Policy Statements

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Patient- and Family-Centered Care and the Role of the Emergency Physician Providing Care to a Child in the Emergency Department
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Disaster Medical Response
Approved by the ACEP Board of Directors June 2006.

Interpretation of Imaging Diagnostic Studies
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Patient- and Family-Centered Care and the Role of the Emergency Physician Providing Care to a Child in the Emergency Department

[Ann Emerg Med. 2006;48:643-645.]

ABSTRACT. Patient- and family-centered care (PFCC) is an approach to health care that recognizes the role of the family in providing medical care, encourages collaboration between the patient, family, and health care professionals; and honors individual and family strengths, cultures, traditions, and expertise. Although there are many opportunities for providing PFCC in the emergency department, there are also challenges to doing so. The American Academy of Pediatrics and American College of Emergency Physicians support the following: promoting patient dignity, comfort, and autonomy; recognizing the patient and family as key decision makers in the patient's medical care; recognizing the patient's experience and perspective in a culturally sensitive manner; acknowledging the interdependence of child and parent as well as the pediatric patient's evolving independence; encouraging family member presence; providing information to the family during interventions; encouraging collaboration with other health care professionals; acknowledging the importance of the patient's medical home; and encouraging institutional policies for PFCC.

Key words: patient- and family-centered care, family-centered care, family member presence, cultural sensitivity, pediatric patient's medical home.

Introduction

Patient- and family-centered care (PFCC) is an approach to health care that recognizes the integral role of the family and encourages mutually beneficial collaboration among the patient, family, and health care professionals. PFCC ensures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions, and expertise that all members of this partnership bring to the relationship. PFCC is the standard of practice that results in high-quality services.[1] PFCC embraces the concepts that 1) we are providing care for a person, not a condition; 2) the patient is best understood in the context of his or her family, culture, values, and goals; and 3) honoring that context will result in better health care, safety, and patient satisfaction.

Although there are many opportunities for providing PFCC in the emergency department (ED), there are significant challenges to doing so.[2] Overcrowding and acuity in the ED may result in delay or disruption of care, challenging the ability of ED staff to provide respectful and sensitive care. The lack of a previous relationship between patient/family and health care professionals and the acute nature prompting an ED visit can make it difficult to create an effective partnership. The many cultural and societal variations among families can increase the difficulty in identifying who is a child's legal guardian. Situations unique to the ED, such as the arrival of a child by ambulance without family, the unaccompanied minor seeking care without the knowledge of family, visits related to abuse or violence, time-sensitive invasive procedures including

resuscitation efforts, and the unanticipated death of a child, require the most thoughtful advanced planning.[3-5]

The option of family member presence during invasive procedures including resuscitation efforts has been recommended in a statement by the Ambulatory Pediatric Association,[2] which was endorsed by the American Academy of Pediatrics (AAP) in November 2004. PFCC includes respect for the privacy of the patient and acknowledgment of the pediatric patient's evolving independence, especially with regard to reproductive issues. Communication between health care professionals in the ED and the child's medical home primary care physician who is accessible and community-based and offers coordinated, comprehensive, continuous, culturally effective care[6] will enhance support of PFCC in the ED.

The AAP and American College of Emergency Physicians have a long tradition of supporting PFCC and have issued independent and joint policy statements in the past.[7,8] This policy statement addresses the particular challenges in, and opportunities for, providing PFCC in the ED setting and is in concert with and as an adjunct to earlier statements.

Recommendations

The AAP and American College of Emergency Physicians support the following:

1. Knowledge of the patient's experience and perspective is essential to practice culturally effective care that promotes patient dignity, comfort, and autonomy.
2. The patient and family are key decision makers regarding the patient's medical care.
3. The interdependence of child and parent, patient and family wishes for privacy, and the evolving independence of the pediatric patient should be respected.
4. The option of family member presence should be encouraged for all aspects of ED care.
5. Information should be provided to the family during interventions regardless of the family's decision to be present or not.
6. PFCC encourages collaboration with other health care professionals along the continuum of care and acknowledgment of the importance of the patient's medical home to the patient's continued well-being.
7. Institutional policies should be developed for provision of PFCC through environmental design, practice, and staffing in collaboration with patients and families.

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REFERENCES

1. Emergency Nurses Association. Position statement: family presence at the bedside during invasive procedures and cardiopulmonary resuscitation. Available at: http://www.ena.org. Accessed March 22, 2006.
2. Henderson DP, Knapp JF. Report of the National Consensus Conference on Family Presence During Pediatric Cardiopulmonary Resuscitation and Procedures. *Pediatr Emerg Care.* 2005;21:787-791.
3. Knazik S, Dietrich A, Gold C, et al. Death of a child in the emergency department. *Ann Emerg Med.* 2003;42:519-529
4. Knapp J, Mulligan-Smith D, American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Death of a child in the emergency department. *Pediatrics.* 2005;115:1432-1437.
5. Emergency Nurses Association. Position statement: end-of-life care in the emergency department. Available at: http://www.ena.org. Accessed March 22, 2006
6. American Academy of Pediatrics. Medical home initiatives for children with special needs project advisory committee. The medical home. *Pediatrics.* 2002;110:184-186.
7. Committee on Hospital Care. Family-centered care and the pediatrician's role. *Pediatrics.* 2003;112:691-696.
8. American College of Emergency Physicians. Cultural competence and emergency care. [policy statement.] *Ann Emerg Med.* 2002; 40:546.

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Disaster Medical Response

[Ann Emerg Med. 2006;48:645.]

The American College of Emergency Physicians (ACEP) supports a national credentialing mechanism and up-to-date database of available physicians and medical volunteers who could be deployed as needed in the face of a national emergency. Provisions must also be in place to provide workers compensation and medical liability protection for medical volunteers deploying to a disaster site at the request of the federal government.

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Interpretation of Imaging Diagnostic Studies

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The American College of Emergency Physicians (ACEP) believes that the quality of patient care is enhanced when emergency physicians interpret and record the results of the diagnostic studies they order at the time of service. While the interpretation of diagnostic studies by other specialists may be important to patient care, the treating emergency physician is in the best position to fully integrate in a timely and effective manner all relevant clinical and other available information to optimize the quality of patient care in the emergency department (ED). Therefore, ACEP endorses the following principles.

- Interpretation of diagnostic studies ordered for the immediate evaluation and management of an ED patient should be done contemporaneously with the ED visit, and should not be delayed until after the patient has left the ED. The contemporaneous interpretation may be done by the emergency physician or by another specialist within the limits of the training, experience, and competence of that physician.
- If the emergency physician believes that urgent consultation is needed for the interpretation of a diagnostic study, the radiologist must be immediately available for discussion and/or consultation with the treating physician.
- Whether the consultation is provided from a hospital staff radiologist or by a teleradiologist, the consultant should be licensed in the state where the images are performed and should meet or exceed the credentialing requirements for radiologists credentialed by the local health care facility, such as board certification/board eligibility.
- The interpretation of the diagnostic studies, both preliminary reading and final reports, must be documented in writing, available contemporaneously with the patient's evaluation, and filed in the patient's medical record.
- The emergency physician providing contemporaneous interpretation of a diagnostic study is entitled to reimbursement for such interpretation even if the study is reviewed subsequently as part of the quality control process of the institution in which the physician practices.

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