

HENDRICKS REGIONAL HEALTH EMERGENCY MEDICINE RULES AND REGULATIONS

I. Scope of Service

The Emergency Department offers emergency care twenty-four hours a day with at least one physician experienced in emergency care on duty, and specialty consultation is available within approximately sixty minutes. Initial consultation through two-way voice communication is available. The hospital's scope of services includes:

- A. Providing acute care for the critically ill and traumatically injured
- B. Caring for patients with acute and chronic illnesses
- C. Maintaining two way communication with the EMS services
- D. Follow-up care on selected patients
- E. Providing EMS direction
- F. Providing examination rooms for "professional services" (courtesy) patients.

The Emergency Department is classified as a Level II Emergency Department.

II. Physician Coverage - Qualifications

Medical coverage of the Emergency Department shall be available twenty-four (24) hours a day.

Original and additional physicians who provide emergency services at the hospital shall be duly licensed to practice medicine in the State of Indiana, shall be a member of the Medical Staff of the hospital, shall have three (3) years residency training in family practice, emergency medicine, internal medicine, and be board eligible or board certified; shall possess ACLS, ATLS, PALS, and Neonatal Resuscitation certification, unless Board Certified in Emergency Medicine; and shall meet and maintain requirements for active membership in the American College of Emergency Physicians (ACEP) or the American Academy of Emergency Medicine (AAEM). With prior consent of the Hospital, temporary physicians may be utilized to staff the Emergency Department and must be duly licensed to practice medicine in the State of Indiana, must be in at least their second post graduate year of residency, and must be ACLS certified. If the physician is a resident in an accredited Emergency Medicine residency program, they must provide either documentation of ACLS certification or a statement from their residency director certifying that they have demonstrated current clinical competency in ACLS skills.

All Emergency Department physicians shall be credentialed and have privileges delineated upon recommendation of the Medical Executive Committee and approved by the Board of Trustees.

Emergency physicians shall not have admitting privileges and relinquish the medical care responsibility to the attending physician at the time of the patient's admission.

Note: Co-signature of the attending physician is required when collaborative admission orders are written by the Emergency Department physician.

Residents working on a moonlighting basis in the Emergency Department shall not be required to have an Indiana CSR or Federal DEA license. Privileges to write prescriptions for controlled substances shall not be granted without an Indiana Controlled Substance Registration and Federal DEA license issued in the name of the resident physician.

III. Call Coverage

A call list is maintained for consultants and for patients who have the need for continuing physician care on an inpatient basis.

IV. Triage

Patients are evaluated on a first-come, first-served basis and are treated according to the need for emergency services by triage determination. "Patients presenting for emergency services will receive a medical screening exam by a physician or physician assistant in a timely manner."

The Medical Screening Exam (MSE) may be completed by a Sexual Assault Nurse Examiner (SANE) on patients presenting to the Emergency Department with Chief Complaint of sexually assaulted. The SANE nurse will have the emergency department physician immediately evaluate the patient if any injuries noted or for other care outside the scope of practice of the Sexual Assault Nurse Examiner.

V. Standing Protocols

The Emergency Department utilizes standing protocols for most common categories of patients served. These are approved by the Emergency Department Medical Director.

VI. Consultations

The emergency physician shall examine, evaluate, and treat patients, requesting consultations and referring patients at his/her discretion.

VII. Patients Requiring Transfer to Another Facility

A. Patient safety and stabilization is the primary consideration of the Emergency Department. No patient will be transferred to another facility until his medical condition is stabilized to a degree capable at this facility that allows for safety during transport."

B. The attending physician determines the disposition of the patient.

C. It is the policy of the Hendricks Regional Health Emergency Department to complete the "Authorization for Transfer" form on all patients transferred to another acute care facility to provide continuity of care for further medical needs.

Appropriate sections of the Authorization for Transfer form will be completed by the ED physician with the remaining sections completed by the ward clerk with the physician's direction.

Each section will be addressed and completed after the patient is stabilized and before the patient leaves the care of the Hendricks Regional Health Emergency Department.

A copy of this document should accompany the patient to the next facility with the original to be sent with the chart to medical records. Under no circumstances will transfer to another facility involve any consideration of the patient's resources to pay.

VIII. Out of Network, Non-emergent Patients in the Emergency Department

- A. Registration will notify the ED Care Coordinator/ staff when an out of network patient registers.
- B. The Care Coordinator/staff will inform the ED physician of out of network status.
- C. The patient will receive a Medical evaluation, and treatment at their first visit. Prior to discharge, the Care Coordinator or ED staff will inform the patient/patient representative of their out of network status, and will document the notification in the patient's record. The patient will be encouraged to follow-up with their primary care physician.
- D. Should the patient continue to present to the Hendricks Regional Health ED, on each occasion the patient will receive a medical evaluation. When it is determined the patient's condition is non-emergent or life/limb threatening, the Care Coordinator or ED staff will issue a notification of non-coverage letter. A copy of the letter will be given to the patient and the original placed on the patient's record.
- E. The patient will be encouraged to utilize their primary care physician/network for non-emergent care.

IX. Patient Medical Record

- A. A complete record of each visit shall be made by hospital personnel to provide a permanent record containing the history, findings, treatment, and the disposition of each patient. The medical information shall be completed and is the responsibility of the attending physician. Periodic reviews of these records shall be made by the Medical Director of the Emergency Department for purposes of reviewing, planning, and improving the Emergency Department.
- B. If the patient is admitted to the hospital, the ER record becomes a part of the inpatient medical record. If the patient is discharged from the Emergency Department, the record shall be submitted to medical records for final disposition and filing.
- C. Dictation of Major Trauma Care: The Emergency Department physician may dictate a narrative summary for major trauma cases treated in the Emergency Department. When dictated, the narrative summary should provide a description of sequential care rendered.

X. EMS Responsibilities

All emergency medicine physicians share in the responsibility of furthering the development of the EMS providers and assist in training, development of policies and procedures, and evaluation of care through quality assurance.

XI. Response to Code Blue Outside the Emergency Department

The emergency physician will respond to an adult code blue outside the Emergency Department in order to render emergency care only at the request of another physician; the attending physician will be notified in order to evaluate the patient, assume further care, and/or determine the need for a physician consult.

The emergency medicine physicians will respond to pediatric code blue anywhere within the hospital.

In the event the Emergency Department Physician is providing care to a critically injured or ill patient in the emergency department at the time a code blue is called in the hospital; the Emergency Medicine physician's responsibility lies with the emergency department patient. The code blue response team must be notified of unavailability of Emergency Department physician.

XII. Disaster Planning

Emergency physicians participate in development and review of internal and external disaster plans and recommend activation of the plan to hospital administration.

XIII. Role of the Medical Director

The physician director shall assume the following specific duties:

- A. Assist in development of Emergency Department policies and procedures.
- B. Develop, implement, and maintain the medical staff quality assurance program for Emergency Medicine
- C. Investigate and resolve patient complaints regarding medical care rendered in the Emergency Department.
- D. Maintain all accrediting and licensing standards.
- E. Make recommendations concerning reappointment of physicians providing Emergency Services.
- F. Serve on appointed medical staff and hospital committees.
- G. Assist hospital in development of Emergency Department objectives.
- H. Makes recommendations regarding capital equipment purchases for the Emergency Department.
- I. Provides continuing education for physicians, hospital personnel, and EMS providers.
- J. Assist in evaluation of hospital staff providing emergency services.

XIV. Obstetrical Patients

When a maternal patient presents to the Emergency Department with a viable gestation

(Pregnancy ≥ 20 weeks) with complaints of abdominal pain or contractions, the patient will be transferred to the Childbirth Center immediately if the patient's obstetrical physician or certified nurse midwife has contacted the hospital prior to the patient's arrival.

NOTE: In the event the physician or certified nurse midwife has not contacted the hospital, "during the triage process, the patient's obstetrician or certified nurse midwife will be paged. If the practitioner returns the call and requests patient transfer to the Child Birth Center (CBC) before the patient is placed in a room, the patient will be transferred to the CBC for assessment."

If the patient's physician or certified nurse midwife has not contacted the hospital prior to the patient being placed in the examining room, the initial medical screening exam/assessment will be performed by the Emergency Department physician or physician assistant prior to the patient's transfer to the CBC.

A vaginal exam may be performed during the initial assessment by the ED physician, physician assistant, or a registered nurse from the CBC unit to determine the status of the cervix. If the patient with viable gestation is medically unstable for transfer to the CBC unit, fetal heart tones or fetal monitoring will be initiated in the ED until the transfer can occur. In the event the patient cannot be transferred expeditiously and it is determined continuous fetal monitoring is indicated, CBC nurse will stay with the patient. Nursing Administration may be notified for staffing adjustments.

When a maternal patient presents to the Emergency Department with a viable infant, post delivery outside the hospital, both mother and baby will be assessed by the Emergency Department physician prior to transfer to the Childbirth Center with the following exception:

Both maternal patient and infant can be directly admitted to the Childbirth Center if the maternal patient's obstetrician is present in the hospital, not otherwise involved in the care of another patient, and agrees to assume care of the both maternal patient and the infant.

In accordance with the Born Alive Infants Protection Act of 2002 Chapter 1 of title 1, United States Code section 8b, an infant born alive at any stage of development, who after such expulsion or extraction from the mother, breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion is entitled to an emergency medical screening to determine if he or she has an emergency medical condition. As such, a chart should be generated on the infant and appropriate measures taken toward comfort measures or resuscitation as appropriate to gestational age and prospect of viability.

XV. Physician Assistants in the Emergency Department

Physician assistants are permitted to provide services in the Emergency Department under the direct supervision of a board certified attending physician at all times. Physician assistant privileges are limited to the scope of privileges developed by their supervising physician.

The primary function of a Physician Assistant is to collaborate with the supervising physician and other members of the healthcare team to assess the patient's medical,

physical, and psychosocial status and initiate and implement a patient-driven plan of care that meets the patient's identified needs.

Cases are all staffed with the attending physician, but not always seen by that doctor. Patients always have the option of requesting a physician see them primarily or in conjunction with, the physician assistant.

Physician assistants must identify themselves and explain to the patient and patient's family that they are in fact physician assistants working strictly under supervision of a physician and are not independent practitioners. Physician Assistants must wear their nametag at all times identifying them as a Physician Assistant.

In all but minor cases, the emergency physician shall make an effort to see any patient seen by the physician assistant. **The Emergency Medicine physician will assess any patient 3 months of age or younger.** If the patient is to be admitted, the physician staffing the case shall make every effort possible to see the patient prior to the physician assistant calling the attending/admitting doctor. In the event of an ICU admission, the emergency physician shall make the call and discuss the case with the admitting physician. Admitting physicians have at any time the option to speak only to the emergency department physician, rather than the physician assistant. This request can be made at any time, and will, Emergency Department load permitting, be honored.

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