

EMERGENCY MEDICAL SERVICES: RECOMMENDED HOSPITAL AND PHYSICIAN REQUIREMENTS

BACKGROUND

Most acute care hospitals in the province of Manitoba offer the public emergency medical services, however, the actual level of service varies widely from institution to institution.

Most urban community hospitals now enjoy the services of Emergency Medical Physicians/Officers (EMOs) with a level of qualification which meets the requirements of the known scope of care offered in that particular institution. In rural Manitoba, the scope of available services varies widely, from hospitals staffed by full time EMOs in regional centres to hospitals with a wide variation in patient volumes staffed by community primary care practitioners on call.

It is imperative for each Regional Health Authority or independent hospital to assess the individual capacity of each facility to deliver emergency medical services to the community. This assessment must take into consideration the treatment/diagnostic resources of the hospital, availability of medical and nursing personnel, geographical location including the facility's proximity to another centre and adequacy of support services such as ambulance, including the level of training of ambulance attendants and other support services.

CATEGORIES OF EMERGENCY UNITS

The following table outlines the four categories of Active Emergency Units:

Type of Emergency Unit	Location	Physician Coverage	Capabilities
Comprehensive	<ul style="list-style-type: none"> · tertiary care setting · pt. volume generally >40,000/yr. 	<ul style="list-style-type: none"> · 24 hr. in-unit emergency physician · 24 hr. in-house availability of critical care specialty services 	
Major	<ul style="list-style-type: none"> · urban/suburban setting · pt. volume generally 25,000-40,000/yr. 	<ul style="list-style-type: none"> · 24 hr. in-unit emergency physician · availability of other critical care specialty services (not necessarily in-house) 	<ul style="list-style-type: none"> · availability of many secondary specialty services
General	<ul style="list-style-type: none"> · suburban/rural setting · pt. volume generally 10,000-25,000/yr. 	<ul style="list-style-type: none"> · 24 hr. in-house physician (not necessarily an in-unit emergency physician) · critical care specialty services may not be available 	<ul style="list-style-type: none"> · to resuscitate, stabilize and, when necessary, transfer recognizing most of these hospitals will have some secondary care available
Basic	<ul style="list-style-type: none"> · smaller, rural setting · pt. volume generally <10,000/yr. 	<ul style="list-style-type: none"> · 24 hr. emergency physician availability (not necessarily in-house) · critical care specialty services not available 	<ul style="list-style-type: none"> · to resuscitate, stabilize and facilitate transfer

FACILITY RECOMMENDATIONS

- *For each hospital, the scope of practice should be defined to ensure that its capability is understood by the local population.*
 - The level of service offered should be consistent, however, where major variability in the level of service occurs, the lowest, continuously available level of care should be that which is made known to the community.
 - As a bare minimum, if an emergency department is operating on an unrestricted access basis, it should offer medically supervised assessment, stabilization, and transfer capabilities on a 24 hour basis.
 - The emergency department and physician staff should be capable of providing both adult and paediatric cardiac resuscitation.
 - If emergency service is not available on a 24 hour basis, then the public should be notified of where such care may be obtained.

- *For each hospital, adequate resources, including support staff necessary, should be provided to maintain the defined scope.*
 - For each level of service, it is expected that the responsible health authority will ensure that only appropriately trained nursing staff are assigned to emergency duties. Even for basic facilities, it is recommended that such nurses have at least Advanced Cardiac Life Support (ACLS) training, and training and experience in the principles and practice of patient triage.
 - For minimally staffed facilities, a formal system of callback should be in place to ensure that the facility can cope with any unexpected multiple emergencies that may arise so that the level of emergent care is not unduly compromised.
 - For each facility, the responsible health authority should ensure that appropriate diagnostic support services are provided which is in keeping with the expected level of services offered. Even for basic level facilities, it is expected that appropriate diagnostic services will be provided by suitably qualified personnel who are available to the facility within 30 minutes of being called.

- *For each hospital, the most appropriate way of accessing a higher level of care for a patient who cannot be cared for comprehensively in the first emergency department should be determined.*
 - This may entail a multiplicity of arrangements involving land and air transportation.
 - Protocols should be established to allow for physician accompaniment for severely ill patients while maintaining Emergency Room coverage.

- *For each hospital, the establishment of appropriate communication and information resources should be ensured. These should include, but are not limited to:*
 - policies and procedures detailing all aspects of emergency services, including limitations on care which are current and reviewed on a regular basis;
 - appropriate use of pagers, cell phones and other electronic means to contact key personnel including physician(s) on call;
 - available fax machines to transmit important data including EKGs to outside consultants as necessary;
 - direct access to the Manitoba Health Information Network (HIN) when available;
 - suitable and current medical references on emergency care for medical and nursing staff.

MINIMAL EMERGENCY PHYSICIAN REQUIREMENTS

The following are recommendations for physicians who are responsible for acute medical care in any emergency department.

- *The emergency medical services in a hospital should be under the direction of a specific physician, or Medical Director.*
 - In smaller hospitals, the Chief of Staff would be the appropriate individual.
- *Each physician who participates in the emergency department should have, in the reappointment process, a specific clause which states he/she will be participating in emergency coverage and has ongoing competence and experience in the scope of practice expected.*
- *A minimal requirement for working in any emergency unit should be Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS). Paediatric Advanced Life Support (PALS) recommended.*
 - In community or larger hospitals, the medical staff should have acceptable training and/or experience in Emergency Medicine. In addition, they should provide evidence of ongoing continuing medical education in Emergency Medicine.
- *ACLS and ATLS should be required for EMOs appointed for the sole specific purpose of full time or regular practice specific to the emergency department. Paediatric Advanced Life Support (PALS) is recommended; and in hospitals providing obstetrical services where the EMO is responsible for responding to obstetrical or neonatal emergencies, the Neonatal Resuscitation Program (NRP or NALS) is also recommended. Other procedures which will be performed on a regular basis should have a specific privileging process in that area. (Schedule D Advanced Emergency Medical Care which should be used only for EMOs hired for full time or for regular practice specific to the Emergency Room.)*
- *Family physicians providing emergency medical services on a rota basis must be qualified to:*
 - Provide treatment to a defined level to all patients who present to the emergency department, including airway and cardiac stabilization of the acutely injured.
 - Determine the type of transportation and appropriate escort level needed from the initial emergency care setting to an institution where more definitive treatment will be administered. (See College Guideline No. 143 "Interfacility Emergency Transportation")
 - Evaluate the patient's health care needs and organize appropriate services in concordance with those needs.
 - Appropriately refer to other physicians, as required.

REFERENCES

1. "Emergency Units in Hospitals", 1988, Health Services Directorate, Health Services and Promotion Branch.
2. The College of Physicians and Surgeons of Manitoba Guideline, No. 143, "Interfacility Emergency Transportation", STNDS/01-95, 1-G73.

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A guideline is practice generally recommended.