UNIVERSITY HOSPITAL AND HEALTH SYSTEM
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street, Jackson MS 39216

PEDIATRIC EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name: _____

☐ Initial Appointment
☐ Reappointment

All new applicants must meet the following requirements as approved by the governing body effective: *1/6/2016*

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document. Site-specific services may be defined in hospital and/or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional governance (MS Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR PEDIATRIC EMERGENCY MEDICINE

To be eligible to apply for core privileges in Pediatric Emergency Medicine, the initial applicant must meet the following criteria:

Current specialty certification in pediatrics by the American Board of Pediatrics or American Osteopathic Board of Pediatrics

OR

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in pediatrics and active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to specialty certification in pediatrics by the American Board of Pediatrics or American Osteopathic Board of Pediatrics.

AND

All applicants must meet <u>one</u> of the following three qualifications:

1. ATLS or PALS certification;

   OR

2. Successful completion of an ACGME accredited fellowship in pediatric emergency medicine;

   OR

3. Current subspecialty certification in pediatric emergency medicine by the American Board of Pediatrics.

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Required Previous Experience: Applicants for initial appointment must be able to demonstrate they have provided pediatric emergency medicine services reflective of the scope of privileges requested to a sufficient volume of patients in the past 24 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Reappointment Requirements: To be eligible to renew core privileges in Pediatric Emergency Medicine, the applicant must meet the following Maintenance of Privilege Criteria:

Current demonstrated competence and a sufficient volume of experience, with acceptable results, reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges. Medical Staff members whose board certificates in pediatrics or pediatric emergency medicine bear an expiration date shall successfully complete recertification no later than three (3) years following such date. For members whose certifying board requires maintenance of certification in lieu of renewal, maintenance of certification requirements must be met, with a lapse in continuous maintenance of no greater than three (3) years.

CORE PRIVILEGES

PEDIATRIC EMERGENCY MEDICINE CORE PRIVILEGES

☐ **Requested** Assess, evaluate, diagnose and initially treat pediatric patients who present in the ED with any symptom, illness, injury or condition and provide services necessary to ameliorate minor illnesses or injuries; stabilize patients with major illnesses or injuries and to assess all patients to determine if additional care is necessary. Privileges do not include long-term care of patients on an in-patient basis. No privileges to admit or perform scheduled elective procedures with the exception of procedures performed during routine emergency room follow-up visits. The core privileges in this specialty include the procedures on the attached procedure list.

CHECK HERE TO REQUEST THE PRIVILEGE DELINEATION FORM FOR PEDIATRIC INPATIENT PRIVILEGES.

☐ **Requested**

SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

If desired, Non-Core Privileges are requested individually in addition to requesting the Core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

ADMINISTRATION OF SEDATION AND ANALGESIA

☐ **Requested** See Hospital Policy for Procedural Sedation by Non-Anesthesiologists for additional information.

- **Section One--INITIAL REQUESTS ONLY:**
  - ☐ Completion of residency or fellowship in anesthesiology, emergency medicine or critical care **-OR-**

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☐ Completion of residency or fellowship within the past year in a clinical subspecialty that provides training in procedural sedation training **-OR-**

☐ Demonstration of prior clinical privileges to perform procedural sedation along with a good-faith estimate of at least 20 such sedations performed during the previous year:
_____

_____
-OR-

☐ Successful completion (within six months of application for privileges) of a UMHC-approved procedural sedation training and examination course that includes practical training and examination under simulation conditions.

- **Section Two--INITIAL AND RE-PRIVILEGING REQUESTS:**

☐ Successful completion of the UMHC web based Procedural Sedation Course/Exam initially and at least once every two years **-AND-**

Provision of a good-faith estimate of the number of instances of each type of procedure where sedation is administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:
_____

_____

–AND-

☐ ACLS, PALS and/or NRP, as appropriate to the patient population. **(Current)**

–OR-

☐ Maintenance of board certification or eligibility in anesthesiology, emergency medicine or critical care specialties, as well as active clinical practice in the provision of procedural sedation

Section Three--PRIVILEGES FOR DEEP SEDATION:

☐ I am requesting privileges to administer/manage deep sedation as part of these procedural sedation privileges.
Deep Sedation/Anesthetic Agents used: _____

_____

APPLICABLE TO REQUESTS FOR DEEP SEDATION ONLY:
I have reviewed and approve the above requested privileges based on the provider's critical care, emergency medicine or anesthesia training and/or background.

_____ _____
Signature of Anesthesiology Chair Date

PEDIATRIC EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name: _____

ULTRASOUND-GUIDED CENTRAL LINE INSERTION

☐ **Requested** See Medical Staff Policy for Ultrasound-Guided Central Line Insertion for additional information.

Initial Privileging:

As for core privileges plus:

- Performance of at least 10 ultrasound-guided central line insertions in the past 24 months; and
- Completion of a UMMC ultrasound-guided central line insertion Healthstream learning module

Maintenance of Privilege:

As for core privileges plus:

- Performance of at least 10 ultrasound-guided central line insertions in the past 24 months; and
- Completion of a UMMC ultrasound-guided central line insertion Healthstream learning module

If volume requirements are not met, the following may substitute:

- Completion of ultrasound-guided central line insertion simulation training in the UMMC Simulation and Interprofessional Education Center; and
- Focused professional practice evaluation to include proctoring of the ultrasound-guided insertion of at least 5 central lines (femoral or internal jugular) within the first 6 months of re-appointment

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Name: _____

CORE PROCEDURE LIST

To the applicant: If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, initial, and date.

- Abscess incision and drainage
- Airway management and intubation
- Arterial puncture and cannulation
- Arthrocentesis
- Basic and advanced cardiopulmonary resuscitation
- Bladder decompression and catheterization techniques
- Blood component transfusion therapy
- Burn management, including escharotomy
- Cardiac pacing to include, but not limited to, external, transthoracic, transvenous
- Cardioversion (synchronized counter shock)
- Central venous access: femoral, jugular, peripheral, internal, subclavian, and cutdowns (femoral and internal jugular access require special privileges for ultrasound guided central line insertion)
- Cricothyrotomy
- Defibrillation
- Dislocation/fracture reduction/immobilization techniques, including splint and cast applications
- Electrocardiography interpretation
- Emergency ultrasound as an adjunct to privileged procedure
- Endotracheal intubation techniques
- Evaluation of oliguria
- Fluid, electrolyte management
- GI decontamination (emesis, lavage, charcoal)
- Hernia reduction
- I & D abscess
- Interpretation of antibiotic levels and sensitivities
- Intraosseous infusion
- Irrigation and management of caustic exposures
- Laryngoscopy, direct, indirect
- Lumbar puncture
- Management of anaphylaxis and acute allergic reactions
- Management of epistaxis
- Nail trephine techniques
- Nasal cautery/packing
- Nasogastric/orogastric intubation
- Order respiratory services
- Order rehab services
- Oxygen therapy
- Paracentesis
- Pericardiocentesis
- Perform history and physical exam
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Peripheral venous cutdown

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Name: _____

- Preliminary interpretation of imaging studies
- Removal of foreign bodies, airway including nose, eye, ear, soft instrumentation/irrigation, skin or subcutaneous tissue
- Repair of lacerations
- Resuscitation
- Slit lamp used for ocular exam
- Spine immobilization
- Telehealth
- Thoracentesis
- Thoracostomy tube insertion
- Thoracotomy, open for patient in extremis
- Tracheostomy
- Wound debridement
- Use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry

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ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at University Hospital and Health System University of Mississippi Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed _____ ***Date*** _____

TRAUMA DIRECTOR'S RECOMMENDATION (AS APPLICABLE)

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Trauma Director's Signature _____ ***Date*** _____

PEDIATRIC EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name: _____

DIVISION CHIEF'S RECOMMENDATION (AS APPLICABLE)

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Division Chief Signature_____ ***Date***_____

CREDENTIALS COMMITTEE REPRESENTATIVE'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Credentials Representative's Signature_____ ***Date***_____

PEDIATRIC EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Department Chair Signature _____ ***Date*** _____

Reviewed:

Revised:
2/3/2010, 9/17/2010, 12/16/2011, 1/4/2012, 2/1/2012, 4/4/2012, 11/07/2012, 4/3/2013, 8/05/2015, 1/6/2016