Policy: Nurse Practitioner Scope of Practice – Adult Hospitalist Service

DEPARTMENT SPECIFIC: Only affects one department.							
Folder	Medical Staff Services			**Sub-Folder (If Applicable)**	Adult Hospitalist Department		
Effective Date	2/23/2016	**Approved** Approver/Date	*Medical Director, Adult Hospitalists: 1/2019; MDRC 03/21/2019; MEC 04/23/2019*				
Last Reviewed/ Revised Date	3/21/2019	**OSHA Category (If Applicable)**	Choose an item	**Standard (If Applicable)**	20 CSR 2200-4.200	**Number of pages**	2

PURPOSE: *Why does this policy exist?*

- To allow nurse practitioners (NP's) to perform at the optimal level permitted by the state of Missouri based on their training and education
- To leverage hospitalist resources to maximize patient care capabilities
- This staffing model will permit the possibility unit-based rounding, the benefits of which have been well documented for patients, physicians and other staff alike.

GUIDELINES: *What are some general statements regarding the use of the policy?*

Missouri state law recognizes nurse practitioners as primary care providers, but does not at this time permit autonomous practice; it therefore requires the establishment of collaborative agreements with physicians, and a process of supervision, before nurse practitioners can engage in the provision of patient care or the prescription of drugs.

While NP roles in the delivery of health care in the out-patient setting state-wide are quite defined and uniform, their roles in the in-patient acute care setting are not, this being left to the discretion of individual hospital bylaws.

This staffing model will permit the possibility of unit-based rounding. The benefits of unit-based rounds to patients, physicians and other staff alike have been well documented in several journal articles.

- Physicians and nurse practitioners will work in teams of two
- Both will meet at the beginning of the shift to 'run the list' and assign patients, and then at the end of shift (in person or by phone) to review and check out daily, but communicate frequently throughout the day as needed
- Rounds will be unit-based; admits will preferably be unit-based as well, but may be flexible depending on bed and staffing logistics
- In the event that new admits and consults were first seen by the NP, the physician will review and discuss the assessment and plan with the NP at the time of admit, and physically see all such patients within the first 24 hours
- Physician will review all test results daily, including those for patients assigned to the NP, and discuss further diagnostic and therapeutic plans

- Physician will be available to meet and/or discuss with all NP-assigned patients, their family/POA, and consultants as requested
- Physician or NP may sign death certificates in accordance with State law
- Physician alone will prescribe controlled substances
- Physician alone will provide written, verbal, or telephone Do Not Resuscitate (DNR) Orders in accordance with state law. Verbal or telephone "No Code Blue" orders must be authenticated and countersigned by a licensed physician member of the medical staff that is currently attending the patient within 24 hours.
- Physician will review all NP charts daily, and co-sign them for the first 6 months of an NP joining the service as part of the preceptorship process, and recommend same to the departmental director and CMO for either enhanced practice, or, if there are concerns about patient care, continued preceptorship for 3 months and subsequent re-evaluation

PROCEDURE: *Include: Definitions, Equipment, Process, and Documentation*

Generally, there will be 2 groups of 4 physicians and 4 NP's each, alternating on a 7 day on, 7 day off basis. Each day, 3 physicians and 3 NPs will work in pairs from 7am – 7pm to complete all daily rounds, discharges, transfers, and admits, while 1 physician and 1 NP (or PA) will work 7pm to 7am for admissions and cross-coverage of all floor and ICU patients on the service.

A team of 1 physician and 1 NP will be deployed to the general medical floor (Med Tele), the second pair to CPC and Surgical (4H/5H), and the third pair to SPCU/Oncology and Neurology floors. The 3 physician/NP teams will also rotate admission/new consult responsibilities from 6am – 11am, 11am – 3pm, and 3pm – 7pm respectively each day, subject to modifications as agreed upon by the group.

REFERENCES: *What resources are used to support the policy and procedure?*

1. pr.mo.gov/nursing-advanced-practice-nursing-collaborative.asp

2. David J. Yu, MD, MBA,FACP, SFHM. Unit-Based Rounding: A Holy Grail? July 2, 2012 edition of The Hospitalist

3. O'Leary KJ, Buck R, Fligiel HM, et al. Structured interdisciplinary rounds in a medical teaching unit: improving patient safety. Arch Intern Med. 2011;171(7):678-684.

4. HB 618 revised statutes 193.015, 193.145 RSMo: Expanded Authorization to Complete Death Certificates, December 23, 2015 http://www.mhanet.com/mhaimages/HB%20618%20Health%20Professional%20Notice%2C%20signed.docx.pdf

Attachments: (Label as Appendix A, B, C, etc.)

None