_\_\_\_\_

Please provide a copy of the most recent JCAHO letter of accreditation for your EC.