EMERGENCY MEDICINE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states policy for Department of Veterans Affairs (VA) medical facility Emergency Departments (ED).

2. SUMMARY OF MAJOR CHANGES: This VHA directive rescinds and replaces VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016.

a. Policy governing VHA Urgent Care locations is now separate from ED policy. Urgent Care offers acute unscheduled care for illnesses and injuries that are significant but not life threatening. Refer to VHA Directive 1101.13, VHA Urgent Care, dated March 20, 2023, for more information.

b. Major changes to ED requirements include:

(1) Removes physician credentialing and privileging details and residency supervision requirements which are provided in other VHA policies, and consolidates staffing criteria in new Appendix A. For staffing and supervision requirements, see VA Directive 5007, Pay Administration, dated April 15, 2002; VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019; and VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

(2) Updates definitions and terminology in paragraph 3.

(3) Adds a requirement for VA medical facilities with EDs to have a Provider Staffing Contingency written plan or Standard Operating Procedure (SOP) (see paragraph 6.c.(3)) and procedures or SOP for Managing High Risk Mental Health Presentations (for further details, see paragraph 13.g.).

(4) Removes requirements for VA medical facilities with EDs to have local policies on care for Observation patients, patient transfers, Acute Ischemic Stroke care and out-of-operating-room airway management because these areas are addressed in other VHA national policies noted in this directive. In some cases, written plans are still necessary, as noted in this directive.

(5) Removes requirements for VA medical facilities with EDs to have local policies on diversion, placement of overflow patients in temporary bed locations, access to support services, coordination of elective and surgical patients, and minimum staffing requirements for EDs to allow for flexibility in local implementation. In some cases, written plans are still necessary, as noted in this directive.

(6) Relocates information in the appendices to the Emergency Medicine SharePoint, including recommended medical, pharmacy and laboratory equipment supplies for the ED; Emergency Medicine Field Advisory Board information; guidance for care of pregnant patients; and Emergency Medicine Improvement Initiative information.

3. RELATED ISSUES: VHA Directive 1094, Inter-Facility Transfer, dated January 11, 2017.

4. RESPONSIBLE OFFICE: The Specialty Care Services Program Office (11SPEC) is responsible for the content of this directive. Questions may be referred to the VHA Emergency Medicine Program at vhaemx@va.gov.

5. RESCISSIONS: VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016; and VHA Memorandum 2020-09-10, OIG-CHIP Recommendations for Emergency Departments and Urgent Care Centers, dated September 8, 2020, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of March 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Erica Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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EMERGENCY MEDICINE

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1. PURPOSE

This Veterans Health Administration (VHA) directive states the requirements for the provision of emergency care in Department of Veterans Affairs (VA) medical facilities. **AUTHORITY:** 38 U.S.C. 1710, 1784A and 7301(b).

2. BACKGROUND

a. VHA is committed to providing timely and high-quality emergency medical treatment for Veterans enrolled in VA's health care system pursuant to VA's general treatment authority, 38 U.S.C. § 1710, as implemented by 38 C.F.R. § 17.38 (VA's medical benefits package). Copayments may apply to receipt of VA ED care, depending on the Veteran's enrollment status.

b. VA is also authorized by 38 U.S.C. § 1784 (known as "Humanitarian Care") to provide hospital care and medical services in emergency cases, provided VHA charges the individual for receipt of such care and services. See VHA Directive 0320, VHA Comprehensive Emergency Management Program, dated July 6, 2020. See 38 C.F.R. § 17.102(b) for a description of the charges to be billed.

c. 38 U.S.C. § 1784A requires VA to provide an appropriate medical screening examination (MSE), within the capability of the ED, including ancillary services routinely available to the ED, to an individual who comes to a VA hospital or the campus of a VA hospital that has an Emergency Department (ED) and who requests, or on whose behalf a request is made for, an examination or treatment of a medical condition. The MSE is to determine whether or not an emergency medical condition exists. If one does, VA is then required to provide, within the staff and facilities available at the hospital, stabilizing treatment or, if applicable, a safe and appropriate transfer (to another hospital where the individual can obtain needed stabilizing treatment not available at the VA ED). See VHA Directive 1094, Inter-Facility Transfer, dated January 11, 2017, and transfer requirements under 38 U.S.C. 1784A. Assuming the individual is not otherwise eligible for VA health benefits, VA must charge for any emergency care or services provided under this authority.

d. The provision of emergency care includes planning for the management of patients whose care needs may exceed VA medical facility capabilities, such as but not limited to, acute myocardial infarction needing emergent cardiac catheterization, major trauma, obstetric and gynecologic emergencies, pediatric emergencies or surgical subspecialty care.

e. The VA Emergency Medicine Improvement (EMI) Initiative is intended to provide a structured method for monitoring, communicating and managing the operational efficiency, quality and safety of care delivered by VA EDs. ***NOTE:*** *For more information on the EMI, visit the EM SharePoint: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%2*

0Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. This is an internal VA website that is not available to the public.

3. DEFINITIONS

a. **Boarding.** Boarding is defined by The Joint Commission as the practice of holding patients in the ED or another temporary location under the control of the ED after a decision to admit or transfer to a ward or unit in that same hospital has been made. ***NOTE:*** *The care of the boarding patient is accommodated in the temporary ED location until an appropriate bed for their intended level of inpatient care is available. Refer to current Joint Commission standards regarding patient flow and boarding timeframes in EDs, available at https://www.jointcommission.org/standards/r3-report/r3-report-issue-4-patient-flow-through-the-emergency-department/. For further details regarding boarding, see paragraph 9.h.*

b. **Direct Line-of-Sight Observation.** Direct line-of-sight observation is the continuous observation by staff of a patient in a mental health intervention room, in lieu of one-to-one observation due to the safety features of mental health intervention rooms. See paragraph 13.g.(1) for more information.

c. **Diversion.** Diversion is a situation in which an individual who is being transferred to the ED from an off-campus location cannot be accepted for evaluation because the appropriate beds are not available, needed services cannot be provided, acceptance of another patient would jeopardize the ability to properly care for those already at the VA medical facility, or disaster has disrupted normal operations.

d. **Emergency Department.** An ED is a unit in a VA medical facility whose primary function is to provide resuscitative therapy and stabilization in life-threatening situations. Additionally, it is available to provide acute, unscheduled care in non-emergent situations. ***NOTE:*** *The ED is staffed and equipped to provide initial evaluation, treatment and disposition for a broad spectrum of illnesses, injuries and mental health disorders, regardless of the level of severity. Emergency care is provided in a clearly defined area dedicated to this function and operates 24 hours a day, 7 days a week. ED staff members are trained and equipped to receive, stabilize and treat patients who arrive via Emergency Medical Services (EMS).*

e. **Emergency Department Observation.** ED observation is a status that ED providers assign to patients receiving extended evaluation and care prior to disposition. ***NOTE:*** *As required by the American College of Emergency Physicians (ACEP), these patients have clinical needs that exceed what can realistically be achieved within 6 hours of an ED visit, but if managed actively will require less than 24 hours of hospitalization. ED observation is designated as non-count beds, and the treating specialty is 1J, Emergency Department observation. Charging and billing for ED observation under the EM Service requires specific documentation and coding outside of the initial ED encounter*. For more information, see VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020.

f. **Emergency Department Provider.** For purposes of this directive, VA ED providers are appropriately credentialed and privileged physicians, physician assistants (PAs) and nurse practitioners (NPs) who provide patient care in VA EDs. See paragraph 6.

g. **Encounter.** An encounter is a professional contact between a patient and a VA provider vested with responsibility for diagnosing, evaluating and treating the patient's condition. ***NOTE:*** *See VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022, for further information.*

h. **Medical Screening Examination.** An MSE is an evaluation performed and documented by a VA physician, NP or PA in a VA ED to determine whether or not an emergency medical condition exists.

i. **Mental Health Intervention Room.** A mental health intervention room is a room where patients who may be at high risk for harm to self or others may be taken immediately on arrival. The purpose of this room is to provide an environment suitable for the rapid medical and mental health evaluation of dangerously unstable situations and the capacity to safely manage and treat the patient. When possible, it should be away from the waiting area and near the nursing station. The mental health intervention room should meet the standards outlined in the Mental Health Environment of Care Checklist (MHEOCC) found at: http://vaww.ncps.med.va.gov/guidelines.html#mhc. ***NOTE:*** *This is an internal VA website that is not available to the public.* To request a copy of the MHEOCC, email the National Center for Patient Safety at ncps@va.gov with subject: MHEOCC Request. For further details regarding provision of mental health services in EDs, see paragraph 13.

j. **One-to-One Observation.** One-to-one observation is the constant monitoring of one patient by one staff member who will not have other responsibilities to ensure the patient is provided constant observation and never left unattended. See paragraph 13.g.(2).

k. **Safety Planning in the Emergency Department.** Safety Planning in the ED (SPED) is an evidence-based intervention for individuals who present to the ED and are identified to be at elevated risk for suicide. This intervention includes safety planning and follow up contact. See paragraphs 5.m. and 13.b. for details.

4. POLICY

It is VHA policy to provide appropriate medical care to all individuals who present to VA EDs for evaluation or treatment of a medical condition.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for supporting the VHA Emergency Medicine Program Office with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **National Program Director, VHA Emergency Medicine.** The National Program Director, VHA Emergency Medicine is responsible for:

(1) Providing national leadership, advice and consultation to all VA EM Services and programs and working with each VISN Director and VISN Chief Medical Officer (CMO) to identify a VISN EM Consultant.

(2) Collaborating with VISN and VA medical facility executive leadership to ensure that high-quality emergency care is made available, immediately accessible by and efficiently provided to all patients presenting to VA medical facility EDs as clinically appropriate.

(3) Acting as the principal advisor to the Under Secretary for Health on EM policies and procedures.

(4) Collaborating with professional organizations and provider groups in affiliated institutions, and with other public and private organizations concerned with the delivery of EM in VA.

(5) Leading the development of clinical practice guidelines, protocols and best practices to be used in the analysis and management of EM Services and programs.

(6) Developing enterprise-wide planning guidelines to support planning strategies for VA medical facility EDs and contributing to VHA strategic-operational planning processes consistent with VHA Directive 1075, Strategic-Operational Planning Process, dated July 27, 2020.

(7) Writing all VHA directives and notices related to EM consistent with VHA Directive 0999, VHA Policy Management, dated March 29, 2022.

(8) Consulting on clinical restructuring requests or other proposed changes in EM Services from VA medical facilities.

(9) Approving or denying waivers submitted by the VA medical facility Director or VISN Director, in accordance with VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023.

(10) In coordination with the Medical Sharing/Affiliate Office, providing clinical review of all contracts for EM clinical services.

e. **Veterans Integrated Services Network Director.** The VISN Director or designee appointed by the VISN Director (e.g., the VISN CMO) is responsible for:

(1) Ensuring that all EDs within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Ensuring that the VISN EM Consultant has at least 10% dedicated administrative time to accomplish their responsibilities.

(3) Reviewing ED data regarding operational vulnerability and data reliability for VA medical facilities within their purview. ***NOTE:*** *See the Emergency Medicine Management Tool User Manual at https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FResource%20Library%2FEmergency%20Medicine%20Management%20Tool%20%28EMMT%29 for more information regarding operational vulnerability metrics. This is an internal VA website that is not available to the public.*

(4) Collaborating with the National Program Director, VHA Emergency Medicine on selecting and appointing a VISN EM Consultant.

(5) Ensuring compliance with VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016, by reviewing and evaluating clinical restructuring proposals and submitting each approved proposal with the associated Business Plan accordingly. ***NOTE:*** *Clinical restructuring proposals should be developed in consultation with the VISN EM Consultant.*

(6) Submitting waiver requests to the National Program Director, VHA Emergency Medicine on behalf of the VISN or, by request, on behalf of a VA medical facility within the VISN, in accordance with VHA Notice 2023-02. The VISN Director must notify the individuals specified in VHA Notice 2023-02 using the waiver request template located at: https://dvagov.sharepoint.com/sites/VACOVHACBI/CBI%20Front%20Door/SitePages/Waivers-to-VHA-National-Policy.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

f. **Veterans Integrated Services Network Emergency Medicine Consultant.** The VISN EM Consultant serves as the Point of Contact (POC) for issues pertaining to EM

in the VISN. This individual must be clinically active in EM or UC medicine. This includes:

(1) Providing leadership, expertise and guidance to EDs at VA medical facilities in the VISN.

(2) Supporting EM research and educational activities.

(3) Consulting on the following, when requested: evaluation and facilitation of quality improvement processes within VA medical facility EDs within the VISN; development and implementation of strategic plans for EM Services within the VISN, including virtual EM Services; and oversight of clinical outcomes, standards of care and best practices for EM at VA medical facilities within the VISN, with the ability to immediately evaluate critical events.

(4) Disseminating information from the VHA Emergency Medicine Program Office to each of the VA medical facilities within the VISN.

(5) Promoting communication between VA medical facilities within the VISN.

(6) Notifying the National Program Director, VHA Emergency Medicine when a new VA medical facility EM Chief is selected.

(7) Serving as an advisor to the VA medical facility Chief of Staff (COS) and EM Chief if questions arise regarding scheduling ED provider shifts greater than 12 hours of clinical time, in accordance with paragraph 6.c.

(8) Working with VA medical facility executive leadership to develop clinical restructuring proposals and initiate waiver applications.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring overall VA medical facility compliance with this directive.

(2) Working with the VA medical facility COS to determine placement of the EM Service within the organizational framework of the VA medical facility that provides processes for quality and safety oversight and reporting to VA medical facility executive leadership. See paragraph 8.a for more information.

(3) Ensuring that the EM Service meets the requirements of this directive.

(4) Developing a local written plan or guidance for diversion (see paragraph 9.k.)

(5) Ensuring that the VA medical facility COS notifies the VISN EM Consultant when a new VA medical facility EM Chief is selected.

(6) Submitting clinical restructuring proposals to the VISN Director.

(7) In conjunction with the VISN EM Consultant, submitting waiver requests to the National Program Director, VHA Emergency Medicine (either directly or through the VISN Director) in accordance with VHA Notice 2023-02. The VA medical facility Director must notify the individuals specified in VHA Notice 2023-02 using the waiver request template located at: https://dvagov.sharepoint.com/sites/VACOVHACBI/CBI%20Front%20Door/SitePages/Waivers-to-VHA-National-Policy.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public. Initiating a waiver may require a clinical restructuring proposal.*

h. **VA Medical Facility Chief of Staff.** The VA medical facility COS is responsible for:

(1) Working with the VA medical facility Director to determine the structure of the EM Service within the organizational framework of the VA medical facility. See paragraph 8.a. for more information.

(2) Determining the final clinical disposition of a patient in instances where responsible ED providers and inpatient providers cannot agree, if necessary. See paragraph 9.g.

(3) Appointing the VA medical facility EM Chief and notifying the VISN EM Consultant of the selection.

(4) Recognizing the VA medical facility EM Chief as a voting member of the hospital Executive Committee of the Medical Staff (ECMS) or equivalent committee as approved through the VA medical facility's medical staff bylaws.

(5) Ensuring that the ED has access to consult services in accordance with paragraph 9.f.

(6) Approving routinely scheduled ED provider shifts greater than 12 hours of clinical time, in accordance with paragraph 6.c.

(7) Working with the VA medical facility EM Chief to develop a Provider Staffing Contingency Plan Standard Operating Procedure (SOP) or other written plan to ensure adequate ED provider coverage 24 hours a day, 7 days week. See paragraph 6.c.(3).

(8) Working with the VA medical facility EM Nurse Manager, Associate Director for Patient Care Services (ADPCS) and EM Chief to create a written surge plan.

(9) Working with the VA medical facility ADPCS to develop written processes for boarding of patients in the ED or area under the control of the ED while awaiting admission or transfer and evaluate the delivery of emergency care services as appropriate. ***NOTE:*** *For further details regarding boarding, see paragraph 9.h.*

(10) Ensuring that all ED staff receive ongoing education and training and that ED provider competencies are up to date to ensure the full range of health care services, including mental health services, are provided at all times either on-site or on-call.

(11) Working with the VA medical facility Director to develop waiver requests in accordance with VHA Notice 2023-02.

(12) Conducting an evaluation, as needed, when emergency physicians (EPs) are repeatedly asked to respond to emergencies that arise outside of the ED. See paragraph 6.c.(2). ***NOTE:*** *The VA medical facility COS may appoint a designee to perform this investigation.*

(13) Working with the VA medical facility Director to support implementation of the SPED intervention by identifying a Facility Champion and ensuring the VA medical facility has an SOP for SPED management that aligns with ED SOPs. ***NOTE:*** *The VA medical facility may create a separate SOP or include content within an existing SOP.*

i. **VA Medical Facility Associate Director for Patient Care Services/Nurse Executive.** The ADPCS/Nurse Executive (referred to as ADPCS) is responsible for:

(1) Appointing a qualified VA medical facility EM Nurse Manager.

(2) Working with the VA medical facility EM Nurse Manager, COS and EM Chief to create a written surge plan.

(3) Working with the VA medical facility COS to develop written processes that address boarding of patients in the ED (see paragraph 9.h.) and evaluate the delivery of emergency care services as appropriate.

(4) Working with the VA medical facility Director to develop waiver requests in accordance with VHA Notice 2023-02.

(5) Working with the VA medical facility EM Nurse Manager to ensure that nursing competency is maintained, develop nursing staffing contingency plans and ensure adequate nursing coverage 24 hours a day, 7 days week. ***NOTE:*** *Nursing staffing contingency plans may be incorporated into the ED provider staffing contingency plan. See paragraph 6.b.*

j. **VA Medical Facility Emergency Medicine Service or Section Chief.** The VA medical facility EM Service or Section Chief, referred to as the EM Chief, is responsible for:

(1) Ensuring that VA medical facility EM staff are appropriately credentialed and privileged as outlined in VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021, and VHA Directive 1100.21, Privileging, dated March 2, 2023.

(2) Working collaboratively with the EM Nurse Manager to establish guidelines, policies and procedures relevant to ED operations, as needed, including sexual assault procedures described in paragraph 20.a. ***NOTE:*** *Standardized local document templates are located at* *https://dvagov.sharepoint.com/sites/VACOVHACOS/10B4/PIRP/10B4/SitePages/Docu*

ment%20Templates.aspx. This is an internal VA website that is not available to the public.

(3) Ensuring all relevant staff receive appropriate training on the correct use of the Emergency Department Integration Software (EDIS) package or electronic health record (EHR) tracking system, in coordination with the EM Nurse Manager. (See paragraphs 9.c. and 21.)

(4) Providing opportunities for health professions education; establishing clinical rotations in EDs, as needed, through collaboration with the VA medical facility Designated Education Officer, appropriate affiliate program directors and VA Residency Site Directors. ***NOTE:*** *In VA medical facilities with academic activities, the EM Chief should provide academic and research opportunities to EPs qualified to teach and participate in other academic activities.*

(5) Developing schedules that optimize ED provider presence during high volume times and effectively managing patient flow to identify and reduce operational risk and ensure high quality care. Participating in the VA medical facility's emergency preparedness planning.

(6) Collaborating with local EMS officials in conjunction with the VA medical facility EM Nurse Manager while participating in the community's emergency resources continuum. This includes a discussion with local and regional EMS leaders about the capabilities of the VA medical facilities in the service area and arrangements for emergency transportation services when needed.

(7) Representing or appointing a representative to serve as the VA medical facility liaison on the regional and local community EMS committees whenever possible, including participating in emergency preparedness activities.

(8) Collaborating with clinical pharmacy services to evaluate and determine medication needs and appropriate storage options for medications within the ED. ***NOTE:*** *For further information, see Appendix B and VHA Directive 1108.07, General Pharmacy Service Requirements, dated November 28, 2022*.

(9) Reviewing cases of delay of care (post-stabilization) resulting in potential patient harm due to boarding while awaiting transfer out of the ED and admission to hospital, pending receipt of ancillary services such as radiology, laboratory and pharmacy or awaiting consultation with VA medical facility executive leadership.

(10) Serving on or appointing a designee to serve on the VA medical facility Peer Review Committee when appropriate to assess EM practice and standards of care. ***NOTE:*** *For further information on the peer review process see VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018.*

(11) Serving as a voting member of the hospital ECMS or equivalent committee as approved through the VA medical facility's medical staff bylaws.

(12) Creating a Provider Staffing Contingency Plan SOP or other written plan, in conjunction with the VA medical facility COS, to ensure adequate ED provider coverage. See paragraph 6.c.(3).

(13) Creating a written surge plan to address situations in which patient demand exceeds ED capacity, in conjunction with the VA medical facility EM Nurse Manager, ADPCS and COS. ***NOTE:*** *This plan must be easily available to all ED staff and address situations where ED provider resources must be quickly mobilized. These plans must authorize ED nursing personnel to contact the EM Chief, or designee appointed by the EM Chief, for implementation of the plan when ED provider staffing is deemed insufficient to handle patient demands.*

(14) Developing written procedures or an SOP for Managing High Risk Mental Health Presentations in the ED in collaboration with the EM Nurse Manager. See paragraph 13.g.

(15) Working with the VA medical facility Chief, Pathology and Laboratory Medicine Service to develop guidelines for availability and timeliness of an ED's laboratory services. See Appendix B.

(16) Assisting VA medical facility executive leadership with development of waiver requests.

(17) In collaboration with the VA medical facility COS, approving routinely scheduled ED provider shifts greater than 12 hours of clinical time in accordance with paragraph 6.c.

(18) In collaboration with the VA medical facility EM Nurse Manager, updating key contacts and characteristics about EM operations quarterly in the EM Electronic Site Directory (see paragraph 9.m.). ***NOTE:*** *For EM Chief staffing criteria, see Appendix A.*

k. **VA Medical Facility Chief of Police.** The VA medical facility Chief of Police has assumed responsibility for ensuring the ED has access to security services 24 hours a day, 7 days week and that VA Police are able to respond to emergencies in the ED 24 hours a day, 7 days a week.

l. **VA Medical Facility Emergency Medicine Nurse Manager.** The VA medical facility EM Nurse Manager is responsible for:

(1) Conducting a full unit nursing staffing methodology process with the VA medical facility nursing expert panel and reevaluating unit staffing in conjunction with the VA medical facility executive leadership team consistent with VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated January 18, 2023.

(2) Working with the ADPCS to ensure that nursing competency is maintained, develop nursing staffing contingency plans and ensure adequate nursing coverage.

(3) Ensuring that staff using EDIS or an equivalent EHR patient tracking system receive appropriate training on the correct use of the EDIS package or EHR tracking system, in coordination with the EM Chief. (See paragraphs 9.c. and 21.)

(4) Collaborating with the EM Chief to establish procedures relevant to ED operations, as needed.

(5) Collaborating regularly with the VA medical facility Chief of Mental Health Services and EM Chief to develop written procedures or an SOP for Managing High Risk Mental Health Presentations in the ED. See paragraph 13.g.

(6) Collaborating with local EMS officials in conjunction with the VA medical facility EM Chief and participating in the community's emergency resources continuum. This includes a discussion with local and regional EMS leaders about the capabilities of the VA medical facilities in the service area.

(7) Creating a written surge plan for situations in which patient demand exceeds ED capacity, in conjunction with the VA medical facility EM Chief, ADPCS and COS. ***NOTE:*** *This plan must be easily available to all ED staff and address situations where ED provider resources must be quickly mobilized. These plans must authorize ED nursing personnel to contact the EM Chief, or designee appointed by the EM Chief, for implementation of the plan when ED provider staffing is deemed insufficient to handle patient demands.*

(8) In collaboration with the VA medical facility EM Chief, updating key contacts and characteristics about EM operations quarterly in the EM Electronic Site Directory. ***NOTE:*** *For EM Nurse Manager staffing criteria, see Appendix A.*

m. **VA Medical Facility Staff.** VA medical facility staff are responsible for administering safety planning and assisting with coordination of follow up contact post-discharge from the ED for SPED interventions as described on the Suicide Risk Identification and Management SharePoint (SPED Resources tab) at: https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/SPED-Resources.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

6. EMERGENCY DEPARTMENT STAFFING

a. **Administrative Staff.** Appropriately trained administrative staff must be available to support the administrative needs of the ED, including but not limited to patient check-in, registration, communications, arranging transfers and follow up appointments and admissions, 24 hours a day, 7 days a week.

b. **Nursing.** Appropriately educated and qualified emergency nursing professionals must be present and able to staff the ED 24 hours a day, 7 days a week.

(1) ED volume, complexity, resources and flow based on patient intake are necessary pieces of information to determine the appropriate number of staff members required. At minimum, two registered nurses (RNs) designated to the ED must be

physically present in the ED at all times. ***NOTE:*** *For other staffing criteria, see Appendix A.*

(2) All VA EDs should have written nursing staffing contingency plans. ***NOTE:*** *This may be incorporated into the ED provider staffing contingency plan.*

(3) A dedicated charge nurse should be assigned within the ED to assist with flow and communication needs between the VA medical facility EM Nurse Manager, EPs, EM Chief and other hospital leadership. The ED charge nurse should be without other clinical assignments to allow for a focus on patient throughput and daily shift operations.

c. **Physicians.** Appropriately credentialed and privileged EPs must be physically present and immediately available in the ED 24 hours a day, 7 days a week. Shift schedules must be completed and published in advance to all providers working in the ED. Shift lengths more than 12 hours may occasionally be scheduled. If shifts greater than 12 hours of clinical time are needed, the VA medical facility EM Chief will discuss approval with the VA medical facility COS; the EM Chief may contact the VISN EM Consultant for advice, if necessary. EDs utilizing shifts greater than 12-hours must monitor this practice closely to be sure the staff members working these extended hours are performing their duties at the highest level. ED providers working more than a 12-hour shift must be provided available space to rest if the situation allows. Shift length may be affected by a family emergency or an illness. In this temporary situation, an extended shift may be approved by the VA medical facility EM Chief or designee appointed by the EM Chief. ***NOTE:*** *For physician staffing criteria, see Appendix A.*

(1) The recommended number of patients per hour for ED providers depends on the acuity mix and the practice environment. Decisions on staffing should be based on patient flow data with the objective of reducing delays in provider evaluation and care.

(2) The EP is not responsible for any inpatient activities outside of the ED except under the following conditions: EPs may respond to emergencies that arise outside of the ED if the emergency is beyond the capabilities of the normal response team, the EP is the most knowledgeable or experienced physician available to manage the emergency and the response will not jeopardize the care of patients in the ED. For repeated instances that require the EP to respond, the VA medical facility COS, or designee appointed by the COS, must investigate the reason and develop an effective solution that does not risk leaving the ED without a physician physically present in the ED.

(3) All EDs must have a Provider Staffing Contingency Plan SOP or written plan to ensure adequate coverage at all times. If using an SOP, EDs must use the standardized SOP template available at *https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0*. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(4) Resident physicians working in EDs must be supervised in accordance with VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019. In addition, other health professions trainees must be supervised in accordance with VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

d. **Physician Assistants.** PAs can work within their scope of practice with a collaborating physician present in the ED. See VHA Directive 1063(1), Utilization of Physician Assistants (PAs), dated December 24, 2013.

e. **Nurse Practitioners.** NPs can work within their scope of practice or credentials and privileges, as applicable, in EDs. For further information regarding full practice authority for NPs, see VHA Directive 1350, Advanced Practice Registered Nurse Full Practice Authority, dated September 13, 2017.

f. **Clinical Pharmacy Specialists.** CPSs are medication experts who are credentialed in accordance with VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015, and provide comprehensive medication management services to support the ED team. The CPS provides coordination of pharmacy services in conjunction with Clinical Pharmacists and Pharmacy Technicians within the inpatient and outpatient pharmacy. ***NOTE:*** *For CPS criteria, see Appendix A.*

g. **Social Workers.** Social workers provide comprehensive psychosocial support services to patients. Each ED must have on-site or on-call access to social work services for ED patients 24 hours a day, 7 days a week. For further information regarding social work practice and services in VHA, see VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019.

h. **Unlicensed Assistive Personnel.** Unlicensed assistive personnel (UAP) including intermediate care technicians (ICTs) may staff ED sites depending on local needs. UAPs include individuals who are trained to perform certain healthcare-related tasks under the supervision of licensed healthcare professionals. ***NOTE:*** *See Appendix A for more information regarding ICTs.*

7. TELEHEALTH

a. Video telehealth, using VA Video Connect (VVC) or other approved video technologies for clinical care, is encouraged in order to provide a virtual access point of care for patients. Telehealth clinics are supported as a mechanism for the delivery of care based on the needs of the patient and the state of technology and should be used to facilitate convenient and effective access to care when appropriate.

b. With a focus on providing basic ED services, tele-capable EDs should collaborate with other VA medical facilities to offer specialty consultation services such as mental health, geriatrics, Tele- Intensive Care Unit (ICU), Tele-Stroke and other appropriate specialty services as deemed clinically appropriate to accommodate patients' care needs.

c. **Tele Emergency Care.** Tele Emergency Care (Tele-EC) can be established in VA EDs to enhance access to emergency care for patients to deliver urgent or emergent, acuity-appropriate episodic care. Services should be integrated with current VISN and VA medical facility pathways available for patients to obtain telehealth services. Appropriate stop codes or encounter-based billing mechanisms must be used when establishing or providing Tele-EC.

8. EMERGENCY DEPARTMENT REQUIREMENTS

a. **Emergency Department Administration.** An independent EM Service reporting directly to the VA medical facility COS is the preferred organizational model to ensure adequate resources are available to provide the highest quality of emergency care. VA medical facility complexity designation, ED volume, operational risk to the VA medical facility, number of ED providers and EM residency academic affiliation must be taken into consideration when determining organizational placement of the EM Service. The Emergency Medicine Field Advisory Board (EMFAB) and the VISN EM Consultant serve as a resource to VA medical facilities as they develop and evolve the practice of EM. ***NOTE:*** *EMFAB is the principal VA advisory body for EM. The role of this council is to support and provide guidance in the practice of EM and UC medicine. For further information regarding EMFAB, visit the EM SharePoint: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. This is an internal VA website that is not available to the public.*

b. **Stop Codes.** All patients receiving face-to-face evaluation in an ED, regardless of the severity of their illness or triage level, must be coded under a 130 stop code encounter. This is inclusive of patients seen in a “Fast Track” or similar process stream. Additionally, Tele-EC visits are coded under a 131 stop code. ***NOTE:*** *A fast track is an ED care flow process under the domain and supervision of ED providers, that may occur within or in close proximity to the ED, where lower acuity ED patients can be seen, treated and discharged.*

c. **Emergency Department Safety.**

(1) **Security.** It is strongly recommended that security be stationed in close proximity to the ED at all times to screen for weapons or other hazardous items and to maintain a safe environment for clinical care. See paragraph 21 for information regarding required training in Prevention and Management of Disruptive Behavior (PMDB).

(2) **Police.** VA recognizes the ED environment as a high-risk area for Veteran and staff safety. VA Police presence in the ED during all hours of operation can serve as a deterrent against violent events, maintaining the safety and security of the clinical care environment. See VA Directive 0731, Police Staffing Policy, dated May 6, 2022, for police staffing requirements in the ED.

(3) Any ED staff member can alert VA Police to the existence of a potential or actual public safety incident or violation of security/conduct requirements occurring on the premises.

(4) Patients who are being clinically evaluated in the ED for an acute mental health emergency, to determine the appropriateness of implementing an involuntary mental health hold or detention under applicable State law and procedures, or those who have already been placed on an involuntary hold under applicable State law provisions and are awaiting transfer, may pose a serious safety risk to the patient themself or to others. VA Police may provide assistance in preventing patients from departing prior to an involuntary mental health evaluation being completed, or subsequent to an involuntary mental health hold being implemented.

(5) While clinical staff are determining whether an involuntary hold/detention is clinically warranted under applicable State law and procedures, or, in cases where positive determinations have already been made and the ED is awaiting transfer of the patient for involuntary inpatient admission, the patient is to be placed in an environmentally safe room with one-to-one observation or in a designated mental health intervention room under direct line-of-sight observation by a trained staff member. If a mental health intervention room does not exist, is in use or not available, ED staff will place the patient in an exam/treatment room with a safety attendant and will remove all objects that could pose a risk of harm to self or others, provided they can be easily removed without adversely affecting the ability to deliver medical care. An ED without an available dedicated mental health intervention room must also place the patient on one-to-one observation by a trained staff member. For reasons of patient and staff safety, the patient's belongings must be removed, secured and screened for hazardous items; valuables must be inventoried. Belongings are not to be returned to the patient until a medical or mental health provider determines it is safe to do so.

(6) VA medical facilities may consider using metal detectors (magnetometers) to screen all patients and visitors for weapons upon entering the ED. If metal detectors are in use, they must be used for all patients and visitors entering the ED. ***NOTE:*** *See VA Handbook 0730, Security and Law Enforcement, dated August 11, 2000, which addresses specific requirements for the use of metal detectors.*

(7) Persons found to be in possession of weapons or other hazardous items during screening are subject to arrest and prosecution. See 18 U.S.C. § 930; 38 U.S.C. § 902; 38 C.F.R. § 1.218(a)(13); VHA Directive 5019.02(1), Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration, dated September 12, 2022; and VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021, which addresses workplace violence prevention at VA medical facilities.

d. **Environment of Care.** The ED must provide a safe environment for patients and staff, make access convenient and protect visual and auditory privacy to the greatest practical extent possible. Appropriate signage indicating convenient access for all individuals presenting for care must be placed at major points of entrance in the VA

medical facility and must clearly indicate directions to access the ED at all times. In general, ingress to the ED should be limited via PIV badge entry, key code or similar security measure. ***NOTE:*** *See VHA PG-18-12: Emergency Department Design Guide found at https://www.cfm.va.gov/til/dGuide.asp and VHA Directive 1608, Comprehensive Environment of Care Program, dated June 21, 2021, for additional information.*

e. **Safety, Comfort and Mobility Design.** Environmental features that promote visual contrast and accessibility and reduce fall risk include handrails and non-slip, non-skid floors and ramps. See VHA PG 18-9 for specific National Safety Foundation requirements (https://www.cfm.va.gov/til/space.asp). Restrooms dedicated for use by mental health patients should be ligature free and follow Mental Health Environment of Care Checklist (MHEOCC) guidance. VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, dated May 12, 2017, provides national policy on the use of the MHEOCC in designing spaces used to evaluate patients presenting to VA EDs with mental health concerns. In addition, all new builds must comply with the ED Design Guide (PG-18-12) located at https://www.cfm.va.gov/til/dGuide.asp.

f. **Equipment, Devices and Supplies.** ED equipment and supplies must be readily available in the VA medical facility at all times; this includes critical and semi-critical reusable medical devices. See VHA Directive 1761, Supply Chain Management Operations, dated December 30, 2020, and VHA Directive 1116(2), Sterile Processing Services (SPS), dated March 23, 2016, for further information. A process for inspection and documentation of the proper functioning of all equipment must be in force; see VHA Directive 1860, Biomedical Engineering Performance Monitoring and Improvement, dated March 22, 2019. ***NOTE:*** *Recommended equipment for the ED can be found on the EM SharePoint: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. This is an internal VA website that is not available to the public.*

g. **Interdisciplinary Support Services.** Standard procedures must allow access to support services 24 hours a day, 7 days a week. See Appendix B for details.

9. GENERAL OPERATIONS REQUIREMENTS

a. **Emergency Department Services.** Patient preference for ED staff gender is to be accommodated to the extent feasible.

b. **Patient Sign In.** All VA medical facilities registering patients in an ED must comply with the VHA Directive 1230. All outpatient appointments meeting the definition of an encounter must be made in count clinics using EHR ED scheduling software.

c. **Patient Tracking System.** All EDs must utilize either Emergency Department Integration Software (EDIS) or EHR tracking system to monitor patient quality and flow metrics for both VA medical facility and national reporting and department flow management. EDs should refer to VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017.

d. **Triage.**

(1) **Emergency Severity Index.** VHA requires RN triage in all EDs consistent with the Emergency Nurses Association (ENA) position statement dated May 2017, Triage Qualifications and Competency, and the use of the Emergency Severity Index (ESI) as the sole triage tool. Triage Nurses must have demonstrated competency in use of the five-tier ESI triage system, to be assessed as part of regular competency validations. The ENA position statement can be found here: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(2) All VA EDs must use the most recent triage template approved by the VHA Emergency Medicine Program Office in the EHR. VA medical facility-specific screening questions necessary for triaging patients safely may be added to the template, provided that such additions do not unnecessarily delay ED provider evaluation and treatment of the patient.

e. **Nurse First Process.** The Quick Look Nurse or Nurse First position is located at the check-in area of the ED and must be staffed by an RN. The primary responsibility of this position is to quickly sort incoming patients into two categories: emergent or non-emergent. This position relies on rapid assessments and requires experienced and knowledgeable nurses trained in triage to perform the job successfully. Quick Look Nurse or Nurse First nurses do not typically assign patients an ESI priority unless the patient's condition warrants them to assist with the full triage and stabilization process. This position may also be responsible for monitoring the patients in the ED waiting area for recognition of changes in their condition, should be without additional clinical assignments and is strongly recommended for all EDs especially during identified queuing times.

f. **Consult Services.** EDs must follow VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016. The VA medical facility COS must ensure access to all necessary consult services 24 hours a day, 7 days a week. Each consult service must provide the ED with an accurate schedule and contact information of on-call staff. The expectation for a return call from an on-call consultant is no longer than 30 minutes, with an on-site or telehealth evaluation, as clinically indicated, within 60 minutes under normal circumstances. No STAT consult may be declined, and all consults are subject to the requirements of 38 U.S.C. § 1784A.

g. **Admissions.** The decision to admit a patient is made when there is adequate clinical information to determine: 1) the admitting service; 2) the level of care; and 3) the suspected diagnosis. ***NOTE:*** *See paragraph 13 for information regarding admission for mental health patients.*

(1) A verbal handoff from the ED to VA inpatient provider(s) occurs concurrently with the decision to admit to the hospital and generally within 30 minutes, independent of whether the VA hospital has open inpatient beds. If the ED cannot reach the admitting team within 30 minutes, the ED may escalate the call to the appropriate service chief. The goal is to transfer primary responsibility to the admitting team as soon as can be safely accomplished and typically at the time of verbal handoff.

(2) Appropriately qualified inpatient providers must be available 24 hours a day, 7 days a week and must be identified in advance to manage the care and activities of patients requiring admission. The ED provider having primary responsibility for the patient determines the ultimate disposition of patients in collaboration with designated inpatient admitting providers.

(3) If after an in-person evaluation, the proposed admitting attending disagrees on the appropriate treating service or level of care, the final disposition will be determined by escalation which may include respective section or service chiefs with involvement of the VA medical facility COS or designee appointed by the VA medical facility COS, if necessary.

(4) ED providers may place initial bed requests and may place additional transition orders to expedite patient movement to the inpatient ward. If transition orders are used to facilitate patient movement, the ED provider should collaborate with the admitting provider to formulate brief, time-limited transition orders specific to clinical care of the patient. Transition orders do not require bedside evaluation of the patient by the inpatient provider prior to being placed. Such limited orders will typically include information regarding the intended bed type, admitting service, activity, safety precautions, diet and general monitoring orders. Additional information can be found at https://www.acep.org/patient-care/policy-statements/writing-admission-and-transition-orders/.

(5) The ED provider must not write any detailed orders that extend care and responsibility for the patient beyond the treatment given in the ED. Once the patient is in admitted status, the ED provider will direct ED and inpatient nursing staff to contact the admitting provider with specific questions regarding future patient care.

(6) Once the patient's care has been transitioned to the admitting team, the admitting team will not extend ED length of stay for completion of an inpatient history and physical, non-emergent labs, testing, medications or interventions.

(7) Once the admitting team assumes primary responsibility of the patient, they are generally responsible for all care, including while the patient is still located in the ED. If the patient's medical status changes to require immediate medical treatment such as for

acute pain or shortness of breath and the admitting team is not present, ED providers must provide interventions as appropriate, including re-evaluation of the patient for changes in level of care or admitting service and communicate these actions to the admitting team.

(8) Admitted patients who remain in the ED after the decision to admit will receive nursing care that is consistent with their admission level of care. This is achieved by ED nursing, inpatient nursing or a combination of the two based on VA medical facility resources.

(9) Inpatient providers who determine that the patient's condition does not warrant admission may be permitted to officially discharge the patient from the ED according to the VA medical facility's SOPs. In such cases, the ED provider and inpatient provider must work together to ensure that all VA medical facility documentation requirements and procedures are followed.

h. **Emergency Department Boarding and High Census Plans or Surge Plan.** All VA medical facilities must have written processes that address the boarding of ED patients to ensure that optimal care is uniformly and expediently delivered when patients must be boarded in the ED due to lack of bed availability on the destination unit. Boarding patients are accommodated in a temporary ED location until an appropriate bed for their intended level of inpatient care is available or the patient is transferred. The Joint Commission recommends that boarding time frames not exceed 4 hours. Further information regarding Joint Commission standards regarding patient flow and boarding timeframes in EDs is available at https://www.jointcommission.org/standards/r3-report/r3-report-issue-4-patient-flow-through-the-emergency-department/. ENA strategies for reducing ED boarding are located at https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. ***NOTE:*** *This is an internal VA website that is not available to the public.* These processes include:

(1) Implementation of a VA medical facility high census/surge plan through a collaboration between the ED Attending and Nurse Manager, Bed Flow Coordinator (BFC) or Flow Coordination Center (FCC), and Nurse on Duty (NOD) or Admitting Department for high census/surge plan initiation and execution.

(2) Identification of locations for overflow patients (i.e., Post Anesthesia Care Unit (PACU), Inpatient Rehabilitation Unit (IRU), Short Stay) outside of the ED.

(3) Deferring transfers into the ED from other VA medical facilities, including off-site VA clinics or Community-Based Outpatient Clinics, during times the high census/surge plan is activated.

(4) Direction of on-site clinic admissions to the ED only for patients who are critical or unstable. The ED should not be used to hold clinically stable patients who are scheduled admits because of lack of inpatient beds.

(5) Direction to decompress the ED of admitted patients to avoid inpatient boarding or diversion to maintain ED treatment capacity.

(6) Development of workflows for appropriate care when boarding patients in the ED or in an area controlled by the ED, including providing a similar level of care for a patient admitted to an inpatient service in all temporary bed locations. ***NOTE:*** *When a patient requires admission to an intensive care unit and no ICU bed is available, it is imperative that the patient receive ICU-level care in an alternative location including monitoring, staffing and treatment consistent with ICU standards by qualified personnel.*

(7) The transfer of care responsibility from ED provider to the admitting provider generally occurs after direct verbal communication between the ED provider and the admitting provider, assuring this can be accomplished safely. See paragraph 9.g.

i. **Transfer Process.** All VA medical facilities with EDs must comply with VHA Directive 1094 and 38 U.S.C. § 1784A for transferring patients to other VA facilities or to facilities in the community.

j. **Discharge Instructions.** All patients discharged from the ED are given specific follow-up care instructions. These instructions must be legible and be reviewed with the patient or caregiver prior to discharge. Documentation of this must be reflected in the patient chart. Additionally, instructions must include relevant updated medication information and education or counseling to ensure effective self-care and follow-up.

k. **Diversion.** Circumstances may dictate the need to divert patients away from the ED. Each VA medical facility with an ED must have a written plan or guidance that provides clear indications for the use of ambulance or other types of diversion and limitations for the length of time spent on diversion. Any VA medical facility diversion plan or guidance must include the ED Nurse Manager or EM Chief as a stakeholder. The EM Nurse Manager or Administrator on Duty will be responsible for diversion communication to local and county EMS. ***NOTE:*** *The ED must never turn away a walk-in individual or one who has arrived via ambulance; additionally, an MSE and, if applicable, stabilizing treatment or an appropriate transfer, must always be performed or provided, in accordance with the provisions of 38 U.S.C. § 1784A.*

l. **Emergency Department Observation.** All VA medical facilities must follow VHA Directive 1036. In accordance with VHA Directive 1036, patients assigned to ED Observation status must be limited to a stay of 23 hours and 59 minutes in the ED itself or an observation unit operated by the ED. Patients who cannot be discharged in this time frame must be admitted or placed in Observation status on an inpatient unit at a location outside of the ED.

m. **Emergency Medicine Electronic Site Directory.** The EM Electronic Site Directory provides information about VA ED sites, including key operational

characteristics and contact information for ED leadership. The information in the EM Electronic Site Directory must be updated on a quarterly basis by the VA medical facility EM Chief and EM Nurse Manager. Access to the EM Electronic Site Directory is provided by emailing VHA EMX (vhaemx@va.gov). ***NOTE:*** *The EM Electronic Site Directory can be found here: https://vaww.pbi.cdw.va.gov/PBI_RS/report/GPE/QSV_HSIPC/EM/DIR_SUM. This is an internal VA website that is not available to the public.*

10. AIRWAY MANAGEMENT

a. **Out of Operating Room Airway Management.** VA medical facilities must not utilize the sole EP for primary response to cardiopulmonary emergencies that arise outside of the ED in lieu of a rapid response team or similar emergent out-of-operating room airway team. (See VHA Directive 1101.04, Medical Officer of the Day, dated February 6, 2019.) The EP may respond to such cases if the emergency is beyond the capabilities of the normal response team, the EP is the most knowledgeable or experienced physician available to manage the emergency and the response will not jeopardize the care of patients in the ED.

b. **Intubation/Airway Management.** ED providers may use anesthetic agents for intubation, with approved privileges and documentation, in accordance with VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018. See VHA Directive 1157(1) for standards and requirements.

11. USE OF ANESTHETIC AGENTS FOR SEDATION IN THE EMERGENCY DEPARTMENT

ED providers ordering, administering or supervising the performance of sedation in support of patient care must be qualified and have appropriate credentials, privileges, or scope of practice to perform sedation. (See VHA Directive 1073(1), Moderate Sedation by Non-Anesthesia Providers**,** dated December 20, 2022.)

12. EMERGENCY DEPARTMENT ACUTE ISCHEMIC STROKE MANAGEMENT

All VA medical facilities with acute care inpatient medical or surgical care beds or VA medical facilities with EDs must have written plans to provide appropriate care to patients presenting with Acute Ischemic Stroke; see VHA Directive 1155(1) for related responsibilities. For acute ischemic stroke, VA medical facilities must comply with VHA Directive 1155(1). Each VISN Director is responsible for assessing the capability of each VA medical facility in the VISN and assigning an appropriate designation for stroke care to each in accordance with VHA Directive 1155(1).

13. EMERGENCY DEPARTMENT MANAGEMENT OF PATIENTS WHOSE PRESENTATION INCLUDES MENTAL HEALTH CONCERNS

a. All sites with EDs must be able to assess the need for the full range of health care services, including mental health services, 24 hours a day, 7 days a week either on-site or on-call. This coverage is to be provided by an Advanced Practice mental health

provider (e.g., psychiatrist, psychologist, social worker, PA, advanced practice nurse, licensed professional mental health counselor). VHA Handbook 1160.01(1), Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, defines minimum administrative and clinical requirements for VHA mental health services provided at all VHA medical points of service.

b. Suicide screening is administered to all patients presenting to EDs via the National Emergency Department/Urgent Care Triage note in the EHR. All patients presenting with suicidal or homicidal ideation must be formally assessed using current screening and evaluation tools. Immediate triage and identification of emergency medical conditions will take precedence over this screening process.

(1) Risk Identification (Risk ID) requirements in the ED can be accessed by visiting https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx and choosing "Setting Specific Guidance". ***NOTE:*** *This is an internal VA website that is not available to the public.*

(2) SPED requirements and procedures can be accessed by visiting the SPED SharePoint site at https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/SPED-Resources.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

c. A medical assessment from an ED provider will occur, including appropriate physical exams and laboratory testing, to identify and rule out medical conditions that could be responsible for the presenting mental health condition.

d. When a VA ED has on-call coverage for mental health, the provider should acknowledge receipt through locally agreed upon processes within 30 minutes of request and begin the telehealth or face-to-face evaluation within 60 minutes of acknowledged receipt. A tele-visit is acceptable for mental health evaluation by an appropriately-telehealth-trained and credentialed mental health provider. ***NOTE:*** *Use of tele-mental health (TMH) to support the delivery of services is appropriate and encouraged for meeting ED mental health coverage requirements. The use of TMH should be clinically determined based on the needs and preferences of the patient and the state of technology and evidence-based practice to facilitate convenient and effective access to care.*

e. A face-to-face assessment by a VHA mental health care provider (a licensed independent provider (LIP) or advanced practice provider) within 60 minutes of a consultation request is preferred whenever possible. In situations where face-to-face evaluations cannot occur, TMH is acceptable. ***NOTE:*** *For a definition of LIP, see VHA Directive 1100.20.*

f. As addressed in paragraph 8, if an individual in the ED is being evaluated for risk of suicidal or homicidal thoughts, they must be immediately placed and maintained in a safe environment until a more in-depth assessment occurs. The in-depth assessment is needed to determine whether the patient qualifies for placement of an involuntary hold

or detention consistent with the requirements and procedures established by applicable State law. Until that in-depth assessment can be made, the patient should be placed in an environmentally safe room with one-to-one observation or in a designated mental health intervention room under direct line-of-sight observation by a trained staff member. Staff must follow their mental health SOPs regarding safe patient care and handling. An ED with an available mental health intervention room is to use direct line-of-sight observation for patients and must follow their mental health SOPs regarding safe patient care and handling. If a mental health intervention room does not exist, is in use, or is not available, ED staff will place the patient in an exam/treatment room with a safety attendant and will remove all objects that could pose a risk for harm to self or others, provided they can be easily removed without adversely affecting the ability to deliver medical care. The patient is to be put on one-to-one observation by a trained staff member. If restraints are used, their use must be consistent with 38 C.F.R. § 17.33(d), The Joint Commission guidance, and VA medical facility procedures. The Mental Health Intervention Room and Mental Health Bathroom environment of care must be reviewed every 6 months by the VA medical facility Interdisciplinary Safety Inspection Team as outlined in VHA Directive 1167.

g. The VA medical facility EM Chief, Chief of Mental Health Services and EM Nurse Manager collaborate to establish local procedures or a Managing High Risk Mental Health Presentations SOP to coordinate the intake, assessment, treatment and, if necessary, inpatient admission of patients who are determined by the VA medical facility to be patients with high risk mental health presentations (e.g. imminent risk for suicide or homicide and for whom an involuntary hold is authorized), consistent with applicable State law terms and procedures. For patients who do not qualify for such holds but who are still considered to have violent, disruptive or self-injurious behaviors, the ED must employ appropriate patient monitoring strategies to maintain patient and staff safety while the patient remains in the ED. If using an SOP, EDs must use the standardized SOP template available at *https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0*. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(1) **Direct Line-of-Sight Observation.** Direct line-of-sight observation of patients is only allowable if the patient is in a mental health intervention room. Staff can observe multiple patients, but must remain in the area with patients, such that if a patient needs immediate intervention, the staff member can immediately intervene and call other staff to help as needed. Observation by cameras may not necessarily substitute for direct line-of-sight observation unless it is determined for clinical reasons to provide a necessary alternative means of observation (e.g., a patient who is currently COVID-19 positive, or who has escalated with aggression to staff). Use of cameras must comply with VHA Directive 1078, Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings, dated November 29, 2021. For further information on observation levels, see Guide of Various Safety Observation Levels Available for Use; please also see Guidance for VA Inpatient Mental Health Units. Both documents are

located at *https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0*. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(2) **One-to-One Observation.** Patients on one-to-one observation must be continuously observed and monitored at all times by a trained staff member. For EDs without an available dedicated mental health intervention room, patients must remain on one-to-one observation. The availability and use of a mental health intervention room does not remove the requirement for (at a minimum) direct line-of-sight observations for patients with suicidal ideation. During one-to-one observation, staff members must remain in close proximity to the patient so that they are able to react immediately to an adverse situation. Any ED staff member can initiate one-to-one observation. While under one-to-one observation, the patient is not to be allowed to leave the room for any reason (e.g., snacks, phone call), and any restroom visit requires a staff person who can continue to visibly monitor the patient for suicidal behavior, provided that such restrictions on the patient's freedom are consistent with statutory and regulatory authority. Use of a MHEOCC-compliant bathroom does not remove the requirement to visibly monitor the patient for suicidal behavior. Patients who may require one-to-one observation include those who are at risk for causing imminent harm to themselves or to others. Observation by cameras cannot substitute for one-to-one observation unless it is determined for clinical reasons to provide appropriate alternative means of observation (e.g., a patient who is currently COVID-19 positive, or who has escalated with aggression to others). If the patient is agitated or has a potential for violence, the staff member should consider observation at two to three arm's lengths away or observation by camera and patient behaviors should be immediately discussed with the treatment team.

(3) In addition, steps must be taken to ensure visitors do not bring objects into the mental health intervention room that patients could use to harm themselves or others. Staff will be sensitive to the dignity and privacy of the patient while maintaining safety and observation; as such, the patient should be asked what gender staff they prefer to have in attendance during the one-to-one observation. ED staffing should account for these potential situations and while every effort is made to address the patient's preference, there may be situations where staffing may not permit the one-to-one observation gender preference to occur. However, during restroom breaks or while the patient is undressing, it is imperative the patient's preference is respected to ensure that patient-centered care is given. A patient is never left unattended while using the restroom, even if that restroom meets MHEOCC standards.

(4) Qualified staff must be available to accompany and remain with such patients from one area of the hospital to another.

(5) All VA EDs must have either one or more dedicated mental health intervention rooms or a treatment space that can be immediately converted to a mental health

exam/treatment room. ***NOTE:*** *The MHEOCC (http://vaww.ncps.med.va.gov/guidelines.html) provides the environmental criteria for the mental health intervention room and mental health bathroom in the ED. This is an internal VA website that is not available to the public. If an ED does not have a mental health intervention room, one should be added during the next planned remodel or redesign of the ED.*

14. CONSENT DURING MEDICAL EMERGENCIES

a. In medical emergencies, the patient's consent is implied by law provided that all of the following conditions are met:

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

(2) The patient is unable to give consent; and

(3) The patient has no surrogate, or the practitioner determines that waiting to obtain consent from the patient's surrogate would increase the hazard to the life or health of the patient. For more information see 38 C.F.R. § 17.32(c)(7) and VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

b. **Signature Informed Consent.** Consistent with VHA Handbook 1004.01(5), the following minor bedside procedures commonly performed in the ED setting generally do not require signature consent, but do require an informed consent discussion with the patient (or surrogate, if the patient lacks decision-making capacity) and documentation of such discussion in the patient's EHR:

(1) Laceration repairs that are not expected to have significant cosmetic or functional impact to the patient and are at low risk of post-repair complication (infection, dehiscence, etc.).

(2) Simple abscess incision and drainage that is at low risk of damaging underlying neurovascular structures.

(3) Simple intradermal foreign body removal that is at low risk of adverse cosmetic or functional impact or damage to underlying neurovascular structures.

(4) If one of the above procedures is likely to be high risk for a particular patient, signature consent is required. A decision tool for determining if signature consent is required is available at: https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Informed_Consent.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

15. CONSENT TO OBTAIN AND DISCLOSE EVIDENTIARY/FORENSIC EVIDENCE

For information regarding consent for release of evidentiary information and material, see VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

16. EMERGENCY CARE OF THE OLDER ADULT

a. EDs are encouraged to have systems in place for providing age-friendly emergency care consistent with the American College of Emergency Physicians (ACEP) Geriatric Emergency Department Guidelines available at https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/geriatrics/geri_ed_guidelines_final.pdf. ***NOTE:*** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*

b. This may include obtaining Geriatric ED accreditation. Effective emergency care of older patients can result in more cost-effective care and better patient outcomes. EM Chiefs are encouraged to work with other services to provide age-friendly emergency care. This includes:

(1) Staffing protocols should include geriatric-trained providers when possible, to provide geriatric education and training opportunities for all ED staff members.

(2) Procedures and protocols supporting age-friendly care of the elderly, including interdisciplinary collaboration, screening of risk for adverse outcomes, additional needs assessments and specific geriatric consultations or interventions. ***NOTE:*** *See VHA Directive 1199(1), Reporting Cases of Abuse and Neglect, dated November 28, 2017, for policy related to the reporting of known and suspected cases of abuse and neglect.*

17. EMERGENCY CARE OF PEDIATRIC PATIENTS

a. All VA medical facilities with EDs must have pediatric/neonatal Basic Life Support (BLS) equipment available for pediatric/neonatal emergencies, and all ED clinical staff must have current BLS and Advanced Cardiac Life Support (ACLS) training. EM board-certified physicians are strongly encouraged, but not required, to have current BLS and ACLS certification. See VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021, for additional information.

b. For EDs that routinely see pediatric patients, full pediatric resuscitation equipment as well as Pediatric Advanced Life Support (PALS) training is required for all clinical staff.

18. OBSTETRIC AND GYNECOLOGIC CARE IN THE EMERGENCY DEPARTMENT

a. VHA Directive 1330.01(6), Health Care Services for Women Veterans, dated February 15, 2017, provides policy for all VHA sites of care, including EDs, to ensure delivery of quality care to female Veterans, including gender-specific medical services,

when accessing VA health care services. Consistent with 38 U.S.C. § 1784A, any individual presenting to a VA medical facility ED must receive an appropriate MSE, within the capability of the ED, including ancillary services routinely available to the ED, to determine whether an emergency medical condition exists. ***NOTE:*** *See 38 U.S.C. § 1784A for a definition of emergency medical condition as it relates to active labor.* For policy regarding delivery of healthcare to transgender and intersex Veterans, see VHA Directive 1341(2), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018.

(1) Every VA ED must be able to perform a gynecologic examination at all times.

(2) Emergency contraception must be available when clinically appropriate at the time of the ED visit or by a prescription that can be filled in time to be effective.

(3) VA EDs must have a plan for managing:

(a) Precipitous deliveries until emergent transport to an appropriate outside VA medical facility occurs.

(b) Maternal hemorrhage and hypertension/preeclampsia.

(4) VA medical facilities caring for pregnant patients on-site must have the following:

(a) Appropriate medications, supplies and processes to assure the timely treatment of an ectopic pregnancy, miscarriage or post-partum hemorrhage. ***NOTE:*** *Recommended obstetric and gynecologic medications and equipment for EDs can be found on EM SharePoint at: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. This is an internal VA website that is not available to the public.*

(b) A plan for performing and interpreting pelvic ultrasound (including transvaginal), either on-site or by transfer agreement.

(c) Focused ultrasonography performed by duly credentialed and privileged EPs to diagnose an intrauterine pregnancy is acceptable only if the interpretation of the results is formally entered into the medical record of the patient, and an appropriate quality assurance process is in place consistent with ACEP policy on ED Ultrasonography available at https://www.acep.org/patient-care/clinical-policies/.

(d) Quantitative and qualitative pregnancy testing (see paragraph 18.d.).

(e) Rh testing and availability of Rho (D) Immunoglobulin (RhoGAM) (see paragraph 18.e.).

(f) Access to specialty care providers (i.e., Ob/Gyn) (on-site, off-site, through transfer to another facility, or via tele-gynecology consultation).

(g) Ability to recognize and provide initial stabilizing care (including emergent transfer for higher level of care) for severe preeclampsia and eclampsia. ***NOTE:*** *See the EM SharePoint for additional guidance on Care of the Pregnant Patient: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. This is an internal VA website that is not available to the public.*

b. As stated in VHA Directive 1330.01(6), all VA medical facilities must develop SOPs for managing obstetric and gynecologic emergencies. These SOPs must clearly describe on-site capabilities and processes/protocols for emergent treatment, stabilization and patient transfer which are consistent with VHA Directive 1094 and must include processes for addressing obstetric and gynecologic emergencies which will differ by VA medical facility depending on the availability of the following:

(1) Obstetricians and gynecologists (on-site, off-site, through transfer to another VA medical facility or via tele-gynecology consultation).

(2) On-site diagnostic and treatment resources (e.g., pelvic ultrasound, operating room capacity).

c. Clinical staff providing emergent care treatment to Veterans must have sufficient training and expertise to care for Veterans presenting with obstetric and gynecologic issues, regardless of the VA medical facility's ability to provide labor and delivery services, as described in VHA Directive 1330.01(6).

d. **Pregnancy Testing.**

(1) As stated in VHA Directive 1330.01(6), all Veterans of child-bearing age (age ≤ 52 years) triaged in a VA ED should be asked about pregnancy status and last menstrual period if deemed appropriate based on information provided by the Veteran. Nursing triage documentation should include this information.

(2) All EDs must have the ability to test and confirm pregnancy. VA EDs must have STAT qualitative (urine and serum) testing with results available to the patient's ED clinician within 1 hour of order and a plan for obtaining urgent quantitative serum results if indicated. Immediate access to point of care qualitative urine pregnancy testing at triage is ideal for initial assessment in Veterans of child-bearing age (≤ 52 years), if deemed appropriate based on information provided by the Veteran, as pregnancy status may impact the evaluation and treatment options. Quantitative serum pregnancy testing is critical for evaluating and managing certain cases (e.g., possible ectopic pregnancy).

e. **Blood Type Evaluation (Type and Screen).** Blood type evaluation and antibody screen must be part of the evaluation of every pregnant Veteran who presents to an ED

with vaginal bleeding. VA medical facilities must develop a process to ensure availability of Rho (D) Immunoglobulin to prevent Rh isoimmunization in Rh negative patients who are pregnant, in the appropriate clinical context.

19. INTIMATE PARTNER VIOLENCE

Every VA medical facility must implement and maintain an Intimate Partner Violence Assistance Program (IPVAP) in accordance with VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019. Veterans, intimate partners and employees impacted by intimate partner violence will have access to services including resources, assessment intervention and referrals to VA or community agencies as deemed appropriate and clinically indicated. Contact information for the IPVAP Coordinator and program is posted and distributed in prominent locations throughout the VA medical facility (e.g., main entrance(s), ED, Women's Health Clinics, websites, directories). VA medical facilities must develop and implement local protocols for screening at-risk populations for IPV in accordance with the national IPVAP Screening Toolkit located at https://dvagov.sharepoint.com/sites/VHACMSWS/IPV/IPVAP%20Directive%20Draft/Forms/AllItems.aspx?id=%2Fsites%2FVHACMSWS%2FIPV%2FIPVAP%20Directive%20Draft%2F2%20Operating%20Guide%20and%20Toolkits. ***NOTE:*** *This is an internal VA website that is not available to the public.*

20. EMERGENCY DEPARTMENT MANAGEMENT OF ACUTE SEXUAL ASSAULT

a. Acute sexual assault is defined as an unwanted sexual contact by an alleged perpetrator. All VA EDs must have procedures in place to evaluate, support and treat patients of reported acute sexual assault consistent with consent requirements in VHA Handbook 1004.01(5), to include the following elements:

(1) Screening for injuries requiring emergent treatment or stabilization;

(2) Preserving evidence collection for forensic examination in consideration of regional law enforcement;

(3) Performing or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient; and

(4) Ensuring access to prophylaxis for sexually transmitted disease and pregnancy when clinically indicated. Follow-up care may include screening and treatment of sexually transmitted diseases, treatment of injuries or access to law enforcement and patient services such as a Rape Crisis Center based on regional availability and mental health services. Acceptable procedures must consider regional law enforcement requirements. Evaluation for collection of forensic evidence should occur within 72 hours after the assault. Individual State guidelines may authorize collection at a later time.

(5) If the forensic examination is being performed in a VA medical facility, the forensic provider must first obtain the individual's informed consent for forensic

examination and also be trained in conducting forensic evidentiary examinations. ***NOTE:*** *Acute sexual assault patients must, as part of the informed consent discussion, be made aware of the applicable limits to confidentiality in the relevant State(s).*

b. The patient has the right to accept or refuse any aspect of the medical evaluation and treatment or forensic evidentiary examination. Refusal of the forensic examination for evidence of sexual assault is not a ground for denial of treatment for injuries or possible pregnancy and sexually transmitted diseases. Refusal of any recommended treatment or procedure must be documented in the EHR and respected. ***NOTE:*** *Patients have the option to have forensic evidence collected anonymously in the event they choose to pursue prosecution at a later date. Regional Counsel should be consulted regarding State laws.*

(1) **Collection and Safeguarding of Evidence.**

(a) ED staff must consult with VA Police regarding the proper collection, sealing and labeling of the evidence.

(b) When the patient has consented to the examination and collection of evidence of sexual assault, VA Police must be notified to safeguard and secure the evidence collected. ***NOTE:*** *The collection and safeguarding of evidence must be done in accordance with VA Handbook 0730.*

(2) **Report of Incident.** See VHA Directive 5019.02(1) and VA Directive 0321, Serious Incident Reports, dated June 6, 2012, for requirements for reporting incidents of harassment or sexual assault.

21. TRAINING

The following training is ***required*** for employees working in VA EDs, including but not limited to, RNs, physicians, NPs and PAs intermediate care technicians (ICTs), health technicians and licensed practical nurses, with a brief description of training requirements below:

a. **Basic Life Support.** BLS training must be provided to and maintained by all staff members working in the ED as noted in VHA Directive 1177. ***NOTE:*** *EM board-certified physicians are strongly encouraged, but not required, to have current BLS certification unless required by the VA medical facility. See VHA Directive 1177 for more information.*

b. **Advanced Cardiac Life Support.** ACLS training must be provided to and maintained by all licensed staff members working in the ED. ***NOTE:*** *EM board-certified physicians are strongly encouraged, but not required, to have current ACLS certification unless required by the VA medical facility. See VHA Directive 1177 for more information.*

c. **Pediatric Advanced Life Support.** PALS training is required of all ED clinical staff who routinely see pediatric patients.

d. **Suicide Prevention.** Suicide prevention training requirements for clinical and non-clinical employees are located in VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

e. **Prevention and Management of Disruptive Behavior.** All ED employees must receive training in PMDB at the appropriate level as determined by the VA medical facility. ***NOTE:*** *For further information about PMDB training, see VHA Directive 1160.08(1). PMDB is VHA's accepted training in verbal de-escalation, personal defense and safety/physical containment for managing disruptive and potentially violent patients.*

f. **Emergency Department Integrated Software Training.** Staff using EDIS or an equivalent EHR patient tracking system must be trained on system requirements during local orientation and training must be documented locally. EDIS training varies based on the local configuration. The EDIS User Guide can be used as a supplement to local training. The EDIS User Guide is located at https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?ga=1&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FResource%20Library%2FEDIS%202%2E2. ***NOTE:*** *This is an internal VA website that is not available to the public.*

g. **Documentation of Training.** Training must be documented for each individual ED staff member and documentation must be readily available for inspection and review.

22. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

23. REFERENCES

a. 38 U.S.C. §§ 902, 1710, 1784, 1784A, 7301(b), 7331.

b. 38 C.F.R. §§ 1.218, 17.32, 17.33, 17.38.

c. VA Directive 0321, Serious Incident Reports, dated June 6, 2012.

d. VA Directive 0731, Police Staffing Policy, dated May 6, 2022.

e. VA Handbook 0730, Security and Law Enforcement, dated August 11, 2000.

f. VA Handbook 5005, Staffing, dated February 4, 2022.

g. VHA Directive 0320, VHA Comprehensive Emergency Management Program, dated July 6, 2020.

h. VHA Directive 0999, VHA Policy Management, dated March 29, 2022.

i. VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017.

j. VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020.

k. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.

l. VHA Directive 1063(1), Utilization of Physician Assistants (PAs), dated December 24, 2013.

m. VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

n. VHA Directive 1073(1), Moderate Sedation by Non-Anesthesia Providers, dated December 20, 2022.

o. VHA Directive 1075, Strategic-Operational Planning Process, dated July 27, 2020.

p. VHA Directive 1078, Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings, dated November 29, 2021.

q. VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated October 7, 2015.

r. VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017.

s. VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.

t. VHA Directive 1100.21, Privileging, dated March 2, 2023.

u. VHA Directive 1101.04, Medical Officer of the Day, dated February 6, 2019.

v. VHA Directive 1106, Pathology and Laboratory Medicine Service, dated July 27, 2018.

w. VHA Directive 1108.07, General Pharmacy Service Requirements, dated November 28, 2022.

x. VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019.

y. VHA Directive 1116(2), Sterile Processing Services (SPS), dated March 23, 2016.

z. VHA Directive 1155(1), Treatment of Acute Ischemic Stroke, dated June 2, 2018.

aa. VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018.

bb. VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

cc. VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, dated May 12, 2017.

dd. VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021.

ee. VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018.

ff. VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019.

gg. VHA Directive 1199(1), Reporting Cases of Abuse and Neglect, dated November 28, 2017.

hh. VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022.

ii. VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016.

jj. VHA Directive 1330.01(6), Health Care Services for Women Veterans, dated February 15, 2017.

kk. VHA Directive 1341(2), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018.

ll. VHA Directive 1350, Advanced Practice Registered Nurse Full Practice Authority, dated September 13, 2017.

mm. VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated January 18, 2023.

nn. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

oo. VHA Directive 1608, Comprehensive Environment of Care Program, dated June 21, 2021.

pp. VHA Directive 1761, Supply Chain Management Operations, dated December 30, 2020.

qq. VHA Directive 1860, Biomedical Engineering Performance Monitoring and Improvement, dated March 22, 2019.

rr. VHA Directive 5019.02(1), Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration, dated September 12, 2022.

ss. VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023.

tt. VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

uu. VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015.

vv. VHA Handbook 1160.01(1), Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

ww. VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

xx. EM Electronic Site Directory: https://vaww.pbi.cdw.va.gov/PBI_RS/report/GPE/QSV_HSIPC/EM/DIR_SUM. ***NOTE:*** *This is an internal VA website that is not available to the public.*

yy. ED Design Guide (PG-18-12). https://www.cfm.va.gov/til/dGuide.asp.

zz. Mental Health Environment of Care Checklist. http://vaww.ncps.med.va.gov/guidelines.html. ***NOTE:*** *This is an internal VA website that is not available to the public.*

aaa. Risk ID SharePoint site. https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

bbb. Signature Informed Consent Decision Tool. https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Informed_Consent.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

ccc. Suicide Risk Identification and Management/SPED SharePoint site. https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/SPED-Resources.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

ddd. VA EM SharePoint. EDIS User Guide. https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?ga=1&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FResource%20Library%2FEDIS%202%2E2. ***NOTE:*** *This is an internal VA website that is not available to the public.*

eee. VA EM SharePoint. Emergency Medicine Management Tool User Manual. https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2

FResource%20Library%2FEmergency%20Medicine%20Management%20Tool%20%28EMMT%29. ***NOTE:*** *This is an internal VA website that is not available to the public.*

fff. VA EM SharePoint. Care of the Pregnant Patient. https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. ***NOTE:*** *This is an internal VA website that is not available to the public.*

ggg. VA EM SharePoint. Recommended Medical, Pharmacy and Laboratory Equipment Supplies for the ED. https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. ***NOTE:*** *This is an internal VA website that is not available to the public.*

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iii. VA EM SharePoint. Guide of Various Safety Observation Levels Available for Use. December 31, 2019. https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0. ***NOTE:*** *This is an internal VA website that is not available to the public.*

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kkk. VHA PG-18-19: Emergency Department Space Planning Criteria (Chapter 256). https://www.cfm.va.gov/til/space.asp.

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ooo. American College of Emergency Physicians (ACEP). Writing Admission and Transition Orders. October 1989: https://www.acep.org/patient-care/policy-statements/writing-admission-and-transition-orders/.

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qqq. Emergency Nurses Association (ENA). System-wide Strategies to Reduce Emergency Department Boarding. November 2017: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive. ***NOTE:*** *This is an internal VA website that is not available to the public.*

rrr. The Joint Commission. R3 Report Issue 4: Patient Flow Through the Emergency Department. December 2012: https://www.jointcommission.org/standards/r3-report/r3-report-issue-4-patient-flow-through-the-emergency-department/.

EMERGENCY MEDICINE INTERPROFESSIONAL TEAM AND STAFFING CRITERIA

This appendix states preferred staffing criteria for the Emergency Medicine (EM) interprofessional team. The appendices in Part II of VA Handbook 5005, Staffing, dated February 4, 2022, state underlying qualification standards for physicians, nurses and physician assistants (PAs). ***NOTE:*** *For additional information regarding credentialing and privileging requirements, see VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021, and VHA Directive 1100.21, Privileging, dated March 2, 2023.*

1. EMERGENCY MEDICINE CHIEF

The EM Chief should be board-certified by the American Board of Emergency Medicine (preferred), the American Osteopathic Board of Emergency Medicine (preferred), or board-certified in Internal Medicine (IM), or Family Medicine (FM), and possess comparable EM qualifications, training and experience.

2. EMERGENCY PHYSICIANS

Physicians credentialed and privileged to work in the ED should be board-certified in EM (preferred), IM or FM. If board-eligible in IM or FM, the physician should have sufficient experience in EM practice as deemed appropriate by the VA medical facility EM Chief.

3. EMERGENCY MEDICINE NURSE MANAGER

The EM Nurse Manager should meet the following criteria:

a. Be a registered nurse (RN) who demonstrates evidence of substantial experience, education and competency in emergency nursing.

b. Hold a current, full, and unrestricted RN license in any State, territory, or Commonwealth (i.e., Puerto Rico) of the U.S. or in the District of Columbia.

c. Graduate of a school of professional nursing approved by the appropriate State-accrediting agency and accredited by one of the following accrediting bodies at the time the program was completed by the applicant: The Accreditation Commission for Education in Nursing or The Commission on Collegiate Nursing Education.

d. Preferred education of either a Bachelor of Science in Nursing or Master of Science in Nursing or a related field. ***NOTE:*** *It is strongly encouraged that the EM Nurse Manager and Assistant Nurse Managers follow the Emergency Nurses Association recommendations of becoming a board-certified Emergency Nurse.*

4. NURSING

At minimum, two RNs designated to the ED with ED experience or current ED competencies must be physically present at all times. Each nurse working in the ED should have documented acute care experience and demonstrate evidence of the knowledge and skills deemed appropriate by the VA medical facility EM Nurse Manager. All nurses working in the ED must hold a current, full and unrestricted license to practice in any U.S. State or territory.

5. NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

NPs and PAs provide patient care either under a scope of practice or through credentials and privileges. A PA provides patient care under a scope of practice that includes physician collaboration. NPs and PAs staffing the ED should have documented clinical skills and credentials deemed appropriate by the VA medical facility EM Chief.

6. CLINICAL PHARMACY SPECIALISTS

The EM clinical pharmacy specialist (CPS) must be credentialed with a scope of practice, in alignment with VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015, with demonstrated training and competency in EM or critical care. With this advanced training and expertise in acute and chronic disease management, EM CPS work independently to deliver comprehensive medication management services following a medical screening examination by a physician, nurse practitioner (NP) or physician assistant (PA), and provide on demand medication expertise for the ED team. Dedicated, onsite CPS have been proven to expand access to care, increase patient safety and be cost-effective collaborative members of ED teams and it is therefore strongly recommended that dedicated CPS are integrated in all EDs.

7. INTERMEDIATE CARE TECHNICIANS

Intermediate care technicians (ICTs) are advanced Health Technicians who have graduated from intensive specialized military medical training programs who work under the supervision of licensed healthcare professionals to provide direct patient care within the Emergency Department (ED). Through demonstrated and documented evidence of education, training, and competencies, ICTs may assist or perform technical health care procedures including obtaining a patient's health history, assisting in evaluating the presenting condition and performing any necessary interventions based on symptoms and established protocols and standards of care. Additional information regarding ICTs is available at https://dvagov.sharepoint.com/sites/VHAOPCIandI/ICT/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

EMERGENCY MEDICINE INTERDISCIPLINARY SUPPORT SERVICES

1. PHARMACY

Medications need to be available 24 hours a day, 7 days a week for the Emergency Department (ED). Medications must be made available to ED patients through clearly defined process ownership via inpatient and/or outpatient pharmacies. The use of automated dispensing cabinets is encouraged to expedite administration of commonly used medications. Department of Veterans Affairs (VA) medical facility Emergency Medicine (EM) Chiefs must work closely with pharmacy administration to evaluate and determine medication needs and appropriate storage options for medications within the ED. For a recommended list of medications available to the ED, visit the EM SharePoint: *https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0*. ***NOTE:*** *This is an internal VA website that is not available to the public.*

2. LABORATORY

Laboratory testing must be available 24 hours a day, 7 days a week to all EDs. Additionally, on-site staff must be capable of performing standard laboratory testing or point of care critical tests, such as glucose and other studies as determined by the VA medical facility. Non-critical tests can be performed by on-call laboratory staff or through off-site contracted facilities. For a list of recommended laboratory capabilities in the ED, visit the EM SharePoint website: *https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FEM%20Directive&FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0*. ***NOTE:*** *This is an internal VA website that is not available to the public.*

a. VHA Directive 1106, Pathology and Laboratory Medicine Service, dated July 27, 2018, outlines the requirements that must be met to perform Clinical Laboratory Improvement Amendments (CLIA) Waived Laboratory Testing in EDs.

b. These tests must be performed under the purview of the VA medical facility laboratory, the VA medical facility Chief, Pathology and Laboratory Medicine Service and the ancillary testing coordinator to ensure the processes comply with all regulatory requirements. EDs must not apply for their own CLIA certificates. All testing performed is under the direct or indirect oversight of the Chief or Director of Pathology and Laboratory Medicine at the VA medical facility even if that VA medical facility has its own CLIA certificate. See VHA Directive 1106 for additional requirements for CLIA testing.

c. For outpatient laboratories, the ED should not serve as the default location for off-tour reporting. Appropriate mechanisms must be in place to allow notification to the ordering provider or their respective surrogate. If the ordering provider or their surrogate cannot be reached, clear processes must be in place to provide timely action on critical results and escalation of notification. Refer to the Communication of Test Results website for related resources: https://dvagov.sharepoint.com/sites/VHAOPCOps/Policy/CTR/SitePages/Home.aspx.
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d. Mechanisms must be in-place to provide notification of test results for patients receiving care in the ED, in accordance with VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated October 7, 2015.

3. COMPUTED TOMOGRAPHY SERVICES FOR EMERGENCY DEPARTMENT PATIENTS

Computed tomography (CT) diagnostic services are essential for the ED to detect life or limb threatening emergencies that may present at any time. CT diagnostic services must be available at all times for all VA EDs.

a. For Complexity 1a, 1b and 1c VA medical facilities, CT diagnostic services must be available in-house at all times.

b. For Complexity 2 and 3 VA medical facilities, it is highly recommended that CT coverage may be provided via an on-call mechanism or memorandum of understanding with a non-VA facility, provided that emergent studies can be conducted within 90 minutes of being ordered. Cases of exceptional delay or delay resulting in potential patient harm must be reviewed by the VA medical facility EM Chief in consultation with VA medical facility executive leadership.