

APPENDIX H

**10 NYCRR 405.9 (c) and 405.19;
Establishment of hospital protocols
and maintenance of
sexual offense evidence.**

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Section 405.9 (c) Sexual offense evidence. The hospital shall provide for the maintenance of evidence of sexual offenses. The hospital shall establish and implement written policies and procedures which are consistent with requirements of this section and which shall apply to all service units of the hospital which treat victims of sexual offenses, including but not limited to medicine, surgery, emergency, pediatric and outpatient services.

(1) The sexual offenses subject to the provisions of this subdivision shall be sexual misconduct, rape, sodomy, sexual abuse and aggravated sexual abuse.

(2) The sexual offense evidence shall include, as appropriate to the injuries sustained in each case, slides, cotton swabs, clothing, hair combings, fingernail scrapings, photographs, and other items as may be specified by the local police agency and forensic laboratory.

(3) The hospital shall refrigerate items of sexual offense evidence where necessary for preservation and ensure that clothes and swabs are dried, stored in paper bags and labeled, and shall mark and log each item of evidence with a code number corresponding to the patient's medical record.

(4) Privileged sexual offense evidence shall mean evidence which is associated with the hospital's treatment of injuries sustained as a result of a sexual offense.

(5) Sexual offense evidence that is not privileged shall mean that which is obtained from victims of suspected child abuse or maltreatment, and that derived from other alleged crimes, attendant to or committed simultaneously with the sexual offense, which are required to be reported to a police agency, such as bullet or gunshot wounds, powder burns or other injury arising from or caused by the discharge of a gun or firearm, or wounds which may result in death and which are inflicted by a knife, ice pick or other sharp or pointed instrument. Nothing in this paragraph shall prevent the reporting of diseases or medical condition required by law to be reported to health authorities.

(6) Upon admission of a patient who is an alleged sexual offense victim, the hospital shall seek patient consent for collection and storage of the sexual offense evidence and explain the specific rights of the patient and obligations of the hospitals as outlined in this paragraph. The hospital shall store the sexual offense evidence in a locked, separate and secure area for not less than thirty days unless:

(i) the patient signs a statement directing the hospital not to collect and keep privileged evidence;

(ii) such evidence is privileged and the patient signs a statement directing the hospital to surrender the evidence to the police before thirty days has expired;

(iii) the evidence is not privileged and the police request its surrender before thirty days has expired;

(7) After thirty days from commencement of treatment, the refrigerated evidence shall be discarded and the clothes shall be returned upon the patient's request.

(8) The hospital shall designate a staff member to coordinate the required actions and to contact the local police agency and forensic laboratory to determine their specific needs and requirements for the maintenance of sexual offense evidence.

Section 405.19 - Emergency services

(a) General.

(1) Emergency services shall be provided in accordance with this subdivision or subdivisions (b) through (e) of this section as appropriate.

(2) If emergency services are not provided as an organized service of the hospital, the governing body and the medical staff shall assure:

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- (i) prompt physician evaluation of patients presenting emergencies;
- (ii) initial treatment and stabilization or management; and
- (iii) transfer, where indicated, of patients to an appropriate receiving hospital.

(b) Organization.

(1) The medical staff shall develop and implement written policies and procedures approved by the governing body that shall specify:

(i) the responsibility of the emergency services to evaluate, initially manage and treat, or admit or recommend admission, or transfer patients to another facility that can provide definitive treatment;

(ii) the organizational structure of the emergency service, including the specification of authority and accountability for services; and

(iii) explicit prohibition on transfer of patients based on their ability or inability to pay for services.

(2) The emergency service shall be directed by a licensed and currently registered physician who is board-certified or board-admissible for a period not to exceed five years after the physician first attained board admissibility in emergency medicine, surgery, internal medicine, pediatrics or family practice, and who is currently certified in advanced trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS. A licensed and currently registered physician who is board-certified or board-admissible in psychiatry for a period not to exceed five years after the physician first attained board-admissibility, in psychiatry may serve as psychiatrist director of a separately operated psychiatric emergency service. Directors of separately operated psychiatric emergency services need not be qualified to perform ACLS and ATLS.

(3) An emergency service shall have laboratory and X-ray capability, including both fixed and mobile equipment, available 24 hours a day, seven days a week, to provide test results to the service within a time considered reasonable by accepted emergency medical standards.

(c) General policies and procedures.

(1) The location and telephone number of the State Department of Health-designated poison control center, shall be maintained at the telephone switchboard and in the emergency service.

(2) All cases of suspected child abuse or neglect shall be treated and reported immediately to the New York State Central Register of Child Abuse and Maltreatment pursuant to procedures set forth in article 6, title 6 of the Social Services Law.

(3) Domestic violence. The emergency service shall develop and implement policies and procedures which provide for the management of cases of suspected or confirmed domestic violence victims in accordance with the requirements of section 405.9(e) of this Part.

(4) The emergency service shall establish and implement written policies and procedures for the maintenance of sexual offense evidence as part of the hospital-wide provisions required by this Part. An organized protocol for victims of sexual offense, including medical and psychological care shall be incorporated into such policies and procedures.

(5) The emergency service, in conjunction with the discharge planning program of the hospital, shall establish and implement written criteria and guidelines specifying the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services but not in need of inpatient hospital care;

(6) An admission and discharge register shall be current and shall include at least the following information for every individual seeking care:

- (i) date, name, age, gender, ZIP code;
- (ii) expected source of payment;

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(iii) time and means of arrival, including name of ambulance service for patients arriving by ambulance;

(iv) complaint and disposition of the case; and

(v) time and means of departure, including name of ambulance service for patients transferred by ambulance.

(7) There shall be a medical record that meets the medical record requirements of this Part for every patient seen in the emergency service. Medical records shall be integrated or cross-referenced with the inpatient and outpatient medical records system to assure the timely availability of previous patient care information and shall contain the prehospital care report or equivalent report for patients who arrive by ambulance.

(8) Review of the hospital emergency service shall be conducted at least four times a year as a part of the hospital's overall quality assurance program. Receiving hospitals shall report to sending hospitals and emergency medical systems, as appropriate, all patients that die unexpectedly within 24 hours upon arrival at the receiving hospitals. These patient mortalities shall be included in both hospitals' quality assurance review.

(d) Staffing. The following requirements are applicable to all organized emergency services:

(1) Emergency Service physician services shall meet the following requirements:

(i) The emergency services attending physician shall meet the minimum qualifications set forth in either clause (a) or clause (b) of this subparagraph.

(a) The emergency services attending physician shall be a licensed and currently registered physician who is board-certified in emergency medicine, surgery, internal medicine, pediatrics or family practice and who is currently certified in advanced trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS. A licensed and currently registered physician who is board-certified in psychiatry may serve as psychiatrist attending in a separately operated psychiatric emergency service. A licensed and currently registered physician who is board-admissible in one of these specialty areas and is currently certified in ATLS or who has training and experience equivalent to ATLS and has successfully completed a course in ACLS or has had training and experience equivalent to ACLS may be designated as attending physician for a period not to exceed five years after the physician has first attained board-admissibility except that the requirement to be qualified to perform ATLS and ACLS shall not be applicable to qualified psychiatrist attendings in a separately operated psychiatric emergency service. Physicians who are board-certified or admissible, for a period not to exceed five years after the physician first attained board-admissibility, in other specialty areas may be designated as attending physicians for patients requiring their expertise.

(b) The emergency services attending physician shall meet the following minimum standards. The physician:

(1) is licensed and currently registered;

(2) has successfully completed one year of post-graduate training;

(3) has, within the past five years accumulated 7,000 documented patient contact hours or hours of teaching medical students, physicians-in-training, or physicians in emergency medicine. Up to 3,500 hours of documented experience in hospital-based settings or other settings in the specialties of internal medicine, family practice, surgery or pediatrics may be substituted for the required hours of emergency medicine experience on an hour-for-hour basis;

(4) has acquired in each of the last three years, an average of fifty hours or more per year of continuing medical education pertinent to emergency medicine or to the specialties of practice which contributed to meeting the 7,000 hours requirement specified in subclause (3) of this clause;

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(5) is currently certified in ATLS or has training and experience equivalent to ATLS; and
(6) has successfully completed a course in advanced cardiac life support (ACLS) or has had training and experience equivalent to ACLS.

(ii) There shall be at least one emergency service attending physician on duty 24 hours a day, seven days a week. For hospitals that exceed 15,000 unscheduled visits annually, the attending physician shall be present and available to provide patient care and supervision in the emergency service. As necessitated by patient care needs, additional attending physicians shall be present and available to provide patient care and supervision. Appropriate subspecialty availability as demanded by the case mix shall be provided promptly in accordance with patient needs. For hospitals with less than 15,000 unscheduled emergency visits per year, the supervising or an attending physician need not be present but shall be available within twenty minutes;

(iii) Other medical staff practitioner services provided in the emergency service shall be in accordance with the privileges granted the individual; and

(iv) Every medical-surgical specialty on the hospital's medical staff which is organized as a department or clinical service and where practitioner staffing is sufficient, shall have a schedule to provide coverage to the emergency service by attending physicians in a timely manner, 24 hours a day, seven days a week, in accordance with patient needs.

(2) Nursing services:

(i) There shall be at least one supervising emergency services registered professional nurse present and available to provide patient care services in the emergency service 24 hours a day, seven days a week;

(ii) Emergency services supervising nurses shall be licensed and currently registered and possess current, comprehensive knowledge and skills in emergency health care. They shall have at least one year of clinical experience, be able to demonstrate skills and knowledge necessary to perform basic life support measures, have successfully completed a course in ACLS or have had training and experience equivalent to ACLS and maintain current competence in ACLS as determined by the hospital;

(iii) Registered professional nurses in the emergency service shall be licensed and currently registered professional nurses who possess current, comprehensive knowledge and skills in emergency health care. They shall have at least one year of clinical experience, have successfully completed an emergency nursing orientation program and be able to demonstrate skills and knowledge necessary to perform basic life support measures. Within one year of assignment to the emergency service, each emergency service nurse shall have successfully completed a course in ACLS or have had training and experience equivalent to ACLS and shall maintain current competence in ACLS as determined by the hospital.

(iv) Additional registered professional nurses and nursing staff shall be assigned to the emergency service in accordance with patient needs. If, on average:

(a) the volume of patients per eight-hour shift is under 25, an additional registered professional nurse shall be available as needed to assist the supervising registered professional nurse with delivery of direct patient care; or

(b) the volume of patients per eight-hour shift is over 25, there shall be a minimum of two registered professional nurses per shift assigned to provide direct patient care. As patient volume and intensity increases, the total number of available registered professional nurses shall also be increased to meet patient care needs;

(3) Registered physician's assistants and nurse practitioners:

(i) patient care services provided by registered physician's assistants shall be in accordance with section 405.4 of this Part;

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(ii) patient care services provided by certified nurse practitioners shall be in collaboration with a licensed physician whose professional privileges include approval to work in the emergency service and in accordance with written practice protocols for these services; and

(iii) the registered physician assistants and the nurse practitioners shall meet the following standards:

(a) The registered physician assistants and the nurse practitioners in the emergency service shall have successfully completed a course in ACLS or have had training and experience equivalent to ACLS when determined necessary by the hospital to meet anticipated patient needs or when a physician assistant or nurse practitioner is serving as the sole practitioner on duty in a hospital with less than 15,000 unscheduled emergency visits per year;

(b) Registered physician assistants and nurse practitioners in the emergency service shall have had training and experience equivalent to ATLS when determined necessary by the hospital to meet anticipated patient needs or when a physician assistant or nurse practitioner is serving as the sole practitioner on duty in a hospital with less than 15,000 unscheduled emergency visits per year.

(4) Support personnel. There shall be sufficient support personnel assigned to the emergency service to perform the following duties on a timely basis: patient registration, reception, messenger service, acquisition of supplies, equipment, delivery and labeling of laboratory specimens, responsible for the timely retrieval of laboratory reports, obtaining records, patient transport and other services as required.

(e) Patient care.

(1) The hospital shall assure that all persons arriving at the emergency service for treatment receive emergency health care that meets generally accepted standards of medical care.

(2) Every person arriving at the emergency service for care shall be promptly examined, diagnosed and appropriately treated in accordance with triage policies and protocols adopted by the emergency service and approved by the hospital. All patient care services shall be provided under the direction and control of the emergency services director or attending physician. In no event shall a patient be discharged unless evaluated and treated as necessary by an appropriately privileged physician, physician's assistant, or nurse practitioner. Hospitals which elect to use physician's assistants or nurse practitioners shall develop and implement written policies and treatment protocols subject to approval by the governing body that specify patient conditions that may be treated by a registered physician's assistant or nurse practitioner without direct visual supervision of the emergency services attending physician.

(3) Hospitals that have limited capability for receiving and treating patients in need of specialized emergency care shall develop and implement standard descriptions of such patients, and have triage protocols and formal written transfer agreements with hospitals that are designated as being able to receive and provide definitive care for such patients. Patients in need of specialized emergency care shall include, but not be limited to:

(i) trauma patients and multiple injury patients;

(ii) burn patients with burns ranging from moderate uncomplicated to major burns as determined by use of generally acceptable methods for estimating total body surface area;

(iii) high risk maternity patients or neonates or pediatric patients in need of intensive care;

(iv) head-injured or spinal-cord injured patients;

(v) acute psychiatric patients;

(vi) replantation patients; and

(vii) dialysis patients.

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(4) Hospitals shall verbally request ambulance dispatcher services to divert patients with life threatening conditions to other hospitals only when the chief executive officer or designee appointed in writing, determines that acceptance of an additional critical patient would endanger the life of that patient or another patient. Request for diversion shall be documented in writing and, if warranted, renewed at the beginning of each shift.

(5) Where observation beds are used, they shall be for observation and stabilization and they shall not be used for longer than eight hours duration. Patients in these beds shall be cared for by sufficient staff assigned to meet the patients needs. At the end of eight hours observation or treatment the patient must be admitted to the inpatient service, be transferred in accordance with paragraph (6) of this subdivision, or be discharged to self-care or the care of a physician or other appropriate follow-up service.

(6) Patients shall be transferred to another hospital only when:

- (i) the patient's condition is stable or being managed;
- (ii) the attending practitioner has authorized the transfer; and
- (iii) administration of the receiving hospital is informed and can provide the necessary resources to care for the patient; or
- (iv) when pursuant to paragraph (2) of this subdivision, the patient is in need of specialized emergency care at a hospital designated to receive and provide definitive care for such patients.

(7) Hospitals located within a city with a population of one million or more persons shall apply and, if accepted, participate to the full extent of their capability in the emergency medical service which is operated by such city or such city's health and hospitals corporation.

(f) Quality assurance. Quality assurance activities of the emergency service shall be integrated with the hospital-wide quality assurance program and shall include review of:

- (1) arrangements for medical control and direction of prehospital emergency medical services;
- (2) provisions for triage of persons in need of specialized emergency care to hospitals designated as capable of treating those patients;
- (3) emergency care provided to hospital patients, to be conducted at least four times a year, and to include prehospital care providers, emergency services personnel and emergency service physicians; and
- (4) adequacy of staff training and continuing education.