Department of Health and Wellness
Emergency Care Standards
April 2014

NOVA SCOTIA
Health and Wellness

Background
In September 2009, the Nova Scotia government appointed Dr. John Ross as its provincial advisor on emergency care. Dr Ross's report, *The Patient Journey Through Emergency Care in Nova Scotia* contained 26 recommendations to improve emergency care in the province. As a follow-up to his report, Dr. John Ross also developed minimum care standards for emergency care in November 2010.

In response to Dr. Ross's recommendations, *Better Care Sooner: The Plan to Improve Emergency Care* was released in December 2010 by the Department of Health and Wellness (DHW). Adoption and implementation of the Emergency Care (EC) Standards is one of the action items in the plan.

As part of the implementation of Better Care Sooner, a project team comprising of representatives from the DHW and District Health Authorities (DHA) was struck to provide a coordinated provincial approach to achieving a common understanding of the standards and to facilitate monitoring and compliance. The team reviewed the EC standards developed by Dr. Ross for clarity, common understanding and measurability.

As a result of the work of this committee, the following set of minimum standards has been established by the DHW for emergency departments across Nova Scotia. DHA are responsible for ensuring that these standards are achieved and maintained. Nova Scotia will be the first province to adopt and implement such standards by December 2014.

To enable consistent measurement and reporting of DHA compliance across the province, a comprehensive set of Compliance & Reporting Requirements were also developed. The Requirements include indicators, reporting frequencies, and definitions to further clarify and facilitate uniform measurement by the emergency care providers.

DHW will work collaboratively with DHA to develop implementation plans and priorities to support DHA achievement of the Standards by 2014. DHW will put reporting processes and mechanisms in place to leverage information technology systems, and minimize data collection and reporting efforts within the DHA where possible.

Nova Scotia Emergency Care Standards
The purpose of the provincial EC Standards is to provide consistency and high quality care in the emergency care system in Nova Scotia. The standards are intended for the staff and management that work in the emergency departments. The standards are meant to complement the Accreditation standards on Emergency Department Services and Trauma Association of Canada standards.

The standards in this document focus on:

• ***Access*** – Access standards will help ensure that people can get emergency care regardless of what community they call home in Nova Scotia.

• ***Triage*** – Triage standards will ensure that all patients will be assessed using the same criteria. These standards apply to all healthcare workers who are responsible for triage in provincial, regional, and community emergency departments.

• ***Transfer*** – Transfer standards will provide an appropriate protocol for transferring a patient to another facility when the type of emergency care is more complex than the type of care normally provided at that facility.

• ***Staffing Qualifications*** – Standards for staff qualifications will support quality care delivery by all healthcare professionals who work in emergency care. Standard qualifications are dependent on where the healthcare professional works. In hospitals that are set up to deal with more complex emergency cases, standards will reflect that level of care. The standards require doctors, nurses, and paramedics to have accreditations, continuing education requirements set out by their professional Colleges, and up-to-date adult and pediatric emergency procedures. These standards will mean better-quality patient care in all regions.

• ***District Health Authority Performance*** – Performance standards will ensure that District Health Authorities provide unrestricted access to emergency care by providing timely assessment, reassessment if necessary, and management of emergency medical and surgical conditions to promote efficient patient flow through the emergency department. Each of the nine District Health Authorities and the IWK must meet requirements for a common information management system to allow performance monitoring.

• ***Clinical Personnel Practice Quality Review*** – Performance reviews will help ensure consistency of care and ensure that emergency health-care professionals are practicing the latest in emergency care. Standards include requirements for a performance review every two years for physicians and all other staff treating patients in emergency departments.

• ***Patient Satisfaction*** – Standards for patient satisfaction will provide guidance for continuous improvement in emergency care. Measures of satisfaction include communications skills of emergency department staff, information and explanation of waiting times, and reduction in waiting times.

• ***Space and Equipment*** – Standards for emergency department equipment will ensure that each facility will be able to respond appropriately to emergencies that come through its doors.

• ***Quality and Safety*** – Each of the nine District Health Authorities and the IWK must meet requirements for surge capacity, disaster or mass casualty events, quality, and patient safety protocols such as end-of-shift care responsibilities and medication safety.

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STD #	STANDARD
1.0 Access	
1.1	A 24/7 Emergency Department should be accessible within approximately one hour's drive under average driving conditions for 95 per cent of the residents of Nova Scotia. **DHA REPORTING NOT REQUIRED**
2.0 Triage	
2.1	All Tertiary, Regional, and Community Emergency Departments and CECs must use the Canadian Triage Acuity Scale (CTAS) when first assessing patients.
2.2	The CTAS targets for immediate assessment are met, and ongoing assessment occurs.
2.3	Initial assessment and triage occur prior to patient registration and/or other administrative processes.
3.0 Transfer	
3.1	All Emergency Care sites provide care on site and/or find the most appropriate level of care for their patients in accordance with triage principles and hospital destination policies.
4.0 Staffing Qualifications	
4.1	All Emergency Department providers performing triage have current CTAS training.
4.2	All staff in Tertiary, Regional, Community, and CEC sites must be familiar with the varied presentation of mental health disorders, rapid risk assessment, the interplay of medical problems, and substance abuse. They also must be familiar with the unique needs of the senior's population, patients with complex conditions, marginalized patients and culturally and linguistically diverse patients. They must also develop the skills needed to provide culturally appropriate care.
4.3	Tertiary (QEII/IWK) - Physicians must be certified by the Royal College of Physicians and Surgeons of Canada in Emergency Medicine or Pediatrics, or the College of Family Physicians of Canada with Special Competence in Emergency Medicine, or the American Board of Emergency Medicine.
4.4	Tertiary (QEII/IWK) - All physicians must meet annual requirements of their respective specialty colleges, including continuing education. In addition they must maintain hospital and university credentialing requirements. **DHA REPORTING NOT REQUIRED**
4.5	Tertiary - QEII Physicians must have current certification in Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) and Advanced Airway Management training or provincially approved equivalents. IWK Physicians must have current certification in Pediatric Advanced Life Support (PALS) and ATLS and Advanced Airway Management training or provincially approved equivalents.
4.6	Tertiary - RNs and NPs must have the Trauma Nursing Core Course (TNCC) or provincially approved equivalent. QEII RNs and NPs must have current ACLS certification or provincially approved equivalent. IWK RNs and NPs must have current PALS, Emergency Nursing Pediatric Course (ENPC) certification or provincially approved equivalent. ENP is strongly recommended for new grad RNs and nurses new to the ED. LPNs must have current BLS certification or a provincially approved equivalent.
4.7	Paramedics employed by the District Health Authority, working in the ED setting, must be licensed and registered under the appropriate regulatory body for Department of Health and Wellness (i.e. EHS). **DHA REPORTING NOT REQUIRED**

4.8	Regional – Certified Emergency Physicians (RCPSC, CFPC-EM, ABEM) must meet the requirements of their respective specialty colleges, including continuing education. **DHA REPORTING NOT REQUIRED**
4.9	Regional - Physicians (CFPC) who are not certified by the Royal College of Physicians and Surgeons of Canada in Emergency Medicine or Pediatrics, or the College of Family Physicians of Canada with Special Competence in Emergency Medicine, or the American Board of Emergency Medicine, must practice within their scope of knowledge and skill and demonstrate to the Department Chief some evidence of continuing education specific to Emergency Medicine as established by the Provincial Emergency Care Advisory Committee.
4.10	Regional Physicians must have current certification in ACLS and ATLS and Advanced Airway Management training and PALS or provincially approved equivalents.
4.11	Regional - RNs and NPs must have current certification in ACLS and TNCC and PALS or ENPC or provincially approved equivalent. ENP is strongly recommended for new grad RNs and nurses new to the ED. LPN must have current Basic Life Support (BLS) certification or a provincially approved equivalent.
4.12	Community - RNs and NPs must have current certification in ACLS and TNCC and PALS or ENPC or provincially approved equivalent. ENP is strongly recommended for new grad RNs and nurses new to the ED. LPNs must have current BLS certification or a provincially approved equivalent.
4.13	CEC - RNs and NPs must have current certification in ACLS and PALS or ENCP, or provincially approved equivalent. LPNs must have current BLS certification or a provincially approved equivalent.
4.14	Community - All physicians must have current certification in ATLS and ACLS and Advanced Airway Management training, and PALS or provincially approved equivalents.
4.15	CEC - All physicians must have current certification in ACLS and PALS or provincially approved equivalent.
4.16	Community – The District Chief of Emergency Med must confirm annually that all physicians participate in continuing education specific to core Emergency Medicine knowledge and skills. **DHA REPORTING NOT REQUIRED**
4.17	Credentialing Committees credentialing new Family Medicine Graduates to work in a Community or Regional ED must fulfill the following requirements and be specifically credentialed by the District Health Authority for emergency department practice.
	a) Successfully complete the mandatory rotation in Emergency Medicine during the first-year residency program and two months elective in Emergency Medicine or one month of Emergency Medicine and at least one month of Anesthesia or Critical Care during the second year. Following successful completion of Certification in Family Medicine, the new graduate must be specifically credentialed by the District Health Authority for emergency department practice
	OR
	b) Successfully complete the Certification in Family Medicine by the CFPC, including the mandatory rotation in first-year residency in Emergency Medicine (unless practice eligible), and demonstrate evidence of up-to-date ACLS, ATLS, and APLS. Before working independently in any ED, the physician shall work in the closest Regional ED under the supervision of an experienced emergency physician until that physician is satisfied that the family physician is prepared for independent emergency department practice. In addition, The District Chief of Emergency Medicine must ensure that the family physician has demonstrated competence in advanced airway techniques including:

	• One- and two-person bag mask ventilation • Use of airway adjuncts, including OPA and NPA • Use of rescue airways (e.g., LMA, King LT) • Laryngoscopy and endotracheal intubation with in-line c-spine stabilization • Use of the bougie • Surgical airway technique(s)
5.0 District Health Authority Performance	
5.1	Hospital staff must accept responsibility for patient care from EHS paramedics within 20 minutes of arrival in the destination Emergency Department, 90 per cent of the time.
5.2	Total length of stay in the Emergency Department from triage to ED departure (admission or discharge) should be eight hours or less 90 per cent of the time for patients CTAS 1–3, and four hours or less 90 per cent of the time for patients CTAS 4 and 5.
5.3	Patients at sites with a Clinical Decision Unit (CDU), who are being observed or receiving active treatment with the goal of discharge in less than 24 hours from triage to departure, are assigned to a virtual or physical CDU bed.
5.4	Patients admitted to an inpatient unit from the emergency department must not wait longer than 24 hours from time of triage to departure from the ED.
5.5	ED staff must initiate all inpatient services, including consultations and therapies, for admitted patients who remain in the ED.
5.6	Total time from Emergency Physician consult request to the decision to admit or discharge the patient must be two hours or less 90 per cent of the time between 0800 and 2259. Emergency Physician consults must occur by 1000 the following day 90 per cent of the time for consult requests made between the hours of 2300 and 0759.
5.7	All Emergency Departments are to use a common information management system that allows for performance monitoring.
6.0 Clinical Personnel Practice Quality Review	
6.1	All full-time and part-time physicians working in Tertiary, Regional, and Community EDs and CECs, must have a performance review of their ED work no less than every two years completed by the Site Chief or DHA designate. The review must, in part, confirm that all physicians participate in continuing education specific to core Emergency Medicine knowledge and skills.
6.2	ED Quality Review Committees, if not already in place, should be established within each DHA, and have representation from each site within the district. Quarterly reviews should be completed with non-patient-specific action items, remediation plans identified, and implementation and evaluation of action items follow-up documented.
6.3	All clinical Emergency Department staff have a performance review no less than every two years, that includes evaluation of their clinical work.
6.4	At Tertiary and Regional Sites: A process for monthly or quarterly case-based interdisciplinary Morbidity & Mortality rounds is in place.
7.0 Patient Satisfaction	
7.1	Each site must determine and improve patient satisfaction through a statistically valid surveying process.
8.0 Space and Equipment	
8.1	Tertiary and Regional EDs have 24/7 timely access to DI including plain radiography, CT, and ultrasound and support from radiology within the district.
8.2	EDs have space and equipment available to care for their patient populations as per the site-specific Space and Equipment Requirements in Appendix 1.

8.3	The Emergency Department is used for response to unexpected illness or injury, and not for preplanned or pre-booked procedures.
9.0 Quality and Safety	
9.1	Each site has a policy and process (es) in place for responding to overcapacity events/situations, using a whole-hospital approach.
9.2	Inter-site, inter-district and intra-district processes are in place to coordinate a response to emergency events, such as a mass casualty event.
9.3	ED related Quality and Safety committees regularly report through to the DHA and the Provincial Emergency Care Advisory Committee (PECAC).
9.4	Systems are in place to reduce medication errors.
9.5	There is a process for transfer of information among providers and between shifts.

Appendix 1
8.2 Space and Equipment Requirements
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	Emergency Department Standard Space and Equipment Recommendations			
	SPACE	CECs	Community	Regional Tertiary
1.	Safe & secure area for mental health assessment and treatment	X	X	X
2.	Spinal immobilization	X	X	X
3.	Injured limb splints, casting	X	X	X
4.	Wound management – suturing, dressing	X	X	X
5.	Procedural sedation		X	X
	EQUIPMENT			
6.	Oral and nasal airways	X	X	X
7.	Bag-mask-ventilator	X	X	X
8.	Oxygen	X	X	X
9.	Oxygen masks and nasal cannulae	X	X	X
10.	Portable CPAP		X	X
11.	Supraglottic airway device(s)	X	X	X
12.	Endotracheal airway devices		X	X
13.	Surgical airway device(s)		X	X
14.	Chest tube tray	X	X	X
15.	Intravenous lines, peripheral	X	X	X
16.	Intraosseous needles	X	X	X
17.	Blood Pressure measuring devices	X	X	X
18.	Inflatable intravenous pressure bags		X	X
19.	IV pumps, warmers, pressure infusor		X	X
20.	Refrigerated type O blood		+/-	X
21.	Arterial line system		X	X
22.	Central line tray (RN familiar with set-up)		X	X
23.	Poisoning antidote kit		X	X
24.	Orogastric lavage tray		X	X
25.	Foley catheter tray	X	X	X
26.	Pulse oximeter	X	X	X
27.	AED	X		
28.	Cardiac monitor/defibrillator/pacer		X	X
29.	12-lead ECG	X	X	X
30.	Broselow tape for pediatrics	X	X	X
31.	Broselow-coloured bags of equipment		X	X
32.	Foreign body in the eye removal equipment	X	X	X
33.	Ophthalmoscope, ENT exam tools	X	X	X
34.	Slit lamp for ophthalmic exam	X	X	X
35.	Intraocular pressure measuring device	X	X	X
36.	CT scan			X
37.	Ultrasound - bedside		+/-	X***
38.	X-ray machine available for plain films	DHAs should have a defined strategy for access to the lab tests and diagnostic imaging to support urgent and emergent care within a clinically appropriate timeframe. The strategy could include having the test available on site, plans to have the test performed at a nearby facility or transfer of the patient.		
39.	Ultrasound – radiology department			
40.	Point of care tests			
41.	Laboratory			

	LEGEND
	X mandatory
	+/- optional
	*** requires special certification