OOD 18: A description of the process by which the CNO or his or her designee participates in credentialing, privileging, and evaluating advance practice nurses. Include the frequency of re-privileging.

Overview

Hospitals are mandated by federal, state and organizational regulations and policies to establish a process for the credentialing and privileging of all practitioners to assess their competency. Attachment OOD 18.a provides a grid of the current regulations. This competency assessment and assurance process must outline role specific performance standards that fall within the discipline’s scope of practice in order to ensure high quality, safe patient care.

The Joint Commission (JC) standards define credentialing as “the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization.” The JC defines privileging as “the process by which a healthcare organization authorizes the specific scope and content of a practitioner’s ability to provide patient care services (i.e. clinical privileges) based on an evaluation of the individual’s credentials and performance” (JC, Medical Staff Overview, MS.06.01.01).

At the Massachusetts General Hospital (MGH) practitioners complete the credentialing and privileging process prior to functioning in their roles and must complete the re-credentialing and re-privileging process every two years. Currently there are 680 Advance Practice Registered Nurses (APRN) and Physician Assistants (PA) that are credentialed and privileged through the MGH process. This is a dynamic number as we are continuously adding to this pool in our workforce. APRNs include Nurse Midwives, Nurse Practitioners, Psychiatric Nurse Mental Health Specialists and Nurse Anesthetists.

Massachusetts General Hospital’s Board of Trustees is the governing body with authority over credentialing and privileging of those professionals who continuously meet the qualifications, standards and requirements set forth in the MGH Bylaws. Consistent with the MGH Bylaws and applicable regulations, the General Executive Committee (GEC) considers and recommends appointments, privileges and other actions involving practitioners to the Committee on Appointments and Privileging, a subcommittee of the Board of Trustees. The GEC delegates the accountability for credentialing and privileging of APRN/PAs to the Senior Vice President for Patient Care and Chief Nurse (CNO), who is a member of the GEC. The following paragraphs describe the steps in the credentialing and privileging process; the flowchart in attachment OOD 18.b provides a visual representation of this process.

Credentialing and Privileging

All APRNs employed by MGH and by the Massachusetts General Physicians’ Organization (MGPO) are required to meet credentialing and re-credentialing guidelines as outlined in the policy, “Credentialing and Authorization of Nurses in the Expanded Role who are MGH and MGPO Employees” (attachment OOD 18.c). APRNs care for patients in MGH/MGPO practice settings. For the purposes of this document the reference MGH will be used to encompass MGH and MGPO. The credentialing and privileging process outlined in this policy reflects the current regulations of the JC, Massachusetts Board of Registration in Nursing, MGH Bylaws and MGH Human Resource Policies.

APRNs are essential members of the treatment team who provide high quality, safe patient care. MGH APRNs have a collaborative/supervising relationship with a physician and work together to develop the credentialing guidelines for their practice area and role. The credentialing and privileging application identifies and describes potential situations and patient presentations that
would require physician consultation or referral. The supervising physician and their department leadership endorsement serves as the basis or first step in the process.

The CNO placed accountability for the credentialing and privileging process within the Institute for Patient Care (IPC) including ensuring compliance with state and federal regulations and organizational policies. Under the direction of the Executive Director of the IPC, a masters-prepared nurse in the role of Professional Development Program Manager is accountable for managing the day-to-day credentialing and privileging process. These responsibilities include 1) fielding questions about the process, 2) directing practitioners to resources, 3) communicating information about the process, 4) managing a database, 5) revising, updating and recommending policy changes, 6) facilitating the review and recommendations of applications to the CNO, and 7) serving as the chair of the Health Professions Staff Committee (HPSC). After departmental endorsement is achieved, each APRN is required to submit a completed Authorization to Practice application outlining the requested privileges to the Professional Development Program Manager within the IPC.

The HPSC (SE 1) is a subcommittee of the GEC which has broad-based membership that includes three Nurse Practitioners; the Chief Registered Nurse Anesthetist; a Psychiatric Nurse Mental Health Specialist; the Chief Nurse Midwife; two Physicians Assistants; an Associate Chief Nurse (ACN); a Staff Specialist and the Professional Development Program Manager. The committee’s members represent a broad range of inpatient and outpatient areas and use their clinical expertise to review the applications for credentialing and privileging and make recommendations regarding application approval. Together, the IPC Professional Development Program Manager and HPSC provide the first quality check of credentialing and privileging applications.

Subsequent quality checks are performed by the responsible ACN, Executive Director of IPC, and the CNO as follows: once reviewed by the HPSC and the decision has been made to recommend the applicant for approval, applications are reviewed by the ACNs accountable for the APRN’s practice area, the application is then signed attesting that they endorse the candidate’s application. Subsequently, the Executive Director of the IPC submits applications to be reviewed and approved at the CNO’s Patient Care Services Executive Committee (PCSEC) Meeting (attachment OOD 18.d). The charges of the PCSEC are included in evidence TL 4. The Professional Development Program Manager works with the APRN and/or collaborating physician to facilitate resolution if anywhere in the process questions or concerns arise. When approved, the CNO presents these applications to the GEC and the to the Board of Trustees’ subcommittee responsible for Appointments and Privileges. APRNs are authorized to practice by these committees once they have met all requirements of the credentialing and privileging process.

Re-Credentialing and Re-Privileging

The re-credentialing process occurs every two years or more frequently if there is a change in a person’s scope of practice or in an individual APRN’s collaborating physician. Since March, 2012, APRNs are also required to submit the “APRN/PA Clinical Reappointment Performance Evaluation” form (attachment OOD 18.c) as part of the re-credentialing process. This form is completed by the collaborating physician who indicates whether they recommend continuing a privilege, limiting or revoking a privilege. The APRN submits the completed reappointment application to the Professional Development Program Manager, who facilitates the same process as previously described with initial credentialing and privileging. The CNO reviews, endorses and presents to the GEC and then the Board of Trustees’ subcommittee for Appointments and Privileges for final approval and reappointment.
Policy Revisions
The CNO is a vital and respected member of many of the MGH’s highest decision-making bodies including the GEC. The CNO represents the interests of the APRNs on policy changes that affect the credentialing and privileging process. The Professional Development Program Manager within the IPC is accountable for the coordination of credentialing and privileging policy changes to ensure they are current and in compliance with local, state and federal regulations. The Professional Development Program Manager works with the HPSC to review and revise the policies as needed and to make recommendations to the CNO for approval. Policies are reviewed and updated at least every three years or more frequently if standards or regulations change.

Evaluating Advance Practice Nurses
MGH has a defined process for evaluating APRN practice that ensures compliance with departmental, organizational, state and federal regulations and policies. APRNs are evaluated using annual performance evaluations, peer review and quarterly prescriptive practice reviews by their collaborating/supervising physicians. The performance appraisal includes direct observation of APRN practice by the supervising physician, ongoing consultation during daily rounds for inpatients, monthly meetings and case presentations, case conferences, review of APRN documentation in patient’s medical records, peer review, and by eliciting feedback from patients.

In 2007, the JC standards required strengthening of the process for credentialing and privileging for physician performance through the implementation of both focused (FPPE) and ongoing professional practice evaluations (OPPE). In order to have consistent requirements for all practitioners, the JC requirements for OPPE and FPPE were extended in 2012 to include all credentialed and privileged practitioners including APRNs.

JC established OPPE requirements for organizations to identify “professional practice trends that impact the quality of care and patient safety in an ongoing manner which allows for more frequent practice evaluation than the previous process which required evaluation annually or during the re-credentialing and privileging process.” (JC standards, MS.08.01.03) FPPE is a “process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competence but who has requested privileges at the organization. This process may also be used when a question arises regarding a privileged practitioner’s ability to provide safe, high quality patient care. FPPE is a time-limited period during which the organization evaluates and determines the practitioner’s professional performance.” (JC standards, MS.08.01.01)

The course of action for improvement to initiate and implement the APRN OPPE/FPPE process was facilitated, supported and organized by the CNO. In November, 2011, the CNO and Executive Director of the IPC, requested a review by the Joint Commission Resources (JCR) consultation team to provide feedback on current processes and to determine MGH alignment with the evolving JC standards. The goal was to ensure any improvement efforts would lead to a sound process for OPPE/FPPE for APRNs at MGH. Consistent with this objective, a timeline was developed to provide information on the process and to establish a plan for OPPE/FPPE for APRNs. The timeline and process was approved by the CNO (attachment OOD 18.f).

Redesigning Credentialing, Privileging and Evaluation of APRN
In March, 2012, we enhanced our existing performance appraisal and peer review process and implemented OPPE/FPPE. OPPE is a JC requirement for routine monitoring and evaluation of clinical competency and professional behavior on all providers with clinical privileges. The process helps to identify, address, and resolve any potential problems with a provider’s performance
and trends that impact quality of care and patient safety in a timely manner. Redesign of the evaluation process to include OPPE was implemented for every APRN and 100% compliance was achieved within six weeks.

OPPE is performed every six months in March and September, on all MGH APRN providers with clinical privileges to evaluate practice. A period of FPPE is implemented for all practitioners who initially request privileges within the first three months of clinical practice. This includes practitioners new to the organization, addition or change to existing privileges and when there are performance concerns that arise if the practitioner falls below established thresholds for competence during the OPPE process. The APRN submits a summary of the OPPE/FPPE evaluations which is documented in the Clinical Re-appointment Evaluation Form which contributes to the application review for re-credentialing and re-privileging.

In the process of establishing the plan for the MGH APRN OPPE/FPPE process, the Professional Development Program Manager and Executive Director of IPC consulted with MGH physician colleagues and consulted with other organizations including another academic medical center which had already implemented the process as recommended by the JCR consultant. After gathering this information and comparing it with the physician metrics, two common metrics were evident – peer review and chart/case review. To ensure consistency of process across disciplines, peer review and chart review were chosen as the current metrics for APRN OPPE/FPPE at MGH.

Chart/Case Reviews

This process allows a reviewer to evaluate three charts or cases of patients cared for by an APRN in the prior six months using the OPPE criteria for measurement. The chart/case review (attachment OOD 18.g) can be performed by an APRN’s peer, Nursing Director, Chief APRN (a leader in their practice area), or Collaborating/Supervising Physician. The chart/case review provides valuable evidence of the person’s performance and skills. The chart/case review includes an assessment of the APRN’s documentation for evidence of technical skills, clinical judgment, interactions with patients, and completeness and accuracy. This includes determining if the APRN ensured that a time out is performed before each procedure and that ‘do not use’ abbreviations are not used when documenting in the patient’s record.

Peer Review

Peer review has been an integral part of the APRN annual performance review process since 2010 (attachment OOD 18.h) and the process was updated in 2012 to meet the new JC requirement by establishing thresholds for performance. The APRN is rated on criteria using a scale that measures clinical knowledge, patient and family relationships, and teamwork and collaboration. Guidelines for the rating of an APRN candidate using the scale include:

- **Excellent**: the APRN consistently performs above and beyond the expectations of the position.
- **Good**: the APRN meets the full expectations of the criteria.
- **Average**: the APRN meets the criteria requirements with room for further development. The APRN’s performance is acceptable and satisfactory.
- **Fair**: the APRN’s performance needs improvement and does not meet the requirements of the position; improvement must occur and an action plan is needed.
- **Poor**: the APRN’s performance is unacceptable; improvement must occur and an action plan is needed.

Peer review and chart review are part of the OPPE/FPPE process used for evaluating performance for APRNs. Relevant information obtained from the ongoing professional practice
evaluation is integrated into performance improvement activities. The OPPE allows the organization to identify professional practice trends that impact quality of care and patient safety. Such identification may require intervention by the organized medical staff regarding adding, maintaining or revoking privileges.
### Massachusetts General Hospital

**APRN Credentialing and Privileging Regulation Grid**

<table>
<thead>
<tr>
<th><strong>FEDERAL</strong></th>
<th><strong>CMS</strong></th>
<th>Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff. Practitioners, both physicians and non-physicians, may be granted privileges to practice at the hospital by the governing body for practice activities authorized within their State’s scope of practice without being appointed as a member of the medical staff. Ref: CMS, A-0045, 482.12(a)(1).</th>
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<tbody>
<tr>
<td><strong>Joint Commission</strong></td>
<td><strong>Physician assistants (PAs) and advanced practice registered nurses (APRNs) who are not licensed independent practitioners may be privileged through either the medical staff process or a procedure that is equivalent to the medical staff process. This procedure must be approved by the governing body and assure communication with and input from the Medical Staff Executive Committee regarding those privileges.</strong> Ref: JC MS overview</td>
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<td></td>
<td><strong>The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.</strong> Ref: MS.03.01.01</td>
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<td></td>
<td><strong>The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege.</strong> Ref: MS.06.01.03</td>
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<td></td>
<td><strong>The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.</strong> Ref: MS.06.01.05</td>
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<tr>
<td></td>
<td><strong>The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege.</strong> Ref: MS.06.01.07 The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance. Ref: MS.08.01.01</td>
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<td></td>
<td><strong>Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.</strong> Ref: MS.08.01.03</td>
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Development, Approval, and Review of Guidelines for Nurse Midwives, Nurse Practitioners and Nurse Anesthetists and Psychiatric Nurse Mental Health Specialists:

(1) All nurses practicing in an expanded role (physician's office, institution or private practice) shall practice in accordance with written guidelines developed in collaboration with, and mutually acceptable to, the nurse and to:
   (a) a physician expert by virtue of training or experience in the nurse's area of practice in 244 CMR 4.00 4/8/94 (Effective 3/11/94) – corrected Revised 9/2/11 w/corrections 10/14/11 the case of the nurse in the physician's office and the nurse in private practice; or
   (b) the appropriate medical staff and nursing administration staff of the institution employing the nurse.

(2) In all cases the written guidelines shall designate a physician who shall provide medical direction as is customarily accepted in the specialty area. Guidelines may authorize the nurse's performance of any professional activities included within her area of practice. The guidelines shall:
   (a) specifically describe the nature and scope of the nurse's practice;
   (b) describe the circumstances in which physician consultation or referral is required;
   (c) describe the use of established procedures for the treatment of common medical conditions which the nurse may encounter; and
   (d) include provisions for managing emergencies.

(3) In addition to the requirements of 244 CMR 4.22(2), the guidelines pertaining to prescriptive practice shall:
   (a) include a defined mechanism to monitor prescribing practices, including documentation of review with a supervising physician at least every three months;
   (b) include protocols for the initiation of intravenous therapies and Schedule II drugs;
   (c) specify the frequency of review of initial prescription of controlled substances; the initial prescription of Schedule II drugs must be reviewed within 96 hours; and
   (d) conform to M.G.L. c. 94C, 105 CMR 700.000: Implementation of M.G.L. c. 94C, and M.G.L. c. 112, §§ 80E, 80G, or 80H as applicable.

(4) A nurse practicing in an institution may not practice in an expanded role until:
   (a) the governing body, including the medical staff and nursing administrative staff of the institution, formally reviews and approves of the guidelines under which she proposes to practice; and
   (b) a physician is designated who shall provide such medical direction as is customarily accepted in the specialty area. If there is no professional staff of nurses and physicians, the guidelines must be reviewed by the Board. Such formal approval must be in writing and otherwise in accord with the governing body's by-laws. Once formally approved, guidelines may remain in effect for two calendar years. Prior to the end of the approved two-year period, a nurse who wishes to continue to practice in an expanded role under the guidelines after their expiration must review them in collaboration with the appropriate persons authorized in 244 CMR 4.22(1) to develop them and the governing body must review and formally approve of them.

Ref: MA BORN 244 CMR 4.22 and 4.23
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<th><strong>ONGANIZATION</strong></th>
<th><strong>MGH By-laws</strong></th>
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<td>Allied Health Practitioners (“Practitioners”), who shall include licensed physician assistants and nurses practicing in the expanded role, are not Members of the Professional Staff. A Practitioner may engage in direct clinical activities only to the extent defined in written protocols or guidelines that have been reviewed and approved by the appropriate committees of the Medical Staff and the Hospital and in accordance with any applicable laws or regulations. The protocols or guidelines shall specify the activities or situations requiring referral to, or consultation with, a Member of the Medical Staff and shall limit the Practitioner to activities in which he or she has documented appropriate professional education, training and experience, and current competence. Each Practitioner must meet, at a minimum, all requirements for professional education, clinical training and experience established by the appropriate state board of registration or other certifying agency and must have appropriate authorization to practice in accordance with procedures established by law and by the appropriate board or agency. If there is not such board or agency, the minimum professional requirements for the Practitioner shall be those approved by the GEC. Ref: MGH By-laws, page 12.</td>
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| **MGH Policies and Procedures** |
| The credentialing and authorization processes at MGH are designed to ensure that nurses in expanded roles (APRNs) are qualified, capable and prepared to perform the services for which they are authorized to provide. APRNs practice within guidelines developed with their collaborating physician. APRNs are authorized to practice once they have completed the credentialing process through the Patient Care Services credentialing program coordinator and approval to practice by the Committee on Appointments and Privileges of the Board of Trustees. Ref: Credentialing and Authorization of Nurses in the Expanded Role Who are MGH and MGPO Employees policy. |
Application submitted to the PDPM

Meets Criteria

PDPM presents at HPSC charged by CNO for credentialing review

Meets Criteria

ACN Review

No

APRN develops guidelines with collaborating/ supervising physician. Departmental endorsement

With re-credentialing and pre-privileging, the collaborating physician completes the clinical re-appointment

APRN credentialed and awarded privileges

Approval

GEC presents to BOT Appointments and Privileging Subcommittee for approval

CNO presents to GEC Recommends to BOT for approval

Abbreviations

ACN- Associate Chief Nurse
BOT- Board of Trustees
CNO- Chief Nursing Officer
GEC- General Executive Committee
HPSC- Health Professions Staff Committee
IPC- Institute for Patient Care
PCSEC- Patient Care Services Executive Committee
PDPM- Professional Development Program Manager
TITLE: CREDENTIALING AND AUTHORIZATION OF NURSES IN THE EXPANDED ROLES WHO ARE MGH AND MGPO EMPLOYEES

POLICY:

The credentialing and authorization processes at MGH are designed to ensure that nurses in expanded roles (APRNs) are qualified, capable and prepared to perform the services for which they are authorized to provide.

APRNs practice within guidelines developed with their collaborating physician. APRNs are authorized to practice once they have completed the credentialing process through the Patient Care Services credentialing program coordinator and approval to practice by the Committee on Appointments and Privileges of the Board of Trustees.

1 DEFINITIONS

1.1 Advanced Practice Nurses (APRN):
The Board of Registration in Nursing recognizes the following role groups as nurses in the expanded role:
- Nurse Midwife
- Nurse Practitioner
- Psychiatric Nurse Mental Health Clinical Specialist
- Nurse Anesthetist

2 CREDENTIALING PROCESS

2.1 Initial credentialing for APRNs:

2.1.0 Initial credentialing process is facilitated by the Patient Care Services credentialing program coordinator. Each applicant will be reviewed and approved in writing by department-specific collaborating physician and chief of service. Any major invasive procedure can only be undertaken under specific written protocols developed with the collaborating physician and which specify the level of supervision the service requires. Such protocols should be described using the scope for practice and must be reviewed by the department-specific collaborating physician and chief of service.
2.1.1 The candidate must submit the completed credentialing application along with the following information when applying for credentialing:

- copy of resume
- copy of current professional license
- copy of current certification
- copy of DEA/DPH certificates (if prescribing)

2.1.2 Prescriptive Privileges

- APRNs must submit copies of DPH and DEA certificates to the credentialing program coordinator to be authorized to prescribe at MGH.

- Prescription or medication orders need to be in accordance with written guidelines, which are mutually developed with his/her collaborating physician. Guidelines must include the process for reviewing prescription-related decisions and practices with the collaborating physician.

- It is recommended that this policy should be read in conjunction with ‘Prescribing Guidelines for Practitioners’ located in the Clinical Policy and Procedure Manual.

- Candidates that have prescriptive privileges are required by state board regulations to perform quarterly prescription audits. The audits will be managed and maintained by the candidate with their department files.

2.1.3 Access to the Operating Room:

- APRNs who want to practice in the operating room with surgical privileges must have credentials reviewed and approved by the Surgical Coordinating Committee, who provide a letter recommending approval to the Health Profession Staff Committee for access to the operating room. The Associate Chief Nurse for Perioperative Services coordinates this process.

- The Certified Registered Nurse Anesthetists’ (CRNA) application is reviewed and approved by the Department of Anesthesia, who will provide a letter recommending approval to the Health Profession Staff Committee.

2.1.4 Following recommended approval from the Health Profession Staff Committee, the application shall be forwarded to Senior Vice President for Patient Care and Chief Nurse and Patient Care Services Executive Committee.

- If questions arise with the privileges requested, the Senior Vice President for Patient Care and Chief Nurse forwards the application to the General Executive Committee, who will assist to resolve the issues, then forward to the Committee on Appointments and Privileges of the Board of Trustees.
2.1.5 All applications that are complete and raise no issues requiring additional review will be presented for approval to the Committee on Appointments and Privileges of the Board of Trustees.

2.1.6 The candidate will receive a final action letter listing the specific clinical privileges granted or refused that will originate from the Patient Care Services credentialing coordinator once the privileges have been approved by the Committee on Appointments and Privileges.

2.2 Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE).

OPPE measures will be performed and evaluated every six months for APRN.

FPPE will be performed within the first three months of clinical work when the candidate is new to MGH or requests a new privilege. A FPPE action plan will be implemented if the candidate falls below established thresholds during OPPE evaluations.

3 Re-CREDENTIALING PROCESS for APRNs

3.1 The re-credentialing process is the same as the initial process with approval by the Committee on Appointments and Privileges of the Board of Trustees.

3.2 Nurses in expanded roles are required to resubmit practice guidelines:
   - At least every two years
   - When the scope of practice changes, or
   - When the collaborating physician changes

3.3 The “Clinical Reappointment Evaluation Form” is completed and submitted with re-credentialing application.

REFERENCES:
Rules and Regulations Governing the Practice of Nursing in the Expanded Role, 244 CMR (www.state.ma.us/reg/boards/rn/default.htm)
Board of Registration in Medicine

Revised and approved: Department of Nursing 8/00
Reviewed and approved: Nursing Executive Operations 08/03
Reviewed and approved: Nursing Executive Operations 08/06
Reviewed and approved: Nursing Executive Operations 09/09
Reviewed and approved: Nursing Executive Operations 06/12
### MASSACHUSETTS GENERAL HOSPITAL
### NURSES IN EXPANDED ROLES
### AUTHORIZATION TO PRACTICE

<table>
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<tr>
<th>Field</th>
<th>Information</th>
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<tr>
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- [ ] Nurse Practitioner
- [ ] Psychiatric Nurse Mental Health Clinical Specialist
- [ ] Nurse Anesthetist
- [ ] Nurse Midwife
INSTRUCTIONS FOR COMPLETING GUIDELINE FORMS

GUIDELINES FOR PRACTICE FOR NURSES IN EXPANDED ROLES:

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 and Emergency Response System” policy in the Clinical Policy and Procedure Manual.

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.

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.

PROCESS
1. Obtain certification signatures from your collaborating physician and chief of service.
2. Submit completed application typed with a copy of your resume, license, certification, DEA and DPH forms to Julie Goldman, RN, Professional Development Program Manager, Institute for Patient Care, Founders House 316.
3. When the approval process is completed you will receive a copy of your approved guidelines for your files.
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, NURSES IN EXPANDED ROLES:

Pursuant to Massachusetts Board of Registration in Nursing Regulations, 244 CMR 4.00; Massachusetts General Laws c94C, 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 of my prescriptions every quarter through rounds, chart reviews, or other mechanisms.

☐ I will maintain documentation of these reviews for two years.

Other:
SCOPE OF PRACTICE FORM FOR NURSES IN EXPANDED ROLES

CLINICAL AREA: ________________________________

NAME: ________________________________ Initial ____

Renewal ____

<table>
<thead>
<tr>
<th>Requested</th>
<th>Scope of Practice</th>
<th>Approved</th>
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<tbody>
<tr>
<td>Yes</td>
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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.

Assesses patients to determine need for physician attention.

Obtains informed consent for the following procedures: (list)
<table>
<thead>
<tr>
<th>Requested</th>
<th>SPECIAL PROCEDURES</th>
<th>Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Please include each procedure as well as the method for achieving and maintaining competence, and level of supervision the service requires.)</td>
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</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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Scope of Practice
General Services

ACKNOWLEDGMENT OF PRACTITIONER:
I have requested only those specific guidelines 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 guidelines 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 guidelines granted to me is waived in an emergency situation.
C. **My signature signifies that I have met the requirements recognized by MGH by-laws, Board of Registration in Nursing and Joint Commission. I hold a current Massachusetts license, current certification as a nurse in the expanded role and if prescribing, have current DEA/DPH certifications.**

Signature(s) indicates review and approval

**CERTIFICATION SIGNATURES:**

Advanced Practice Nurse

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Collaborating Physician:

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Nursing Director:
(where applicable)

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Chief of Service

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<th>(Date)</th>
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**REVIEW SIGNATURE:**

Associate Chief Nurse:

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<th>(Date)</th>
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**CONDITIONS/EXCEPTIONS:**
The preceding specified services have been approved with the following conditions and/or exceptions:

<table>
<thead>
<tr>
<th>PROFESSIONAL ACTIVITY</th>
<th>CONDITION/MODIFICATION/EXCEPTION</th>
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**REVIEW SIGNATURE:**

Health Professions Staff Committee
Chair or designee

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<th>(Signature)</th>
<th>(Date)</th>
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</table>

**REVIEW SIGNATURE:**

Senior Vice President for Patient Care and
Chief Nurse or designee. Signature
also indicates review and approval of
Patient Care Services Executive
Committee

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<th>(Signature)</th>
<th>(Date)</th>
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Effective From: _____/____/____ to _____/____/____
Patient Care Services Executive Committee  
February 22, 2012  
2:30 to 4:00 p.m.  
Massachusetts General Hospital  
Trustees Room

MINUTES  

Presiding: J. Ives Erickson, RN, DNP
Present:  
G. Banister, RN, PhD, D. Burke, RN, L. Carbunari, RN,  
D. Colton, M. Ditomassi, RN, DNP, R. Evans, T. Gallivan, RN, M. E.  
Gioiella, MSW, LICSW, L. Holden, RN, PhD,  
R. Lipkis-Orlando, RN, K. Perleberg, RN, G. Reardon, S. Taranto, C.  
Vega-Barachowitz, MS, CCC-SLP, K. Whitney, RN
Guests: K. Marple  
Staff Support: M. Greenberg

(D) For Review and Approval: APRN and PA OPPE/FPPE Credentialing Policies–  
G. Banister, RN

- J. Ives Erickson, RN, DNP, briefed the group about the revised credentialing process policy.  
  Both G. Banister, RN, PhD, and J. Goldman, RN, have been diligently working on this  
  initiative.
- G. Banister, RN, PhD, announced that as of January 1, 2012, there would be a minimum of  
  two clinically relevant measures for all groups: peer review, and chart/case review.
- The Senior Vice President of Patient Care Services approves the Nurses in the Expanded Role  
  and Physicians Assistants credentialing.
- Required approvals for the new policy proposal include the following: Associate Chief  
  Nurses; the Senior Vice President for Patient Care and Chief Nurse; the Professional Practice  
  Assessment Steering Committee; the Health Profession Staff Committee; and, Compliance.  
  In addition, the General Executive Committee, Patient Care Services Executive Committee,  
  and Chiefs need to approve.
- All documentation must be kept for seven years.
- G. Banister RN, PhD, shared that the roll-out of the new procedures would take place  
  beginning March 1, 2012.
- The communication plan involves email messages to the APRNs/PAs, articles in Caring  
  Headlines and Fruit Street Physician, and announcements at Nursing Directors,  
  Administrative Directors, and APRN forum meetings.
- J. Ives Erickson, RN, DNP, asked the PCSEC members for a vote, and 100% of the group  
  voted in favor of the new policy.
(F) **PCS Strategic Plan – J. Ives Erickson, RN, DNP**

- J. Ives Erickson, RN, DNP, led the group in a review of the 2012 PCS Strategic Plan.
- **Goal # 1: (Develop an Efficient and Effective Patient- and Family-Centered Model of Care Delivery Advancing a Relationship-Based Care Philosophy.)** – J. Ives Erickson, RN, DNP, announced a March 19, 2012, roll-out of the new Innovation Units.
- **Goal # 2: (Design and Implement New Programs to Improve Patient and Family Satisfaction.)** – R. Evans is developing a strategic plan that will be presented to the Patient Experience Leadership Council early next week. He will share this plan at the next PCSEC meeting.
- M. Ditomassi, RN, DNP, shared that the Volunteer and Interpreter Services departments are implementing new programs to enhance the patient experience.
- For example, the MGH Beacon System allows the volunteers to be more mobile, thus allowing them to be more welcoming to the public.
- **Goal # 3: (Lead Patient Affordability Direct Care Initiatives.)** – J. Ives Erickson, RN, DNP, shared that at a future meeting, D. Tenney, RN, will be able to update the group about the Periop Committee initiatives.
- G. Reardon shared that the Clinical Advisory Council is looking at advanced wound care and the products associated with it.
- T. Gallivan, RN, shared that there have been reductions in patients’ length-of-stay. However volume of patients in the ED has increased.
- **Goal # 4 (Participate in Care Redesign Team Efforts) – The work behind this goal is ongoing, and no additional issues were brought forward at this time.**
- **Goal # 5 (Advance the Culture of Excellence Every Day.)** – K. Perleberg, RN, announced that Joint Commission Resources will be visiting the MGH again at the end of next month. There will be an environment of care expert here on March 13 and 14, 2012. Tracers and mock surveys continue, and are very helpful.
- J. Ives Erickson, RN, DNP, announced that scope of practice will be an agenda item for the next PCSEC meeting.
- G. Reardon shared that the same standards are across the board in infection control.
- M. Ditomassi, RN, DNP, shared that the first drafts of the Magnet sources of evidence are being posted.
- **Goal # 6 (Design and Implement Clinical and Business Information Systems that Support Patient Care and Research.)** – J. Ives Erickson, RN, DNP, noted that Goal # 6 will be critically reviewed at the next meeting to determine if it should remain in the Strategic Plan.

(H:\2 22 12\2012 PCS Strategic Plan FINAL)

(F) **Joint Commission Updates – J. Ives Erickson, RN, DNP**

- J. Ives Erickson, RN, DNP, reviewed the Environment of Care/Life Safety and Medical Staff Chapters in preparation for Joint Commission accreditation.
- J. Ives Erickson, RN, DNP, shared that The Joint Commission survey preparations for medical staff include the new voting policy for Nurses in the Expanded Role and Physicians Assistants. That is the Patient Care Services part of this initiative.
• Testing, maintenance and cleaning of all equipment is consistently noted in the logbook. An issue arises when the stickers are missing from the pieces of equipment, when they have already been cleaned and maintained, and logged in the logbook.
• Biomed will be sending reports to the Environment of Care Committee.
• An area needing improvement is related to signage for the isolation rooms.

(I) Updates – All
• L. Holden, RN, PhD, announced a keynote presentation for Patient Safety Awareness Week by Dr. Elizabeth Rafferty, Director of Breast Imaging, about Tomosynthesis, to be held on March 8, 2012, from 12:00 – 1:00 p.m., in the O’Keeffe Auditorium. All are invited.
• L. Holden, RN, PhD, announced that an electronic, anonymous survey about safety culture will be launched on March 14, 2012. This survey will target most MGH staff whose work impacts patient care. Please encourage your staff to complete the survey.
• S. Taranto shared that the HealthStream system is currently down. Efforts are underway to restore it.
• K. Perleberg, RN, shared that there needs to be a consistent tracking system, either on paper or online, of the completed HealthStream courses. Concise documentation is important for the Joint Commission.
• J. Ives Erickson, RN, DNP, shared that a report can be generated to show how many people are in compliance.
• M. Ditomassi, RN, DNP, shared that Elizabeth Behrmann in HR is coordinating the final review of job descriptions that will be forthcoming via email.
• D. Burke, RN, announced that the Pharmacy has asked for implementation of all Omnicell passwords to expire on a routine basis. The Pharmacy agreed to a 180-day change, versus every 30 days.
• G. Banister, RN, PhD, shared that Innovation Unit educational sessions are underway and going well.
• G. Banister, RN, PhD, announced that funding has been received for the Connell Research Scholars and the Connell Ethics Fellowship. A call for applications has been sent out.
• K. Perleberg, RN, announced that on February 13, 2012, a new staff specialist, Patricia Shanteler, RN, joined the PCS Office of Quality & Safety.
• M. E. Gioiella shared that some students from Revere High School will be meeting with the HAVEN advocates to join in a discussion on teen violence. This is an innovative program, and School Vacation Week was chosen to invite the students to the MGH.
• R. Evans shared that the HCAHPS inpatient data for the first 6 weeks of 2012 looks positive. Scores on nurse communication and quiet/clean have improved.
• G. Banister, RN, PhD, announced that the PCSEC approved the policy: Emergency Privileges for Nurses and other Health Professionals. Policy is attached.
G. Banister, RN, PhD, announced the summary of credentialing for nurses in the expanded role and physician assistants in preparation for committee review on February 22, 2012. New appointments: 5 new NPs, 5 new CRNAs: three of these in three different practice sites; and, 2 new PAs. There were 12 nurse practitioners for reappointment, 1 CRNA for reappointment, and 1 PA for reappointment. The total is 26 candidates for review and approval, with three candidates for more than one site as noted above. List is attached below.
APRN/PA Clinical Reappointment Performance Evaluation

Provider Name: ________________________________

Clinical Performance Review Measures:

<table>
<thead>
<tr>
<th>Institutional Measures</th>
<th>Satisfactory</th>
<th>Unsatisfactory*</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Review of all patient complaints and/or commendations.</td>
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<td>Certification up-to-date.</td>
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<tr>
<td>Appropriate interpersonal and communications skills.</td>
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<tr>
<th>Service-specific Measures:</th>
<th>Satisfactory</th>
<th>Unsatisfactory*</th>
<th>N/A</th>
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<tbody>
<tr>
<td>All APRN/PA</td>
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<tr>
<td>Peer review</td>
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<tr>
<td>Chart review</td>
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** Completed by Chief APRN/PA or collaborating/supervising physician or designee.

*Corrective Action Plan: __________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

The above criteria have been reviewed in regard to the reappointment of ____________________________

This provider meets or exceeds the expected level of performance. To the best of my knowledge, there are no concerns about the provider's professional performance, judgment or clinical skills.

Applicant

Date

Chief APRN/PA (if applicable)

Date

Collaborating/Supervising Physician

Date

Approved: GEC 2/2012
Implementation Plan for
Nurses in the Expanded Role and Physician Assistants
OPPE/FPPE

February 22, 2012: Approval from General Executive Committee and Patient Care Services Executive Committee.

February 22, 2012: Pilot measures on 2 APRNs in Cardiology and Oncology.

February 22, 2012: Notification of approval to practice sent to candidate, nursing director and collaborating MD.

February 23, 2012: Pilot the measures with 2 PAs in the cardiac surgery practice areas.

February 27, 2012: Contact key members of the Health Profession Staff Committee (chief nurse midwife, the chief cardiac surgery PA, a psychiatric clinical nurse specialist, chief nurse anesthetist and nurse practitioner leader in in-patient cardiology) to have them implement the form in their practice areas; attend staff meetings for their groups to discuss OPPE/FPPE requirements.

February 28, 2012: Conduct educational session for administrative directors about OPPE/FPPE requirements for APRN/PA.

February 28, 2012: Conduct educational sessions for cardiac nurse practitioners on Ellison 11 about OPPE/FPPE requirements for APRN/PA.

February 29, 2010: Conduct educational sessions for staff of the Gynecology Clinic about OPPE/FPPE requirements for APRN/PA.

March 1, 2012: Conduct educational sessions during the monthly CRNA meeting about OPPE/FPPE requirements for APRN/PA

March 1, 2012: Conduct educational sessions for physician assistants in cardiac surgery about OPPE/FPPE requirements for APRN/PA

March 1, 2012: Direct email with OPPE/FPPE measures and Talking Points to all nurses in the expanded role, physician assistants with a cc to the administrative directors/managers. Clinicians asked to start the use of the forms immediately; expectation of 100% compliance with use of the measures by March 20th.

March 1, 2012: Follow-up with practitioners in Occupational Health, ED, Ortho, Dialysis, OB, Thoracic, Oncology and Yawkey, and outpatient settings on process and form.

March 1, 2012: Sent re-credentialing candidates the new forms in order for them to be included with re-credentialing materials.
March 1, 2012: Provide Yawkey outpatient areas educational information on OPPE/FPPE requirements and use of forms for APRNs/PAs.

March 7, 2012: Conduct educational session on OPPE/FPPE requirements at the monthly APRN educational forum.

March 7, 2012: Resend direct email previously sent to all groups on March 1, 2012.

March 8, 2012: Attend Health Profession Staff Committee meeting to answer questions about OPPE/FPPE requirements for APRN/PA and follow up with feedback.

March 12, 2012: Attend Administrative director meeting for Q&A.

March 14, 2012 and March 19, 2012: Resend the direct email previously sent to all groups on March 1, 2012.

March 24, 2012: Conduct educational session to APRN/PAs about OPPE/FPPE requirements for APRN/PA at an additional APRN educational forum.

March 27, 2012: Conduct an update for the administrative directors/managers at their monthly meeting regarding the importance of the documentation; resend the direct email previously sent to all groups on March 1, 2012; attend meetings to assist in answering questions and gaining compliance with use of the measures (e.g. APN forum, combined leadership etc.).

Goals for compliance:

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<th>Date</th>
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<td>March 1, 2012</td>
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<td>March 7, 2012</td>
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<td>March 15, 2012</td>
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<td>March 20, 2012</td>
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<td>April 1, 2012</td>
<td>100%</td>
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## PRACTICE-BASED LEARNING & IMPROVEMENT LOG

**Review Type:**
- [ ] FPPE: Focused Professional Practice Review (Initial Privileging within the first three months of clinical work or Remediation)
  - Three direct observations required.
- [ ] OPPE: Ongoing Professional Practice Review (Every six month review of practice). Three direct observations or chart reviews required.

### Name of APRN/PA candidate reviewed

### Practice Area:

### Collaborating/Supervising Physician (Print Name)

### Evaluation Period:

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Please note - Threshold for Remediation <80% of criteria met for each chart/case will require a FPPE Action Plan

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<tr>
<th>Case 1</th>
<th>Assessment</th>
<th>Yes</th>
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<td>Technical skill demonstrated</td>
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<td>Date of review</td>
<td>Clinical judgment evident</td>
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<td>Interactions with patient appropriate</td>
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<tr>
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<td>Documentation complete and accurate</td>
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<td></td>
<td>Time out performed</td>
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<td>Zero “Do Not Use” Abbreviations</td>
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<td>Technical skill demonstrated</td>
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<tr>
<td>Date of review</td>
<td>Clinical judgment evident</td>
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<td>Zero “Do Not Use” Abbreviations</td>
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Date

Signature of APRN/PA Peer OR Collaborating/Supervising Physician completing the form

Printed Name

Approved: GEC 2/2012
### APRN/PA Peer Review

**Relationship with patients and families:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor</th>
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<tr>
<td>Interpersonal skills promote therapeutic relationships with patients and families.</td>
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<td>Provides culturally competent care to patients and families.</td>
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<td>Tailors communication and teaching to ensure patient and family understanding and comprehension.</td>
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**Clinical Knowledge and Decision Making:**

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<th>Criteria</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor</th>
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<tr>
<td>Clinical practice and decision making is evidence based.</td>
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<td>Initiates independent learning to learn or maintain technical skills and clinical knowledge.</td>
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<td>Clinical judgment and decision making reflects an understanding of the current clinical situation as well as future implications.</td>
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**Teamwork, Care Coordination and Collaboration:**

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<th>Criteria</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor</th>
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<tr>
<td>Demonstrates forethought in anticipating, planning and coordinating the patient’s care across the continuum.</td>
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<td>Communicates with all members of the health care team in a respectful, professional manner to ensure the best patient outcome.</td>
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<tr>
<td>Shares knowledge and information with all members of the health care team to elevate the standard of practice.</td>
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**Comments:**

Signature of Peer Reviewer: ___________________________ Date __________

Signature of Employee: ___________________________ Date __________