Nurse practitioners in emergency medicine

Background

Nurse practitioners (NP) in emergency care address the needs of patients—individuals, families, and populations—across the lifespan. NPs in emergency care practice in a variety of primary, acute, and tertiary settings, including emergency departments (ED) in urban, suburban, and rural hospitals; trauma centers; ambulatory and medical mobile clinics; urgent and emergent care centers; air and ground transport services; prisons; and schools.

According to the Emergency Nurses Association (ENA), NPs in emergency care provide healthcare within an ethical framework, through assessment, diagnosis, and management of health/illness status, to persons of all ages who seek emergency care in an environment that is complex and unpredictable. NPs practice autonomously based on state regulation and engage in effective interdisciplinary collaboration with healthcare professionals.

In addition to diagnosing and managing acute episodic and acute exacerbations of chronic illnesses, NPs in emergency care provide health promotion, disease prevention, and injury prevention services to their patients and families. NPs in emergency care also teach and counsel patients and families and act as advocates, consultants, and researchers.

NPs in the ED are licensed RNs with advanced, specialized education in emergency care. To qualify for practice, they must have completed an accredited nursing educational program at the master’s, post-master’s, or doctorate level. There are currently seven NP programs in the United States that educate nursing students to practice specifically in emergency care settings.

In addition to graduate course completion, NPs in emergency care obtain further educational preparation through various pathways, including successful academic course completion, continuing education course completion, and/or on-the-job instruction in emergency care.

State laws regarding NPs’ training, certification, and scope of practice vary. Check with state entities when creating privileges for NPs in emergency care.

Involved specialties

Emergency medicine NPs
Positions of specialty boards

**BCEN**

The Board of Certification for Emergency Nursing (BCEN) offers the Certified Emergency Nurse Examination, which is the certification specific to emergency nursing. BCEN certifications provide designations to nursing professionals who demonstrate the knowledge essential to the specialty of emergency nursing care, associated specialties, and subspecialties.

To sit for the certification examination, applicants must have either a current, unrestricted RN license or nursing certificate that is equivalent to an RN in the United States or its territories. In addition, candidates must also have two years of experience in their related subspecialty.

The objectives of certification are to promote quality emergency nursing care by:

- Establishing a level of knowledge, competency, requirements, and achievements
- Measuring the attainment of a defined body of knowledge needed to function at the competent level
- Encouraging participation in continuing education
- Promoting professional development and career advancement
- Providing employers, patients, and peers a mechanism to recognize knowledgeable professionals
- Promoting self-confidence

Positions of societies, academies, colleges, and associations

**ENA**

The ENA published a document called *Competencies for Nurse Practitioners in Emergency Care*, which describes entry-level competencies for NPs practicing in emergency care, regardless of setting (e.g., urgent care, fast track, ED). This document was intended to supplement the core competencies for all NPs, as well as population-focused NP competencies.

With regard to the management of patient health/illness status, an NP should be able to:

- Triage patients’ health needs/problems
- Complete Emergency Medical Treatment and Active Labor Act (EMTALA)–specified medical screening examination
- Respond to the rapidly changing physiological status of emergency care patients
- Use current evidence-based knowledge and skills in emergency care for the assessment, treatment, and disposition of acute and chronically ill and injured emergency patients
- Specifically assess and initiate appropriate interventions for violence, neglect, and abuse (e.g., physical, psychological, sexual, substance)
➤ Specifically assess and initiate appropriate interventions and disposition for suicide risk
➤ Assess patient and family for levels of comfort (e.g., pain, palliative care, end of life, bad news) and initiate appropriate interventions
➤ Recognize, collect, and preserve evidence as indicated (e.g., forensic evidence)
➤ Order and interpret diagnostic tests
➤ Order pharmacologic and non-pharmacologic therapies
➤ Order and interpret electrocardiograms
➤ Order and interpret radiographs
➤ Assess response to therapeutic interventions
➤ Document assessment, treatment, and disposition

With regard to their professional role, NPs in emergency medicine should:
➤ Function as a direct provider of emergency care services
➤ Direct and clinically supervise the work of nurses and other healthcare providers
➤ Participate in internal and external emergencies, disasters, and pandemics
➤ Maintain awareness of known causes of mass casualty incidents and the treatment modalities required for emergency care
➤ Act in accordance with legal and ethical professional responsibilities (e.g., patient management, documentation, advance directives)

With regard to airway, breathing, circulation, and disability procedures, an NP in emergency medicine should be able to:
➤ Assess and manage a patient in cardiopulmonary arrest (e.g., neonatal resuscitation, leads code team, rapid response team)
➤ Assess and manage airway (e.g., endotracheal intubation, ventilated patients)
➤ Assess and obtain advanced circulatory access (e.g., intraosseous)
➤ Assess and manage patients with disability (e.g., neurologic)
➤ Assess and manage procedural sedation patients

With regard to skin and wound care procedures, an NP in emergency medicine should be able to:
➤ Perform ultraviolet examination of skin and secretions (e.g., Wood’s lamp)
➤ Treat skin lesions (e.g., foot callus, skin tag, plantar lesion, decubitus care)
➤ Inject local anesthetics
➤ Perform nail trephination
➤ Remove toenails (e.g., partial or complete removal for ingrown toenail)
➤ Perform a nail bed closure
➤ Perform closures (e.g., single layer, multiple, staple, adhesive)
➤ Revise a wound for closure
➤ Debride minor burns (e.g., non-adhering blister)
➤ Incise, drain, irrigate, and pack wounds
With regard to head, eye, ear, nose, and throat procedures, an NP in emergency medicine should be able to:
➤ Dilate eye(s)
➤ Perform fluorescein staining
➤ Perform tonometry to assess intraocular pressure
➤ Perform slit-lamp examination
➤ Perform cerumen impaction curettage
➤ Control epistaxis

With regard to the chest and abdomen, an NP in emergency medicine should be able to:
➤ Perform a needle thoracostomy for life-threatening conditions in emergency situations (e.g., tension pneumothorax)
➤ Replace a gastrostomy tube

With regard to neck, back, and spine procedures, an NP in emergency medicine should be able to:
➤ Clinically assess and manage cervical spine
➤ Perform lumbar puncture

With regard to gynecologic, genitourinary, and rectal procedures, an NP in emergency medicine should be able to:
➤ Incise and drain a Bartholin’s cyst
➤ Assist with imminent childbirth and postdelivery maternal care
➤ Remove fecal impactions
➤ Incise thrombosed hemorrhoids
➤ Perform sexual assault examination

With regard to extremity procedures, an NP in emergency medicine should be able to:
➤ Perform digital nerve block
➤ Reduce fractures of small bones (e.g., fingers, toes)
➤ Reduce fractures of large bones with vascular compromise (e.g., traction splint)
➤ Reduce dislocations of large and small bones
➤ Apply immobilization devices (e.g., splint)
➤ Bivalve/remove casts
➤ Perform arthrocentesis (e.g., knee, elbow)
➤ Measure compartment pressure

In addition to the competencies listed above, an NP in emergency medicine also should be able to:
➤ Perform radio communication with pre-hospital units
➤ Interpret patient diagnostics (e.g., vital signs, 12-lead ECGs) as communicated by pre-hospital personnel
➤ Remove foreign bodies (e.g., from orifices and soft tissue)
The American College of Emergency Physicians (ACEP) published a policy statement on the role of NPs in the ED. The statement, Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department, says that NPs provide services in various roles in EDs, including out-of-hospital patient care, patient triage, patient care in the ED, and selective administrative functions. The ACEP endorses the following guidelines for EDs that utilize NPs:

➤ Due to variations in state regulations, it is imperative that the emergency physician be aware of the scope of practice for NPs, including physician supervision where applicable.

➤ NPs working in EDs should have or acquire specific experience or specialty training in emergency care, should participate in a supervised orientation program, and should receive appropriate training and continuing education in providing emergency care. They should possess knowledge of specific ED policies and procedures. NPs must be aware of and participate in the performance improvement activities of the ED.

➤ NPs may be placed in clinical and administrative situations in which they will supplement and assist emergency physicians. NPs do not replace the medical expertise and patient care provided by emergency physicians.

➤ The NP's scope of practice must be clearly delineated and must be consistent with state regulations. This delineation should include a list of symptom complexes that may initially be evaluated and addressed by the NP. The delineation also should include a list of the medical procedures that NPs may perform:
  — Without consultation with the physician
  — Before consultation with the emergency physician
  — Only after consultation with the supervising emergency physician
  — Only under the direct supervision of an emergency physician

➤ Although NPs are sometimes required to work under the supervision of an emergency physician who is present and available for consultation in the ED, independent practice is authorized in some states. Each emergency physician shall determine which NP patient’s evaluation and care will be reviewed in greater detail prior to disposition in accordance with the defined NP scope of practice and state law. When such is required, the supervising physician for each NP encounter should be specifically identified. The ED medical director should define the number of NPs whose clinical work can be simultaneously supervised by one emergency physician, guided by ED clinical needs and state laws.

➤ The medical director of the ED or a designee has the responsibility of providing the overall direction of activities of the NP in the ED.

➤ Credentialing procedures for NPs in the ED must be specifically stated and must meet the requirements of the state or federal jurisdiction in which they practice and should be appropriately certified.
NONFP

The National Organization of Nurse Practitioner Faculties (NONPF) publishes general competencies for all NPs. Regardless of population focus, the NONPF states that all NPs should possess these competencies at the time of graduation from their programs. You can read the competencies by visiting www.nonpf.com/associations/10789/files/IntegratedNPCoreCompsFINALApril2011.pdf.

Position of accreditation bodies and regulatory agencies

CMS

CMS has no formal position concerning the delineation of privileges for emergency medicine NPs. However, CMS’ Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6), stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them. Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.
CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

In addition, CMS includes in the surgical services standards §482.51(a)(4) that hospitals must specify surgical privileges for each practitioner who performs surgical tasks. The CoPs go on to state that “if the hospital utilizes registered nurse first assistants (RNFA)s, surgical physician assistants (PA)s, or other non MD/DO surgical assistants, then the organization must establish qualifications, criteria, and a credentialing process to grant specific privileges … Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines.”

The Joint Commission

The Joint Commission (formerly JCAHO) has no formal position concerning the delineation of privileges for emergency medicine NPs. However, in its Comprehensive Accreditation Manual for Hospitals, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

According to the Joint Commission standards, hospitals must, at a minimum, credential and privilege all licensed independent practitioners (LIP)—practitioners who are permitted by law and by the healthcare organization to provide patient care without supervision or direction.

The practitioners who are considered LIPs vary by state, but all states regard physicians, dentists, and podiatrists as LIPs. In some states, clinical psychologists, and APRNs (which may include CNSs) are considered LIPs by license. However, these disciplines may or may not function independently within acute care organizations. Because hospital patients’ acuity levels are much higher, hospitals may require psychologists and APRNs such as certified registered nurse anesthetists, CNSs, nurse practitioners, and certified nurse-midwives to function under physician sponsorship, a collaborative agreement, or supervision.
Nurse practitioners in emergency medicine

Practice area 408

APRNs and physician assistants providing a medical level of care must be privileged through the medical staff process as outlined in the Joint Commission standards. The following comments are specific to the Joint Commission medical staff privileging process.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

➤ Developing and approving a procedures list
➤ Processing the application
➤ Evaluating applicant-specific information
➤ Submitting recommendations to the governing body for applicant-specific delineated privileges
➤ Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
➤ Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

➤ The need for all LIPs who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
➤ Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
➤ A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
➤ A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
➤ A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
➤ Updating of information regarding any changes to practitioners’ clinical privileges as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current license status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for NPs in emergency medicine. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.
It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

Specific to allied health professionals (AHP), HFAP requires that the privileges, responsibilities, and duties be consistent with federal and state regulations (and limitations) for the discipline and that they do not exceed the scope allowed. The privileging form(s) must identify those privileges requiring physician supervision—direct or indirect—and include co-signature requirements.

AHP files must contain applicable laws, codes, or regulations that govern the scope of practice for the AHP, or the hospital may establish a central file in human resources or the medical staff office for this purpose.

Supervision of AHPs must be consistent with state law and specified in a policy (i.e., ratio of physicians to AHPs).

All AHPs authorized to provide care must have an annual competence/skill assessment.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.
The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

Det Norske Veritas (DNV) has no formal position concerning the delineation of privileges for NPs in emergency medicine. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4). Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

Specific to AHPs, DNV follows CMS by stating that “all practitioners performing surgery shall have surgical privileges.”
CRC draft criteria

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this practice area. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

Minimum threshold criteria for requesting core privileges for NPs in emergency medicine

Basic education: Completion of a master’s, post-master’s, or doctorate from an NP program accredited by the Commission on the Collegiate of Nursing Education or the National League for Nursing Accrediting Commission with emergency medicine concentration,

AND

Current certification by the American Nurses Credentialing Center or an equivalent body,

AND

Current active licensure to practice as an advanced practice RN in the NP category in the state in which the applicant resides,

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the governing body,

AND

Current basic life support (BLS), advanced cardiac life support (ACLS), trauma nursing core course, and PALS certification, or emergency nurse pediatric course,

AND

Required current experience: Demonstrated current competence and provision of care, treatment, or services for an adequate volume of patients in the past 12
months, or completion of master’s/post-master’s degree program in the past 12 months. Experience must correlate to the privileges requested.

References
If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently worked.

Core privileges in NP—emergency medicine
Core privileges for NPs in emergency medicine include the ability to assess, evaluate, diagnose, promote health and protection from disease, stabilize, manage, and treat acute and chronically ill and injured patients of all ages who present in the ED with any symptom, illness, injury, or condition. Privileges do not include long-term care of patients on an inpatient basis. The core privileges in this specialty include the following procedures and such other procedures that are extensions of the same techniques and skills:

Patient management
➤ Perform history and physical exam
➤ Administer medications and perform other emergency treatment
➤ Assess for levels of comfort (e.g., pain, palliative care, end of life, bad news) and initiate appropriate interventions
➤ Complete EMTALA-specified medical screening examination
➤ Counsel and instruct patients, families, and caregivers as appropriate
➤ Direct care as specified by medical staff–approved protocols
➤ Initiate appropriate referrals
➤ Order and initial interpretation of diagnostic testing and therapeutic modalities, such as laboratory tests, medications, hemodynamic monitoring, treatments, x-ray, EKG, IV fluids and electrolytes, etc.
➤ Perform sexual assault examination
➤ Record progress notes
➤ Specifically assess and initiate appropriate interventions for violence, neglect, and abuse (e.g., physical, psychological, sexual, substance)
➤ Specifically assess and initiate appropriate interventions and disposition for suicide risk
➤ Triage patients’ health needs/problems
➤ Dictate discharge summaries

Anesthesia
➤ Inject local anesthetics
➤ Perform regional nerve block and digital nerve block
**Diagnostic procedures**

➤ Anoscopy
➤ Arthrocentesis (e.g., knee, elbow)
➤ Compartment pressure measurement
➤ Insert and remove nasogastric tube
➤ Perform slit-lamp examination
➤ Tonometry

**Genital/urinary**

➤ Perform urinary bladder catheterization (e.g., Foley, suprapubic)

**Head and neck**

➤ Control of epistaxis
➤ Removal of rust ring

**Resuscitation**

➤ Cardiopulmonary resuscitation
➤ Neonatal resuscitation

**Hemodynamic techniques**

➤ Insert and remove arterial catheters
➤ Insert and remove central venous catheters
➤ Intraosseous infusion
➤ Peripheral venous cutdown

**Skin and wound care management**

➤ Apply, remove, and change dressings and bandages
➤ Debridement, suture, and general care for superficial wounds and minor superficial surgical procedures
➤ Laceration repair—simple, intermediate, complex

**Obstetrics**

➤ Assist with imminent childbirth and postdelivery maternal care

**Other techniques**

➤ Arterial puncture and blood gas sampling
➤ Perform excision of thrombosed hemorrhoids
➤ Remove foreign bodies (ears, nose, rectum, soft tissue, throat, vaginal)
➤ Replace gastrostomy tube
➤ Incision and drainage of abscess
➤ Insert Heimlich (small gauge) valve
➤ Perform ear, nose, rectum, soft tissue, throat, vaginal, and gastric lavage
➤ Perform venous punctures for blood sampling, cultures, and IV catheterization
➤ Trephination of nails and removal of nails

*Skeletal procedures*

➤ Fracture/dislocation immobilization techniques (e.g., casting, splinting)
➤ Fracture/dislocation reduction techniques
➤ Spine immobilization techniques

*Special requests for NPs in emergency medicine*

In addition, there are several noncore privileges that may be requested:
➤ Administration of sedation and analgesia
➤ Perform lumbar puncture
➤ Perform endotracheal extubation and intubation
➤ Perform thoracentesis
➤ Perform paracentesis
➤ Insert thoracostomy tube
➤ Prescriptive authority

*Reappointment*

To be eligible to renew privileges as an NP in emergency medicine, the applicant must demonstrate competence and an adequate volume of experience for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Experience must correlate to the privileges requested. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, current certification by the American Nurses Credentialing Center or an equivalent body and maintenance of BLS, ACLS, and PALS certification are required.

*Affiliation with medical staff/physician involvement*

[Note: This section may not be applicable in some organizations. If the NP is practicing independently and a signed collaborative or supervising agreement is not required by law or by the organization, this section is not applicable.]

The exercise of these clinical privileges requires a designated collaborating/supervising physician with clinical privileges at the hospital in the same area of specialty practice. All practice is performed in accordance with a written agreement and policies and protocols developed and approved by the relevant clinical department or service, the medical executive committee, nursing administration,
and the governing body. A copy of the written agreement signed by both parties is to be provided to the hospital.

In addition, the collaborating/supervising physician must:
➤ Participate as requested in the evaluation of competency (i.e., at the time of reappointment and, as applicable, at intervals between reappointment, as necessary)
➤ Be physically present on hospital premises or readily available by electronic communication or provide an alternate to provide consultation when requested and to intervene when necessary
➤ Assume total responsibility for the care of any patient when requested or required by the policies referenced above or in the interest of patient care
➤ Sign the privilege request of the practitioner he or she supervises, accepting responsibility for appropriate supervision of the services provided under his or her supervision, and agree that the supervised practitioner will not exceed the scope of practice defined by law and the written agreement
➤ Cosign entries on the medical record of all patients seen or treated by the supervised practitioner in accordance with organizational policies

For more information

American Academy of Nurse Practitioners Certification Program
Capitol Station, P.O. Box 12926
Austin, TX 78711
Telephone: 512/442-5202
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American Association of Colleges of Nursing
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Fax: 202/785-8320
Website: www.aacn.nche.edu

American College of Emergency Physicians
1125 Executive Circle
Irving, TX 75038-2522
Telephone: 800/798-1822
Fax: 972/580-2816
Website: www.acep.org
American Nurses Credentialing Center
2209 Dickens Road
Richmond, VA 23230
Telephone: 804/565-6333
Fax: 804/282-0090
Website: www.acopeds.org

Board Certification for Emergency Nurses
915 Lee Street
Des Plaines, IL 60016-6569
Telephone: 877/302-2236
Website: www.ena.org/BCEN/Pages/default.aspx

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877/267-2323
Website: www.cms.hhs.gov

DNV Healthcare, Inc.
400 Techne Center Drive, Suite 350
Milford, OH 45150
Website: www.dnvaccreditation.com

Emergency Nurses Association
915 Lee Street
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Telephone: 800/900-9659
Website: www.ena.org

Healthcare Facilities Accreditation Program
142 East Ontario Street
Chicago, IL 60611
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