

INSTRUCTIONS FOR COMPLETING GUIDELINE FORMS

GUIDELINES FOR PRACTICE: (FORM A)

NATURE AND SCOPE OF PRACTICE:

Specifically describe the nature and scope of your practice including the most common diagnoses and ages of patients cared for, as well as the settings in which this care is provided.

CLINICAL STANDARDS WHICH SERVE AS GUIDELINES:

List textbooks, professional journals, clinical practice guidelines, or standards that have been mutually agreed upon as providing acceptable scientific knowledge and standards of care for conditions within the nature and scope of practice as described above. Include procedures/protocols specifically developed for your practice, if necessary. If you are prescribing medications, you should include a reference for pharmacologic intervention in your Standards.

SITUATIONS WHICH REQUIRE REFERRAL OR CONSULTATION:

Describe potential situations and patient presentations in your practice that would require physician consultation/referral. Examples include: life or morbidity threatening conditions, diagnostic dilemmas, or unresponsiveness to generally accepted treatment modalities.

PROVISIONS FOR MANAGING EMERGENCIES:

Outline process for managing emergencies in your practice setting including, support measures as needed, consultation with a physician, and otherwise responding as directed in the "Code Call Response System" policy in the *Clinical Policy and Procedure Manual* (V-B-1)

SCOPE OF PRESCRIPTIVE PRACTICE:

Describe scope as prescribing Schedule II-VI medications unless prescriptive authority is limited. Include protocols for the initiation of intravenous therapy and Schedule II drugs.

METHODS FOR MONITORING PRESCRIPTIVE PRACTICE:

Describe process for review of your prescribing decisions and practices with the supervising physician. Must include initial review of Schedule II drugs within 96 hours and a process for reviewing an appropriate sample (no fewer than 12 prescriptions per quarter, but otherwise as determined by the nurse and physician).

PRIVILEGE REQUEST FORM:

Describe those professional activities for which you are requesting authorization. Under "Special/New Procedures" list invasive or other procedures which require additional preparation or are unique to your practice. When requesting these privileges, include the procedure as well as the method for achieving and maintaining competence.

Signatures

1. **Obtain certification signatures** from your collaborating physician and the appropriate Chief of Service.
2. Submit completed application with a copy of your resume, license, DEA and DPH forms to Carol Camooso, RN, Founders House 641.
3. When the approval process is completed you will receive a copy of your approved guidelines for your files.

**MASSACHUSETTS GENERAL HOSPITAL
ADVANCED PRACTICE NURSE
PHYSICIAN ASSISTANT
AUTHORIZATION TO PRACTICE**

NAME:

_____ Please Print _____

MGH ID NUMBER:

JOB CODE:

MGH ADDRESS:

MGH PHONE NUMBER:

MGH Email Address:

Nurse Practitioner

Psychiatric Clinical Nurse Specialist

Nurse Anesthetist

Nurse Midwife

Physician Assistant

MASSACHUSETTS GENERAL HOSPITAL

**GUIDELINES FOR PRACTICE
FORM A**

(Please check activities that apply to your practice and add any additional information)

NATURE OF PRACTICE:

Describe primary population(s) including age and primary diagnoses as well as the setting(s) care is provided.

CLINICAL STANDARDS WHICH SERVE AS GUIDELINES FOR THIS PRACTICE:

SITUATIONS WHICH REQUIRE REFERRAL OR CONSULTATION

- Diagnostic dilemmas.
- Patient not responding to current treatment and/or interventions
- Patient and/or family request

Other:

PROVISIONS FOR MANAGING EMERGENCIES:

- Immediate notification and consultation with collaborating physician or his/her designee.
- Employing emergency measures as necessary.
- If in an outpatient setting, transfer of the patient to an emergency department.

Other:

SCOPE OF PRESCRIPTIVE PRACTICE:

Pursuant to Massachusetts Board of Registration in Nursing Regulations, 244 CMR 4.00; Massachusetts General Lawsc94C, Massachusetts Board of Registration, 243 CMR 2.10; and Department of Health Regulations, 105 CMR 700.001- 700.010:

- Prescribes Schedule II-VI medications in accordance with guidelines developed with the supervising physician.
- Has a current license from the Massachusetts Department of Public Health, Division of Food and Drugs
- When prescribing controlled substances, has a certificate from the Drug Enforcement Administration.
- Consultation with the attending physician is obtained when:
 - A. Medication/treatment failures occur
 - B. Medication/treatment is outside the individual practitioner guidelines

Other:

METHODS FOR MONITORING PRESCRIPTIVE PRACTICES:

- Initial prescriptions for Schedule II medications will be reviewed within 96 hours either by telephone, chart review or in-person consultation.
- The supervising physician will review an appropriate sample (no fewer than 12 prescriptions) of my prescriptions every quarter through rounds, chart reviews, or other mechanisms. The sample will include initial prescriptions issued by me.
- I will maintain documentation of these reviews for two years.

Physician Assistant's please review and check:

Guidelines shall be reviewed and dated and initialed by both the supervising physician and the Physician Assistant at the time of each review.

Other:



SCOPE OF PRACTICE FORM

CLINICAL AREA: _____

NAME: _____

Initial _____

Renewal _____

REQUESTED		<i>Scope of Practice</i> GENERAL SERVICES	ACTION		
<i>YES</i>	<i>NO</i>		<i>APPROVED</i>	<i>CONDITIONS</i>	<i>DENIED</i>
		Obtains health and medical history, performs physical examination, and constructs problem list.			
		Collects, records, and interprets patient data.			
		Orders appropriate laboratory, radiologic, and other diagnostic studies.			
		Interprets studies performed/ordered.			
		Initiates consultations and referrals.			
		Prescribes medications as specified in Guidelines.			
		Assess patients to determine need for physician attention.			
		SPECIAL PROCEDURES <i>(Please include procedure as well as the method for achieving and maintaining competence)</i>			

ACKNOWLEDGMENT OF PRACTITIONER:

I have requested only those specific privileges which by education, training, current experience and demonstrated performance I am qualified to perform and which I wish to exercise at The Massachusetts General Hospital.

I understand that:

- A. In exercising any specified privileges granted and in carrying out the responsibilities assigned to me, I am constrained by any hospital and medical staff policies and rules applicable generally and applicable to the particular situation.
- B. Any restriction on the specified privileges granted to me is waived in an emergency situation.

CERTIFICATION SIGNATURES:

Advanced Practice Nurse or:
Physician Assistant _____ (Signature) _____ (Date)

Collaborating Physician: _____ (Signature) _____ (Date)

Nurse Manager:
(where applicable) _____ (Signature) _____ (Date)

Chief of Service: _____ (Signature) _____ (Date)

REVIEW SIGNATURE:

Associate Chief for Nursing
Practice: _____ (Signature) _____ (Date)

CONDITIONS/EXCEPTIONS:

The preceding specified services have been approved with the following conditions and/or exceptions:

<i>PROFESSIONAL ACTIVITY</i>	<i>CONDITION/MODIFICATION/EXCEPTION</i>

APPROVAL SIGNATURE:

Credentialing Steering Committee
Designee: _____ (Signature) _____ (Date)

AUTHORIZATION SIGNATURE:

Senior Vice President for Patient Care
Chief Nurse Executive
Chair, PCS Executive Committee _____ (Signature) _____ (Date)

Effective From: ____ / ____ / ____ to ____ / ____ / ____