Hi All

Just a reminder to all of you who are relatively new in the ED.

When you were credentialed you were granted 'core privilieges".
In fact, if you go to the link and look under **Physician Resources-** and click on "advanced practitioners"-you should be able to click on your name and find that ***you have been granted core privileges*.**
At the end of your second year here, you will be re-credentialed by the professional staff-only this time you will be requesting specific privileges.

Those privileges are as follows: You will need to record 5 for each of these categories except for non complex lacerations (10)

EMERGENCY DEPARTMENT			Anterior nasal cautery
			Burn care (<10 % TBSA)
			Digital block
			Flourescein stain-opthomalogic
			Foreign body removal-superficial
			HEENT care
			Gynecologic exam with collection of cultures
			Incision and drainage
			Knee arthrocentesis
			Laceration repair, including layered closures (excluding lacerations that require Z plasty)
			Lumbar puncture
			Occular tonomentry
			Slit lamp exam
			Splint application
			Trephination and removal of nail

Therefore-it is imperative that you keep track of what you do so that you have evidence of competency enabling the prof staff to grant you the privileges for which you are applying for.
The essential information needed:

1. Patient name
2. procedure
3. MD signature
4. date

In the past people have kept track of this several ways. Some have books that they write procedures down in ("procedure log")
Others keep track electronically through their in basket and have MDs sign a printed out confirmation.

Whatever system you work out is fine-as long as you are able to produce the paperwork when called for-

Please don't' hesitate to call with any questions:

Sue B and Ali

Susan M. Bednar RN, MSN, APN
Manager: NP/PA Emergency Services
Northshore University Health System

Sbednar@northshore.org
(847) 570-1335
(847) 570-1223 (fax)
pager 8829

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