Emergency Medicine Privileges
Department of Emergency Medicine

Name: _____
(Please print)

_____ Initial privileges (initial appointment)
_____ Renewal of privileges *(reappointment, on 2-year specialty cycles)*
_____ Modification of privileges *(request for any additional privileges beyond those previously granted)*

Basic Education: MD or DO

Minimal formal training: Successful completion of an ACGME or AOA accredited residency in emergency medicine, family medicine or internal medicine and current certification or board eligible (with achievement of certification within 5 years of training completion) leading to certification in emergency medicine by the ABEM or the AOBEM.

Maintenance of ACLS, PALS and ATLS (only if applicant is not board certified by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine

Required current experience: Active practice in an ED, reflective of the scope of privileges requested, in the past 12 months with a census equal to or exceeding 3,000 patient visits annually, or successful completion of an ACGME or AOA-accredited residency or clinical fellowship within the past 12 months.

Facility (Check ALL that are applicable to your request)				
Baroness*	Children's**	North	East	Bledsoe/Sequatchie

** Includes BEH Main Hospital, Miller Eye Center, Plaza Surgery and all Erlanger Ambulatory Clinics*
***Includes Children's Hospital Inpatient, Children's Ambulatory clinics, Children's OR and Kennedy Children's Outpatient Center*

Core Emergency Medicine Privileges:

Core privileges for emergency medicine include the ability assess, evaluate, diagnose, and initially treat patients of all ages who present in the ED with any symptom, illness, injury, or condition. They also include the ability to provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness and injury. Privileges include the performance of history and physical examinations, the ordering and interpretation of diagnostic studies, including laboratory, diagnostic imaging, and electrocardiographic examinations, and the administration of medications normally considered part of the practice of emergency medicine. Privileges do not include admitting privileges, long-term care of patients on an inpatient basis, or the performance of scheduled

elective procedures.

The core privileges in this specialty include the procedures on the following procedures list and such other procedures that are extensions of the same techniques and skills.

The following list is not intended to be an all-encompassing procedures list. It defines the types of activities/ procedures/privileges that the majority of practitioners in this specialty perform and inherent activities/ procedures/privileges requiring similar skill sets and techniques.

Airway techniques

- Airway adjuncts
- Capnometry
- Cricothyrotomy
- Foreign body removal
- Intubation
- Mechanical ventilation
- Noninvasive ventilatory management
- Percutaneous transtracheal ventilation

Anesthesia

- Local
- Regional nerve block
- Sedation—analgesia for procedures (in accordance with hospital policy)

Diagnostic procedures

- Anoscopy
- Arthrocentesis
- Blood, fluid, and competent therapy administration
- Compartment pressure measurement
- Cystourethrogram
- Lumbar puncture
- Nasogastric tube
- Paracentesis
- Pericardiocentesis
- Peritoneal lavage
- Slit lamp examination
- Thoracentesis

Tonometry

Genital/urinary

Bladder catheterization (Foley catheter, suprapubic)

Testicular detorsion

Head and neck

Control of epistaxis

Drainage of peritonsillar abscess

Laryngoscopy

Lateral canthotomy

Removal of rust ring

Tooth stabilization

Hemodynamic techniques

Arterial catheter insertion

Central venous access

Intraosseous infusion

Peripheral venous cut-down

Obstetrics

Delivery of newborn

Resuscitation

Cardiopulmonary resuscitation

Neonatal resuscitation

Skeletal procedures

Fracture/dislocation immobilization techniques

Fracture/dislocation reduction techniques

Spine immobilization techniques

Thoracic

Cardiac pacing (cutaneous, transvenous)

Defibrillation/cardioversion

Thoracotomy

Universal precautions

Biohazard decontamination

Other techniques:

Dental reduction

Escharotomy/burn management

Excision of thrombosed hemorrhoids

Foreign body removal

Gastric lavage

Gastrostomy tube replacement

Incision/drainage

Intracardiac injection

Ocular pH determination

Ocular tonometry

Pain management

Perichondral hematoma incision and drainage

Puncture cannulation, artery and vein

Sexual assault examination

Spine immobilization

Thoracostomy tube insertion

Tracheostomy

Trephination nails

Trephination skull

Violent patient management/restraint

Wound closure techniques

Wound management

Special Non-Core Privileges in Emergency Medicine:

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include point of care ultrasound and toxicology.

Procedure	*Baroness*	*Children's*	*North*	*East*	*Bledsoe/Sequatchie*
Point of care ultrasound					
Toxicology					

Administration of Moderate sedation and analgesia (see below for criteria 5 per year required)					
Deep Sedation (see below for criteria – 10 per year required)					

Request for Privilege Not Listed in Core or Special Non-Core *(please list the privilege and provide justification as well as any accompanying certifications or case logs)*

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_____

Special Procedures Privileges Criteria
Moderate Sedation
CRITERIA – To administer Moderate Sedation
Moderate Sedation (formerly Conscious sedation) is defined as: A medically controlled state of depressed consciousness that (1) allows protective reflexes to be maintained; (2) retains the patient's ability to maintain an airway independently and continuously; and (3) permits age-appropriate response by the patient to physical stimulation or verbal command, e.g. “open your eyes”).

1. Basic education: MD, DO, DDS, or DMD
2. Successful completion of a post-graduate residency training program of at least three years’ duration.
3. Trained in the professional standards and techniques to administer pharmacologic agents to predictably achieve either minimal or moderate sedation and monitor patients carefully in order to maintain them at either of these levels of sedation-either intentionally or unintentionally. Acceptable training may be the completion of a course offered by any local hospital or the local Medical Society. Documentation of completion is required.
4. Must be able to evaluate and document evaluation of the patient prior to performing minimal or moderate sedation.
5. Must be qualified to rescue patients from *deep* sedation and trained to manage a compromised airway and to provide adequate oxygenation and ventilation.
6. Current proof of ACLS and/or PALS unless ABEM or AOBEM certified/eligible
7. Able to demonstrate that he/she has administered minimal or moderate sedation or analgesia to at a minimum of five (5) patients during the past 12 months.

Deep Sedation
CRITERIA – To administer deep sedation
Deep Sedation is defined as: A medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by partial or complete loss of protective reflexes, and by the inability to maintain a patient airway independently and respond to physical stimulation or verbal command. Agents considered deep sedatives when used in any dose include, but are not limited to, Propofol, Etomidate, and Ketamine as well as sufficient doses of other analgesics such that the patient achieves the clinical state outlined in the deep sedation definition above. Use of these medications in life-threatening situations or for rapid sequence intubation (RSI) is considered an exception to this definition and is not considered use of deep sedation.)

1. Basic Education: MD, DO, DDS, or DMD and completion of residency/fellowship in at least one of the following:
    a. Anesthesiology, Emergency Medicine, Medical Critical Care, Surgical Critical Care, Pediatric Critical Care
2. Be a credentialed practitioner to order and/or select the medication(s) to achieve Deep Sedation.
    a. Must be credentialed to provide Moderate Sedation, Deep Sedation, and to perform intubation
3. Be familiar with proper dosages, administration, adverse reactions, and interventions for adverse reactions and overdoses. Know how to recognize airway obstruction and demonstrate skill in airway management resuscitation.
4. Have ACLS and/or PALS Certification unless board certified in Anesthesiology, Emergency Medicine, Medical Critical Care, Surgical Critical Care, or Pediatric Critical Care.
5. Agents likely to produce deep sedation must be administered only by a qualified credentialed physician.
    a. This credentialed physician must be specifically and solely focused on the administration of the medication and monitoring of the patient's response to the medication.
        i. Exception 1: It is recognized that the Emergency Department is a unique environment where patients present on an unscheduled basis with problems that often require urgent or emergent interventions to prevent morbidity and mortality.
        ii. The supervising Emergency Medicine physician may be the same physician that is performing the procedure ONLY when a delay may increase morbidity and mortality, provided that the procedure may be abandoned without compromise to patient safety and there is not a second physician available to provide deep sedation.
        iii. If the patient has a secured airway (well positioned endotracheal or tracheostomy tube), deep sedation

medications can be given for the purposes of performing a procedure by a CCRN (provided a second RN is present to record vital signs and record assessments). In this case a single credentialed physician may perform the procedure.

6. Pre-Procedure Assessment Responsibilities of the Physician
    a. Obtain baseline history. Assess the airway including mouth and neck and note ASA status. An airway assessment and ASA classification must be present prior to the administration of sedation. Obtain and document appropriate informed consent. Address NPO status.
    b. The patient will be reassessed by the physician performing the sedation immediately prior to the procedure, and the reassessment will be documented in the record.
7. Intra-Procedure Monitoring • Qualified personnel will be present in the room throughout the conduction of all cases requiring deep sedation.
    a. The minimum number of personnel available for all cases requiring deep sedation shall be two: (1) the operator (physician) and (2) the qualified personnel administering and monitoring sedation unless one of the exception rules is met as outlined above.
    b. Please see the full policy for details of required documentation for the sedation procedure
8. Post-Procedure Assessment Responsibilities of the Physician for Deep Sedation, the physician who administered the sedation and analgesia will perform and document a post-procedure evaluation no later than 48 hours following the deep sedation procedure but no earlier than the time from which the patient is considered sufficiently recovered from the sedation so as to participate in the evaluation (e.g. answer questions appropriately, perform simple tasks).
    a. The elements of an adequate post anesthesia evaluation should be clearly documented and include the following: Respiratory function including respiratory rate, airway patency, and oxygen saturation; Cardiovascular function including pulse rate and blood pressure; Mental status; Temperature; Pain; Nausea and vomiting; Post procedure hydration.

NOTE: Deep Sedation is limited to Anesthesia/CRNAs, Critical Care, and Emergency Medicine and full Anesthesia is limited to Anesthesiologists and CRNAs and is outlined in their delineation of privileges.

Department Chief Recommendation:

I have reviewed the requested clinical privileges and supportive documentation for the above-named applicant.

_____ Recommended as Requested

_____ Recommended with Modifications (See comments below)

_____ Not Recommended (See comments below)

Chief Comments: _____

_____

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_____

_____ _____
Provider Signature Date

_____ _____
Chief Signature Date

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