The Process Protocol Workbook

CALIFORNIA 2012 EDITION

A Manual for the Development of
Process-Oriented Standardized Procedures
For Nurse Practitioners

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My thanks to the many nurse practitioners whose suggestions, commentary and discussions led to this revision of The Process Protocol Workbook. My thanks also to Kathleen Kauffroath JD, Jeanette Wackerly, MBA RN NEC, and my husband.

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PREFACE TO THE 2012 EDITION

On the following pages you will find a format to write a customized set of standardized procedures. It is geared for furnishing nurse practitioners in a primary care setting, although the flexibility of the process model allows it to be adapted to other acute and specialty practices. Each sample standardized procedure has an associated work page with a discussion of points I thought needed clarification or background information. As you will see, the framework and basic research is done, but you still have to modify it for your individual practice. You, an associate physician, and an administrative representative (if you have a separate administration) all need to understand the standardized procedures and agree on them. It's a bit of work. That's why this is a workbook.

In order to make producing your final document easier, a CD is included that contains a file with just the text portions of the Workbook, without the discussion or work pages. You need to fill in the blanks, edit where necessary and print out your customized standardized procedures. (The CD has now been replaced with a web-based word processing file).

As you probably know, there is a national movement to adopt the Advanced Practice Registered Nurse (APRN) consensus model which would make the education, roles, and titles of advance practice nurses, and their certification and recertification process, uniform in all states. I gave some thought to incorporating the consensus model in this edition of the Workbook, but decided against it since California has not adopted the model (although educators and academic institutions are moving in that direction) and the Board of Registered Nursing (BRN) has not integrated the standards. Once that has occurred, another edition of the Workbook will be forthcoming. In this edition, there are occasional references to the APRN consensus model, but I did not use the APRN roles and titles.

That said, I do want to address the issue of establishing competency, which is of concern to both the California Board of Registered Nursing and the organizations promoting the APRN consensus model. A key feature of California's Nursing Practice Act is the recognition that nursing is a dynamic field in which there will always be a sharing of functions between RNs and MDs. The guidelines were written so that the role of nurses could expand, while providing a structure for safeguards to protect the health and safety of consumers. The benefit of such an open structure is evident in the wide range of advanced practice nurses today; from family practice in urban and rural areas, to highly technical and specialized fields in acute settings. Although exciting and full of potential, one of the difficulties with such leeway, particularly for those looking to add new skills or broaden their scope of practice, is establishing clinical competency. Competency is not established by "see one – do one – bill one". "Clinically competent" means that one possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate

discipline in clinical practice.[1] It means not only does your scope of practice need to be safe, but also your training documented to a standard that would pass muster by a jury of your peers. Competency is foremost about health and safety, but it's also the law. If you are expanding your practice or considering taking on new skills, I urge you to have documented criteria for competency – available through existing institutions and continuing education programs. Where missing or unavailable, you need to work with colleagues and educators to establish criteria that include documenting training, an effective review process, and continuing education to ensure continued competency until formal certification is available to you.

After all is said and done, there are few substantive changes in this edition - mostly corrections, updated language and a little rethinking. I did delete the standardized procedure for Supervising Medical Assistants, as it turns out that was not in our bailiwick after all[2], and added a procedure on Authorizations. I also decided to continue to separate Health Care Management into primary, secondary and tertiary care. Some may find this cumbersome, especially if you're already thinking in terms of APRN roles and populations, but I've found that working through how these levels of care will be handled and establishing a plan for consulting remains beneficial. Please feel free to streamline.

Lastly let me remind you that if you are an RN practicing beyond the scope of nursing and into the scope of medicine (i.e. a nurse practitioner), and you are in California, you must have written standardized procedures to practice legally. Having standardized procedures won't make you a better nurse practitioner, but if you find yourself in litigation, not having them could be considered practicing medicine without a license. Also, I don't pretend to be addressing the requirements of health insurance or malpractice companies. This Workbook is simply one method of creating standardized procedures based on the guidelines and codes provided to us by the BRN. It is your obligation to understand the requirements and meet them.

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[1] "General Information: Nurse Practitioner Practice", rev. 04/2011; www.rn.ca.gov/pdfs/regulations/npr-b-23.pdf

[2] "Nurse Practitioners and Nurse Midwives - Supervision of Medical Assistants", rev. 11/2010 www.rn.ca.gov/pdfs/regulations/npr-b-41.pdf.

INTRODUCTION TO THE CALIFORNIA NURSING CODES AND THE REQUIREMENT FOR STANDARDIZED PROCEDURES

In order to understand the need for standardized procedures, you need to be familiar with the development of nursing codes in California as they pertain to nurse practitioners. Each state has codes that define the scope of practice of professions, such as nursing and medicine. The Nursing Practice Act (NPA)[1] is the body of codes regulating California nursing practice. The NPA includes portions of the Business and Professions Code (B&P Code) and California Code of Regulations (CCR). The Board of Registered Nursing (BRN) is the division of the State Department of Consumer Affairs which regulates nursing and nurse practitioners. The Medical Board of California (MBC) is the division that regulates the practice of medicine.

In the 1973-74 legislative sessions, legislators recognized that nursing practice had naturally overlapped into medical practice. In order to account for this dynamic change in nursing and to permit an ongoing sharing of functions within health care systems, legislators amended the Code[2], creating a legal mechanism for expanding nursing roles. The pertinent portion of the amended Code states, in summary, that nurses can observe signs and symptoms of illness or conditions, determine if they are abnormal, and then implement appropriate reporting, referral or *standardized procedures*. Standardized procedures are a written description of the conditions under which a nurse may perform specified, traditionally medical activities or functions. It is this legislative authority allowing nurses to implement written standardized procedures based on their findings that legalizes the independent medical activities of the nurse practitioner.

The legislators required the BRN and the MBC to develop guidelines for writing standardized procedures[3] with the purpose of protecting consumers and providing uniformity to all standardized procedures. Uniformity was an admirable goal, but over the years interpretation of the Guidelines generated two fundamental styles of standardized procedures. The disease based style is one in which all the guidelines are addressed for each disease the nurse is authorized to manage. The other style is the process model.

Process-oriented standardized procedures describe and define the functions of advanced practice nurses. Those functions that are within the scope of nursing practice[4], independent of physician action or approval, don't need to be defined or standardized; for example, taking a history and physical assessment. Those functions that are within the scope of medical practice, but are performed independently by a nurse, do require a written standardized procedure. Since the scope of medicine includes the diagnosing of physical and mental

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[1] www.rn.ca.gov/regulations/npa.shtml
[2] www.rn.ca.gov/regulations/bpc.shtml#2725
[3] "An Explanation of Standardized Procedure Requirements for Nurse Practitioner Practice", 12/1998 www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf
[4] "Explanation of RN Scope of Practice and Nurse Practitioner Practice", 12/1998 www.rn.ca.gov/pdfs/regulations/npr-b-19.pdf.

conditions, the use of drugs, and the severing or penetrating of tissues in human beings, much of what a nurse practitioner typically does requires a standardized procedure. When you standardize a medical function, you, and an associate physician, are defining it based on the BRN Guidelines and agreeing on what the rules or protocols will be when performing that function.

Regardless of how nursing regulations evolved, how independent nurse practitioners currently are, or where national standards may take us in the future, for now the law states that nurses, (including nurse practitioners), performing functions beyond the scope of nursing must have written standardized procedures to practice in California. Although there are now codes that pertain to advanced practice nurses specifically, (e.g. Furnishing Drugs and Devices), the fundamental legal basis for advanced practice is unchanged and applies to all nurses. Not having them makes you legally vulnerable regardless of your education and certification. The BRN makes it clear that both process oriented and disease specific standardized procedures are acceptable[1] provided that all the Guidelines are addressed. Ultimately the style of standardized procedure used is up to the persons using them. Determine what works best for you and get them done.

[1] "An Explanation of Standardized Procedure Requirements for Nurse Practitioner Practice", 12/1998 www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf

KEY TO THE STANDARDIZED PROCEDURE GUIDELINES

The following cross-reference will direct you to the section of the Workbook that addresses each guideline found in the BRN Standardized Procedure Guidelines.

GUIDELINE NUMBER	GUIDELINE	WORKBOOK PAGE
a	Standardized procedures shall include a written description of the method used in **developing** and **approving** them and any **revision** thereof	7
	Each standardized procedure shall:	
b1	Be in **writing, dated** and **signed** by the organized health care system personnel authorized to **approve** it	4
b2	Specify which standardized procedure **functions** registered nurses may perform and under what **circumstances**	15-43
b3	State any specific **requirements** which are to be followed by the registered nurses in performing particular standardized procedure functions	15-43
b4	Specify any **experience, training,** and/or **education requirements** for performance of standardized procedure functions	9
b5	Establish a method of **initial and continuing evaluation** of the competence of those registered nurses authorized to perform standardized procedures	9
b6	Provide for a method of maintaining a **written record of those persons authorized to perform standardized procedure functions**	7
b7	Specify the **scope of supervision** required for performance of standardized procedure functions, for example, immediate supervision by a physician	9
b8	Set forth any special circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition	11
b9	State the limitations on **settings**, if any, in which standardized procedure functions may be performed	7
b10	Specify **patient record keeping requirements**	9
b11	Provide for a method of **periodic review** of the standardized procedures	7

KEY WORK PAGE

Here are the Standardized Procedure Guidelines verbatim from the Nursing Practice Act[1]. Since the Guidelines weren't written in a way that was conducive to the process style used in this Workbook, I included this key. It will provide quick access to the exact wording of the Guidelines while you work on your document.

[1] "Standardized Procedure Guidelines", rev. 01/2011
www.rn.ca.gov/pdfs/regulations/npr-i-19.pdf

STANDARDIZED PROCEDURES FOR THE NURSE PRACTITIONERS AT

[YOUR AGENCY]

INTRODUCTION TO THE STANDARDIZED PROCEDURES (IN)

The purpose of these Standardized Procedures is to define the scope of practice of _____ at _____ (IN1) in order to meet the legal requirements for the provision of health care by nurse practitioners. They are established to assist all health care providers with an understanding of the role and scope of practice of the nurse practitioner and to provide a safeguard so that providers and patients alike may be assured of the best health care possible.

These Standardized Procedures are based on the Guidelines established by the Board of Registered Nursing and the codes and regulations circumscribing California nurse practitioners (collectively referred to as the Nursing Practice Act). (IN2) In order to provide the highest standard of care, these Standardized Procedures incorporate the following qualities:

ADAPTABILITY, in order to allow for the unique management needs of each individual patient;
FLEXIBILITY, to accommodate the rapidly changing and complex nature of the health care field and to acknowledge that medicine is not an exact science;
PRACTICALITY, in order to be useful in a setting that must incorporate a variety of educational backgrounds and personal management styles; and
SPECIFICITY, to address the intent of the Standardized Procedure Guidelines, the codes regulating nurse practitioners and to protect the health care consumer.

The Standardized Procedures consist of the following: (IN3)

GENERAL POLICIES: Define the general conditions of and give authorization to the nurse practitioner to implement the Standardized Procedures.

HEALTH CARE MANAGEMENT STANDARDIZED PROCEDURES: Delineate the medical functions requiring a standardized procedure and, using policies and protocols, define the circumstances and requirements for their implementation by the nurse practitioner.

INTRO WORK PAGE

IN There was a time when the process style for standardized procedures was quite controversial and the methodology had to be spelled out to get everyone on board. This introduction served that purpose. It can still be useful as a starting point for the document. It generally describes the purpose of standardized procedures and tells the reader what the goals are. None of the introduction is required, but some of it may be helpful.

IN1 Put your name here or use the general term "nurse practitioners". Use the agency name, e.g. Small Town Community Clinic. Get the plurals and singulars straight.

IN2 The codes and regulations provide the background information and justification for doing all this and may be useful in educating personnel unfamiliar with standardized procedures. In the footnotes will be the BRN website link to the codes and the BRN advisories interpreting the codes.

IN3 What I found as I went through the Guidelines and applied them to my practice is that many of them were addressed the same way, regardless of the medical function I was performing. So, rather than reiterate the same response to the Guidelines on development, review, revision, etc. over and over, I lumped them all into a business section and called it General Policies. I also found that there were some Guidelines I wanted to address broadly in the General Policies and then also more specifically in the Health Care Management Standardized Procedures. The actual medical functions are defined by policy and protocols in the second section called Health Care Management Standardized Procedures.

STATEMENT OF APPROVAL AND AGREEMENT (AA)

This document was jointly developed and approved by the _____(AA1)
for
_____(AA2)
in accordance with the codes regulating nursing practice on _____ (AA3).

Signature on this statement implies

- Approval of the Standardized Procedures and all the policies and protocols contained in this document.
- Agreement to maintain a collaborative and collegial relationship.
- Agreement to abide by the Standardized Procedures in theory and practice.

_____

Name/Title Date

_____

Name/Title Date

_____

Name/Title Date

_____

Name/Title Date

_____

Name/Title Date

_____

Name/Title Date

_____

Name/Title Date

APPROVAL WORK PAGE

AA This is a sample signature page. Guideline b1 and the Code on Furnishing require that standardized procedures be approved by the Organized Health Care System authorized to do so; which includes physicians, nurses and representation from administration. This is an easy way to do that. The written description of the method of development and approval, revision and review is in the General Policies.

How you word this statement depends on the situation you're in. If all the nurse practitioners and physicians are developing, approving and agreeing to the standardized procedures, then you only need one Statement of Approval and Agreement. In **AA1** put your names, or use the general titles of "nurse practitioners and physicians", **AA2** gets your agency name and **AA3** a date.

On the other hand, a committee may be acting on behalf of providers who are not in a position to individually develop and approve the standardized procedures, but who must agree and abide by them nonetheless. If that's the case then put the name of the committee (or names of the committee members) in **AA1**, **AA2** gets the agency name and **AA3** a date. If you want you can have spaces for the committee members to sign separate from those who didn't actually develop the document but are agreeing to it. Some offices like the Statement of Approval and Agreement to be signed just by the collaborating parties and have a separate list of the NPs of record who are authorized to implement the standardized procedures.

Finally, you may want a similar signature page with slightly different wording to document Review and Revision when you get to that.

GENERAL POLICIES

GENERAL POLICIES (GP)

It is the intent of this document to authorize _____ at _____ (GP1) to implement the Standardized Procedures without the immediate supervision or approval of a physician. The Standardized Procedures, including all the policies and protocols, are defined in this document and will be referred to generally as the "Standardized Procedures".

DEVELOPMENT, APPROVAL, REVISION AND REVIEW

The Standardized Procedures have been developed and approved by _____(GP2) Review, and if necessary, revision, of the Procedures will be done _____(GP3) by _____(GP4) The completion of these tasks, including notification of revisions, is the responsibility of _____(GP5)

AGREEMENT (GP6)

All nurse practitioners and associate physicians will signify agreement to the Standardized Procedures following the approval process. Signature on the Statement(s) of Approval and Agreement implies the following: approval of all the policies and protocols in this document, the intent to abide by the Standardized Procedures, and the willingness to maintain a collegial and collaborative relationship with all the parties.

SETTING (GP7)

The nurse practitioners will perform these Standardized Procedures at _____.

RECORD OF AUTHORIZED NURSE PRACTITIONERS (GP8)

The Statement of Approval and Agreement signed by the nurse practitioners will act as the record of nurse practitioners authorized to implement the Standardized Procedures.

GENERAL POLICIES WORK PAGE

GP This is the administrative or "business" end of the standardized procedures. In these General Policies you will determine much of the "who, what, where, when, why, how" of the Standardized Procedure Guidelines.

GP1 Put your names in here or use the general title of "nurse practitioners" along with the agency name. Get those pronouns right if you change to singular.

GP2 Per Guideline a and b11, you need a written description of the method used in the development, approval, review and revision of the document. Put your names, general titles or a committee name here.

GP3 How often are you going to review and revise the standardized procedures once they have been developed? In the past I've picked a season and said annually. The BRN[1] has an example that states "every three years and as practice changes". In another of their advisories[2] it's suggested that they be "updated frequently enough to ensure that patients are receiving appropriate care. Factors to consider include patient population and acuity, treatment modalities and advances in technology and pharmacology".

GP4 Will this be by the same people who did the original development, or will all the providers using the standardized procedures be asked to review and make suggestions for revisions?

GP5 The Guidelines do not say you have to name someone, but somebody, preferably with a title like "chairperson" or "medical director", needs this job or it won't get done. It still might not get done, but you'll have someone to ask. Who will it be?

GP6 I know this is a restatement of the signature page but I like to keep all the policies together. Also, some agencies prefer to use the modifier "collaborating" or "supervising" physician. Regardless of who or what committee develops and approves the standardized procedures, I believe all the nurse practitioners and physicians need to agree to them.

GP7 Guideline b9 requires you to state any limitations on setting. The setting is the office or facility in which you work. If you take call you may want to note that here. If you work in multiple offices, hospitals or nursing homes you need standardized procedures for each one. The documents could be more or less the same, but need to reflect the collaboration of nursing, medicine and administration for each facility.

GP8 You have to keep a record of who is authorized to implement the standardized procedures (Guideline b6); it seems like the signature page does that nicely enough.

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[1] "An Explanation of Standardized Procedure Requirements for Nurse Practitioner Practice", 12/1998 www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf

[2] "Frequently Asked Questions Regarding Nurse Practitioner Practice", rev. 12/2004 www.rn.ca.gov/pdfs/regulations/npr-i-25.pdf

EDUCATION AND TRAINING (GP9)

The nurse practitioners must have the following:

- Possession of a valid California License as a Registered Nurse.
- Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner. (GP10)
- Furnishing Number.
- DEA Number.
- Certifications. (GP11)

EVALUATION OF CLINICAL CARE (GP12)

Evaluation of the nurse practitioner will be provided in the following ways:

INITIAL EVALUATION

- Chart Review based on written criteria. (GP13)
- Informal evaluation during consultations.
- Feedback from co-workers.
- Evaluation at the end of the probationary period based on written criteria.

CONTINUING EVALUATION (GP14)

- Annual evaluation based on written criteria including chart review.
- Verification of Continuing Education.
- Verification of current certifications.

PATIENT RECORDS (GP15)

The nurse practitioner will be responsible for the preparation of a complete medical record for each patient contact per existing office policies.

SUPERVISION (GP16)

The nurse practitioner is authorized to implement the Standardized Procedures in this document without the direct or immediate observation, supervision or approval of a physician, except as may be specified on individual Health Care Management Standardized Procedures. Physician consultation is available at all times, either on-site or by electronic means.

GENERAL POLICIES WORK PAGE (cont.)

GP9 Here you need to describe the education and training the nurse practitioner must have before practicing under these standardized procedures (Guideline b4). All nurse practitioners must be licensed RNs and certified as nurse practitioners by the State of California in order to hold out as a nurse practitioner. A Furnishing number is standard of practice, as is a DEA number for NPs ordering any Scheduled substances (further discussion of DEA numbers is in the Ordering Scheduled Controlled Drugs protocol). Recall that new graduates may not have these numbers right away, but all should have the potential to get them. This is not a job announcement or wish list – state only the basic requirements for practice.

GP10 As you know from the preface to this 2012 edition, the APRN consensus model is moving us towards a national standard of education, uniform roles and titles, and certification and recertification processes. Assuming these standards will be adopted and incorporated into California regulation and usage, the terminology used here will eventually change to reflect the updated titles and role requirements. Currently, however, when you are certified by the BRN, the specialty you were trained in (e.g. FNP, ANP, PNP, Ob-Gyn) is not stated on your license and there is no requirement for national certification.

GP11 In order to be sure that the nurse practitioner following the standardized procedures has been adequately trained in the field in which she/he will be employing them, it is advisable to include appropriate academic certification or professional qualifications. If you are working in a specialized field for which there is no certification you will want to document clinical competency (see Continuing Evaluation). Not having competency in your scope of practice is both negligent and illegal. Remember, in litigation you would be held to the standard of an NP trained in the practice specialty.

Along the same lines, many organizations have numerous specialized departments that employ nurse practitioners. Each department will need to have standardized procedures that address their situation. If specific training, beyond the appropriate certification, is required for all NPs in the department, you could add it in here (e.g. Colposcopy Training). Another option, however, is to make a general statement in this section like, “Additional training requirements may be noted on Health Care Management Standardized Procedures” (for an example see Procedures and Minor Surgery).

CONSULTATION (GP17)

The nurse practitioner will be providing health care as outlined in this document. In general, communication with a physician will be sought for all the following situations, and any others deemed appropriate. Whenever a physician is consulted, a notation to that effect, including the physician's name, must be made in the chart. (GP18)

- Whenever situations arise which go beyond the intent of the Standardized Procedures or the competence, scope of practice, or experience of the nurse practitioner.
- Whenever patient conditions fail to respond to the management plan as anticipated.
- Any patient with acute decompensation or rare condition.
- Any patient conditions which do not fit the commonly accepted diagnostic patterns for a disease or disorder.
- At the patient's, nurse practitioner's or physician's request.
- All emergency situations after initial stabilizing care has been started.

GENERAL POLICIES WORK PAGE (cont.)

GP12 So how is your competence going to be evaluated? Guideline b5 requires a method for both initial and continuing evaluation but doesn't say what that process should be or who should be doing the evaluating. Ideally evaluations are helpful, uncomplicated and have reasonable time frames so that the whole process is doable. In addition to assessing clinical competency (including Furnishing and Procedures), you might also want to take into consideration any evaluation or review requirements from your funding sources, personnel policies or the malpractice company so you can cover all your needs at once (that'll slow you down!). Do not forgo the documentation; establish written criteria for evaluation and document completion. Again, you'll need a method for Initial Evaluation and Continuing Evaluation.

GP13 This could be anything from a random review of a set number of charts to all charts for a stated period of time. For example: Joint review of all charts for the first two weeks, followed by weekly review of 5 randomly pulled charts for the following ten weeks. You could also review charts by complexity or diagnosis. Do NPs or MDs do the review? Who creates and keeps a written record of it?

GP14 Add the tools and details that suit your situation. Consider including interdepartmental audits such as those from Quality Management and Pharmacy as appropriate. Also consider including language that requires relevant continuing education and recertification.

GP15 You have to "specify patient record keeping requirements" (Guideline b10) which means you have to chart on each patient. If you have written policies on record-keeping practices, keep this reference. By the way, although third party payers or other entities may want physician co-signature, there is no BRN requirement for charts to be co-signed by an MD.

GP16 I believe most nurse practitioners function under this kind of general supervising requirement (Guideline b7). Exceptions have come up however, which prompted me to include this phrase about individual standardized procedures. Cervical and endometrial biopsies and flex sigmoids were procedures for which some felt a physician should be on site if an unexpected finding or adverse reaction occurred. Note that there is no requirement that a physician be on site. It does seem reasonable that she or he be close enough geographically to be beneficial to you.

GENERAL POLICIES WORK PAGE (cont.)

GP17 This section on consulting is fairly broad. My idea was to create a bottom line; the final word on when you need to consult in order to meet Guideline b8. I also want to make it clear that consulting is a good practice when you find yourself over your head for any reason. There are any number of phrases you could include here, use as many as you like or write your own. Before you add or delete anything you may want to read all the Health Care Management Standardized Procedures that follow – the one on Secondary care adds more specifics.

GP18 If you've consulted, you've obviously encountered something you aren't comfortable handling alone. By noting a consultation in the chart, you show that you didn't independently go beyond the scope of your practice. I've also seen the following wording: "The participation of each provider will be documented in the medical record, including signatures."

HEALTH CARE MANAGEMENT
STANDARDIZED PROCEDURES

HEALTH CARE MANAGEMENT - PRIMARY CARE (PC)

POLICY

Primary Care includes acute and episodic conditions, chronic conditions, and health care maintenance. (PC1) The nurse practitioner is authorized to diagnose and manage Primary Care conditions under the following protocols:

PROTOCOLS

1) Assessment and treatment plan is developed based on the resources listed in this document. (PC2)

2) Lab work and diagnostic studies ordered are appropriate to the condition being evaluated. (PC3)

3) Durable medical goods and therapies ordered, such as physical therapy, occupational therapy, dietary counseling and psychological services, are appropriate to the condition and consistent with internal policies. (PC4)

4) Patient education and follow up is given as appropriate.

5) All other applicable Standardized Procedures in this document are followed during health care management. (PC5)

6) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

PRIMARY CARE WORK PAGE

PC The Health Care Management Standardized Procedures describe the circumstances and requirements under which the nurse is authorized to perform those functions which overlap into medicine (Guidelines b2 and b3). They begin with diagnosing and treatment, and then go on to the specifics of furnishing, procedures, etc.

In this Workbook, the authorization to diagnose and treat health care conditions is broken down into Primary, Secondary and Tertiary Care so you get a feel for what parameters you might establish with the different levels of care. In fact, you don't have to use all three. You could address all the levels of care in one Standardized Procedure for Health Care Management using relevant protocols from the three levels of care. Note that I am not using the APRN definitions of primary care and acute care.

By the way, let me make this clear now that when I use the term "nurse practitioner", it assumes that you have a Furnishing number. I'm not going to always say Furnishing NP, but that's what I mean.

PC1 In the first editions of the book not only did I use this language but also examples of the conditions the NP was authorized to treat. Some people still like this delineation, but you can make up your own. If you want to use role and population language from the APRN consensus model, this would be a fine place to do so.

PC2 For a discussion on the use of written resources and references for treatment plans, see the Resources Work Pages.

PC3 In previous editions of the Workbook there were separate standardized procedures for Ordering Labs and Xray. One can easily make the case that ordering labs and diagnostics is simply part of the assessment process and doesn't need to be mentioned at all. You can decide for yourself and include this as you see fit. Regardless of whether you include the language here, it goes without saying that labs and diagnostics should be ordered apropos to your differential; if the results are over your head, get help.

PRIMARY CARE WORK PAGE (cont.)

PC4 The ordering of non drug therapies is part of primary care. I list them here to be clear that they are part of the options in a treatment plan. The exception is durable medical equipment. There is a directive that ordering durable medical equipment is by authority of a standardized procedure[1]. If you don't want to list other therapies that's fine, but if you order DME then it needs to be stated. I put in the comment about internal policies because in this document you don't want to get into things like how many visits the insurance will cover or the need for prior authorizations. If there are other limitations you want to make on ordering these things, put them here. FYI: Workers Comp, State Disability, etc. are discussed in Authorizations.

PC5 This statement and the next will be on all of the Health Care Management Standardized Procedures. Perhaps it doesn't need to be stated again and again, but I want to make it clear that all the General Policies in the rest of the document apply in each of the Health Care Management Standardized Procedures.

[1] "Nurse Practitioners: Laws and Regulations", rev. 2/2010 www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf

HEALTH CARE MANAGEMENT - SECONDARY CARE (SC)

POLICY

Secondary Care conditions are unfamiliar, uncommon, unstable or complex conditions. The nurse practitioner is authorized to evaluate and treat Secondary Care conditions under the following protocols:

PROTOCOLS

1) Assessment to the level of surety plus differential diagnosis. (SC1)

2) A physician is communicated with regarding the evaluation, diagnosis and/or treatment plan. (SC2)

3) Management of the patient is either in conjunction with a physician or by complete referral to a physician or other treatment center.

4) The physician is notified if her/his name is used on a referral to a specialty physician or department. (SC3)

5) The consultation or referral is noted in the patient's chart including name of physician.

6) All Secondary Care charts are co-signed by a physician. (SC4)

7) All other applicable Standardized Procedures in this document are followed during health care management.

8) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

SECONDARY CARE WORK PAGE

SC This standardized procedure is authorizing you to assess a situation to the best of your ability and then consult or refer. It came about for two situations: the times when a condition I was familiar with suddenly took a turn for the worse, or when I ended up seeing someone for the first time that I knew would be over my head and yet needed to stabilize before sending them on. I knew I would be consulting, and I wanted the rules clear on my authority, limits and responsibility. The conditions for Consulting that you set out in the General Polices may suffice for you – or you can elaborate here.

SC1 These words are from a BRN handout[1]. I liked them.

SC2 What exactly does it mean to communicate with a physician? This was the subject of much discussion between me and the other nurse practitioners I talked to regarding this Workbook. The upshot was that we all agreed it was important for a physician to be involved with the care, but we differed on how and when on a case-by-case basis. For example, one NP had a terrific grasp of Internal Medicine so would leave the chart of a complex patient with a new treatment plan to be reviewed by the supervising physician at his/her convenience. I, on the other hand, wouldn't have let the patient out of the building until I consulted on the treatment plan. We both have communicated with a physician, but the timing is different. When we communicated depended on our knowledge and our prior experiences with the physicians. Ultimately, you do need to be in contact with a physician, when and how is up to your good judgment.

Now think about this: do you always consult with a supervising physician before you refer to a specialty physician or department? If yes, then you might want to add the word "supervising" before physician. If you sometimes consult with or refer directly to a specialist, without going through a supervising physician, then you might leave this the way it is.

SC3 This is really a courtesy, so that the physician is familiar with the patient if contacted regarding the referral.

SC4 Another question is the co-signing of charts. Once you've consulted, in some ways you've gone back to a traditional RN-MD relationship and "orders" should be signed off. On the other hand, when you confirm an innocent murmur or rash, do the charts really need to be co-signed? I would suggest that minimally any unusual, unorthodox, uncommon, or uncomfortable treatment plans be co-signed. It also might protect you later should the consult be forgotten.

[1] "An Explanation of Standardized Procedure Requirements for Nurse Practitioner Practice", 12/1998 www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf

HEALTH CARE MANAGEMENT - TERTIARY CARE (TC)

POLICY

Tertiary Care conditions are acute, life-threatening, emergency conditions. The nurse practitioner is authorized to evaluate Tertiary Care conditions under the following protocols:

PROTOCOLS

1) Initial evaluation and stabilization of the patient may be performed with concomitant notification of a physician or emergency department, and immediate referral. (TC1)

2) The referral is noted in the patient's chart including name of physician and/or facility referred to.

3) All other applicable Standardized Procedures in this document are followed during health care management.

4) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

TERTIARY CARE WORK PAGE

TC In subsection (d) of Section 2725 of the Code[1] it states that nurses can not only implement reporting, referral or standardized procedures, but can also "initiate emergency procedures". You can leave it at that and not use this standardized procedure, or you can define what you mean by "emergency procedures".

TC1 The idea here is to make it clear that you will stabilize a patient with an acute, life threatening condition to the best of your ability. Your best ability may be CPR and dialing 911, or perhaps intubation and starting IVs is your standard operating procedure. Whatever you do, it's important to talk about this in your practice. Get clear on what everyone's skills are, determine what you truthfully can do in an emergency (in my office, several practice codes brought out the worst and best!) and make sure your equipment matches the skills of those who are there. If you develop Emergency Procedures, put them in a notebook called In House Protocols and then list the notebook in the Resources section. (See the discussion in the Resources section). Don't put the Emergency Procedures in this document; you'll never find them in an emergency!

If you are in a setting where you *are* 911, and not just dialing it, then you undoubtedly have medical protocols to follow in emergencies. Again, don't put them here. List references in the Resources section of your standardized procedures. In the Protocol section here, write something like:

1) Evaluation and stabilization of the patient will be performed based on the resources listed in this document.

2) Management of the patient is either in conjunction with a physician or by complete referral to a physician or hospital.

[1] "Nurse Practitioners: Laws and Regulations", rev. 2/2010 www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf

PROCEDURES AND MINOR SURGERY (PM)

POLICY

The nurse practitioner may perform the listed procedures under the following protocols:

- Casting, simple.
- Chemical or electrocautery of external, non-facial, non-malignant lesions less than 1cm in size, e.g. warts.
- Epidermal cyst removal (non-facial) less than 3 cm in size.
- Incision and drainage of non-facial abscess less than 5 cm in size.
- Suture non-facial laceration less than 5 cm in size.
- Mole removal (non-facial).
- Punch or shave biopsy.
- Toenail removal.
- IUD insertion.
- Flexible Sigmoidoscopy
- Cervical biopsy
- Endometrial biopsy

PROTOCOLS

1) The nurse practitioner has been trained to perform the procedure(s), has been observed satisfactorily performing the procedure(s) by another provider competent in that skill, and continued competency is assessed per written criteria. (PM1)

2) The nurse practitioner is following standard medical technique for the procedures as described in the Resources listed in this document. (PM2)

3) Appropriate patient consent is obtained before the procedure. (PM3)

4) All moles and biopsied tissue are sent for a pathology report.

5) Physician consultation/or presence on site is required for the procedure. (PM4)

6) All other applicable Standardized Procedures in this document are followed during health care management.

7) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

PROCEDURES AND MINOR SURGERY WORK PAGE

PM This standardized procedure broadly addresses various medical functions that more or less come under the category of severing and penetrating tissue, and which are often done by nurse practitioners. Review the list, adding and deleting procedures as you see fit. Note that the limitations I've written on size and locations were based on the experience and comfort zones of those I worked with; again, you'll have your own. Next: If all the nurse practitioners do all the procedures, then once you fine-tune the descriptors you can go on. If not all the NPs do all the functions, you'll need some record of those authorized to perform the functions (Guideline b6).

PM1 Many nurse practitioners are trained in school or in continuing education programs to do procedures. The training should be documented, competence observed, and continuing education and evaluation requirements determined. If you train your own staff, you'll need to set up a program with written criteria and the same kind of assessment of competence, continued education and evaluation as there is with more formal training.

PM2 Check your Resources to be sure the basic procedures are listed and reflect your standard operating procedures. If not, then you need to find or write your own procedures and put them in your In House Protocols. (See the discussion in the Resources section.) You don't want the "how to" description here because you wouldn't be able to update or amend it without disturbing this document.

PM3 I put in 3) and 4) for consideration only, they could be in your procedures reference.

PM4 Sometimes an office will have particular requirements which preclude your performance of a procedure. One example might be that a physician reviews an x-ray before casting; another example could be that a physician be on site when specific procedures are performed: If you have these kinds of over-arching policies, you can put them here.

FURNISHING DRUGS AND DEVICES (FD)

POLICY

The nurse practitioner is authorized to Furnish drugs and devices under the following protocols:

PROTOCOLS

1) The nurse practitioner has a current Furnishing number.

2) The Standardized Procedure was developed and approved in collaboration with a physician, nurse practitioner and facility administrator or the designee.

3) All drugs and devices ordered are limited to the Formulary, OR are per the recommendations in the Resources listed in this document. (FD1)

4) The drugs and devices ordered are consistent with the nurse practitioner's educational preparation or for which clinical competency has been established and maintained. (FD2)

5) The drug or device ordered is appropriate to the condition being treated. (FD3)

6) Patient education is given regarding the drug or device. (FD4)

7) The name, title, and Furnishing number of the nurse practitioner is written on the transmittal order. (FD5)

8) The Statement of Approval and Agreement signed by the nurse practitioners will act as the record of nurse practitioners authorized to Furnish. (FD6)

9) No single physician will supervise more than four nurse practitioners at any one time. (FD7)

10) A physician must be available at all times in person or by telephonic contact. (FD7)

11) All other applicable Standardized Procedures in this document are followed during health care management.

12) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force. (FD8)

FURNISHING WORK PAGE

FD When it comes to Furnishing, "standardized procedure" not only refers to the Guidelines we've been using so far, but also to specific requirements in the Code for Furnishing.[1] Furnishing is "the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure". In practical terms, Furnishing means that you can legally call in an order for a drug or device or write the order on a prescription pad and sign it yourself.

The requirements for Furnishing change depending on what drugs you are ordering. There are basic rules for all prescriptions, and then there are rules for Schedule IV and V substances, rules for Schedule III, and rules for Schedule II. What I suggest is that you start with a Standardized Procedure for Furnishing to get the basics down. Then add the Standardized Procedure for Scheduled Drugs (coming up next). If you want more rules than just the bare bones for Furnishing, see the Standardized Procedure for Medication Management. By the way, I've included all the Furnishing requirements here even though several repeat some of the general guidelines for standardized procedures.

FD1 You have to state "which drugs or devices may be furnished or ordered" and under what "circumstances". How and to what degree the drugs and devices are limited has been a much debated issue. The drugs and devices may be listed in a formulary[2] which certainly simplifies the first portion of this requirement. If you don't want to come up with a formulary then you need to circumscribe them another way such as using medical references and stating the chapter and page numbers that the drug recommendation is listed in. The need for chapter and page numbers of reference texts to substantiate the medical "circumstances" for which you are Furnishing is discussed in the Resources section.

FD2 Regardless of the drugs and devices listed, the authority to Furnish is circumscribed by your scope of practice, educational preparation, and clinical competency. This language is taken right out of the Code[3].

FD3 You can further delineate the circumstances for Furnishing with phrases like this. If you like this idea, take a look at Medication Management.

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[1] "Criteria for Furnishing Number Utilization by Nurse Practitioners", rev. 12/2004
www.rn.ca.gov/pdfs/regulations/npr-i-16.pdf, and
"Nurse Practitioners: Laws and Regulations", rev. 2/2010
www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf

[2] "Frequently Asked Questions Regarding Nurse Practitioner Practice", rev. 12/2004
www.rn.ca.gov/pdfs/regulations/npr-i-25.pdf

[3] See footnote 1.

FURNISHING WORK PAGE (cont.)

FD4 The requirement for patient education comes from the BRN advisory on Furnishing[1], which I believe is based on the following language:

> "1986 Legislation: Section 9.5 of Stats. 1986, c. 493, provides:
> 'By adding Sections 2725.1 and 2836.1 to the Business and Professions Code, the Legislature intends that registered nurses, prior to dispensing drugs or devices, and nurse practitioners, prior to Furnishing drugs or devices, provide the patient with appropriate educational information regarding those drugs or devices.' "

FD5 A transmittal order can be a prescription pad.

FD6 You have to specify which nurse practitioners can Furnish. If all the standardized procedures (including controlled substances) apply to all the Nurse Practitioners then the list generated by the Statement of Approval and Agreement could suffice if you so designate it here. Otherwise, you'll have to fiddle with it.

FD7 Physician supervision is required for Furnishing. Protocols 9) and 10) are right out of the Code. I think 9) is clear, but to give an example...if there are six NPs in a practice with one physician, only four of them can be Furnishing at any one time. If you have more parameters than this, plus what you have on Supervision in General Policies, put it here.

FD8 Method of periodic review of your competence and review of the provisions of the standardized procedures are specified for Furnishing. Be sure they are included in your evaluation process.

[1] "Criteria for Furnishing Number Utilization by Nurse Practitioners", rev. 12/2004
www.rn.ca.gov/pdfs/regulations/npr-i-16.pdf

ORDERING SCHEDULED CONTROLLED SUBSTANCES (SS)

POLICY

The nurse practitioner is authorized to order scheduled controlled substances per the following protocols:

PROTOCOLS

General (SS1)

1) The nurse practitioner follows the provisions of the Standardized Procedure for Furnishing. (SS2)

2) The nurse practitioner's name, title, Furnishing and DEA numbers are on a secure transmittal order. (SS3)

3) The scheduled substances that may be ordered are on the List of Scheduled Drugs in the appendix of this document. (SS4)

4) Relevant scheduled drug contracts, DEA requirements, and all State and Federal regulations are adhered to. (SS5)

5) Schedule III and II substances are ordered following the Patient Specific Protocol, in addition to these General Protocols for Scheduled substances.

6) All other applicable Standardized Procedures in this document are followed during health care management.

7) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

ORDERING SCHEDULED CONTROLLED SUBSTANCES WORK PAGE

SS Let me begin by pointing out that as a Furnishing nurse practitioner you don't *have* to order scheduled substances; you *can*. You can also choose to Furnish IV and V but not III, or III–V and not II. If you wish to order any scheduled substances, however, you have to follow the rules. By the way, there is a terminology change here. With non-scheduled drugs, NPs are Furnishing, but when it comes to controlled substances, federal regulations have us Ordering.

SS1 This standardized procedure starts with the protocols that apply to all the scheduled substances and then adds rules based on the schedule level: least problematic to most hassle. Schedule II and III require a "patient specific protocol", Schedule IV and V do not. If you are not ordering any Schedule III or II drugs then delete 5) and stop with the basic, general protocols.

SS2 This standardized procedure is only to be used with the Furnishing Standardized Procedure; it does not stand alone.

SS3 You must have a DEA number for the level of scheduled substances you intend to Furnish. Getting a number for Schedule III–V is fairly straightforward. Schedule II requires BRN approved coursework. Although there are exceptions, generally speaking you need to be using a tamper resistant, secure order form for all controlled substances. Do all the NPs have the same level of DEA number? Check for consistency between your Education and Training requirement and the Record of Authorized NPs and reconcile accordingly. You may need a separate record of NPs authorized to order Schedule III and II substances. Note that you may not use your Furnishing number with a physician's DEA number.

SS4 The scheduled drugs you are going to Furnish must be "limited to those agreed upon by the NP and MD and specified in the standardized procedure". I believe this means a specific list of scheduled substances that can be ordered. If you are ordering these drugs from a formulary, state so here. A sample list of scheduled drugs follows. I wouldn't put the list in this part of the document; it should go as an appendix or with your other medically specific Resources.

SS5 I don't do a great deal of pain management, but I appreciate that there are thoughtful and thorough ways it can be approached. Please encourage patients to augment their medical pain management with other modalities. If you have narcotic contracts and so forth in your practice, please enact them when needed. As you know, State and federal agencies have rules on the use of these drugs. I'm not going to list them but you can; refer back to your course work on Schedule II drugs. If you didn't take the course you can go to the DEA website for regulations. See item (10) for more on pain management.

ORDERING SCHEDULED CONTROLLED SUBSTANCES (cont.)

SCHEDULE III PATIENT SPECIFIC PROTOCOL (SS6)

Schedule III substances may be ordered when the patient is in one of the following categories and under the following conditions:

Category:	Example: (SS7)
Acute Illness, Injury or Infection	Fractures, Sprain, Cough
Acute Recurring Pain	Sickle Cell Anemia
Persistent Limited, and Chronic Pain	Burn, Cancer, Shingles

8) Subjective and Objective assessment has been made and findings are consistent with a diagnosis that would support the use of Schedule III substances. (SS8)

9) Acute Conditions:
Limit order to a maximum of _____days/number; no refill without reevaluation.

10) Chronic, Acute Recurring Pain, and Persistent Limited:
- The Pain Management Protocol is adhered to. (SS9)
- Treatment plan is established in conjunction with a physician, and is reviewed, with documentation, every 6-12 months. (SS10)

11) Amount given, including all refills (maximum of 5 in 6 months) is not to exceed a 120 day supply as appropriate to the condition.

12) Education and follow up is provided.

SCHEDULE II PATIENT SPECIFIC PROTOCOL (SS11)

Schedule II substances may be ordered when the patient has one of the following diagnoses and under the following conditions: (SS12)

A. Severe pain from surgery or trauma or intractable, terminal illness when the pain is unresponsive to or inappropriately or inadequately treated by Schedule III–V substances.
- Order for acute conditions is limited to a maximum of _____ days/number; no refills without evaluation.
- Pain Management Protocol is adhered to. (SS13)
- Long-term use of these drugs must be established in conjunction with a physician and reviewed, with documentation, every 6-12 months.

B. Attention Deficit Hyperactivity Disorder when the:
- Diagnosis is made and treatment plan outlined based on the medical guidelines in Resources. (SS14)

ORDERING SCHEDULED CONTROLLED SUBSTANCES WORK PAGE (cont.)

SS6 The Code for ordering Schedule III and II substances calls for a "patient specific protocol" (PSP). The Code itself doesn't state what a patient specific protocol is, but the BRN advisory [1] states that it is one that "specifies which categories of patients may be furnished this class of drugs". The categories that come up consistently are cough and pain, with pain being further categorized into acute, intermittent but recurrent, and chronic. You will want to look at all that the BRN has to say on this subject as well as other professional organizations. If you've taken the course work for Schedule II drugs, then review the recommendations they make. Obviously the conditions and categories I give may not be relevant to your practice. While in the end, you and the physician(s) you work with need to determine what is appropriate for your workplace, bear in mind that community standards may also influence the boundaries of your scope of practice.

SS7 Schedule III doesn't specify diagnoses the way Schedule II does; you can use examples if you want to. The examples I give are just that; not recommendations.

SS8 This is the first time I've included this kind of statement for your consideration. I'm adding it because so often I see phrases like this in the Schedule II course work for patient specific protocols. It confirms the obvious perhaps, but can be reassuring.

SS9 To me this is the important part of pain management. What information do you and the patient need to launch into managing pain, especially the long term use of scheduled substances? What are the signs and symptoms of pain, the familial and psychosocial issues, the fears, and the red flags that will direct treatment choices and help you evaluate responsiveness? The family practice clinic I worked at had assessment forms, evaluation tools and contracts that we had to use for the long term use of scheduled substances. If you don't have that in your facility, may I suggest that you adopt one. General medical text books have a chapter on Pain Management and there are many resources online. FYI: Perhaps I'm being conservative but this is not the place to just casually reference a chapter in a book. I think it is important that you adopt a useful and specific system, write it up (or photocopy), have it signed off and include it in the Resources.

SS10 My bias: With anything other than acute, self-limiting use of these drugs, consider establishing a plan with a physician. Are there any other specific requirements for consulting or supervision that you want to make?

SS11 In all honesty, I don't have any practical experience with the use of Schedule II drugs. Typically nurse practitioners that are using these drugs are working in Oncology, Surgery, Trauma or Hospice, or have a specialty that includes ADHD.

[1] "Criteria for Furnishing Number Utilization by Nurse Practitioners", rev. 12/2004 www.rn.ca.gov/pdfs/regulations/npr-i-16.pdf

ORDERING SCHEDULED CONTROLLED SUBSTANCES WORK PAGE (cont.)

SS12 A provision for ordering Schedule II controlled substances is addressing the diagnosis of the illness, injury or condition. Those of you working in these fields should list the appropriate diagnoses.

SS13 See the discussion on pain management. **SS9**.

SS14 Here you are stating that you will be ordering Schedule II substances for this specific diagnosis and then directing the reader to a disease based protocol that defines the medical parameters for assessment, diagnosis and treatment. This written protocol should be dated and signed off. As you know by now, I prefer to keep medical guidelines referenced here, but actually kept where you can find them useful. Doing so may allow for medical policies to change without having to rewrite this document. But that's your call. You could put it here. Again, I think you need to be adopting specific medical guidelines for the diagnosis and treatment of conditions that warrant Schedule II substances. I don't think a casual reference to a chapter in a book is appropriate; be specific and intentional in the guidelines for the use of these drugs.

SS15 On the following pages is a sampling of scheduled drugs. It is not my intention to set a standard or be comprehensive; this is just an example to get you thinking. Please put in the strengths and routes that are appropriate for you. I've also seen this statement used: "Individualize dosage according to indications".

LIST OF SCHEDULED DRUGS (SS15)

SCHEDULE V DRUGS

Cough
- codeine cough syrup (Robitussin AC, others)

Diarrhea
- diphenoxylate/atropine sulfate (Lomotil)

Pain
- acetaminophen w/codeine elixir

SCHEDULE IV DRUGS

Anxiety
- lorazepam (Ativan)
- diazepam (Valium)
- alprazolam (Xanax)

Insomnia
- zolpidem (Ambien)
- flurazepam (Dalmane)
- temazepam (Restoril)

Obstructive Sleep Apnea
- modafinil (Provigil)
- armodafinil (Nuvigil)

Weight Loss
- phentermine (Adipex-P, others) (state form and strengths)

SCHEDULE III DRUGS

Pain/Cough
- codeine w/ acetaminophen (TyCo #3, #4)
- hydrocodone w/ acetaminophen (Vicodin, others)
- hydrocodone w/ibuprofen (Vicoprofen)
- hydrocodone cough syrup (Hycodan)

Headache
- butalbital w/aspirin (Fiorinal)
- butalbital w/acetaminophen (Fioricet)

LIST OF SCHEDULED DRUGS (cont.)

SCHEDULE II DRUGS

Pain

- fentanyl transdurmal (Duragesic)
- hydromorphone (Dilaudid)
- meperidine (Demerol)
- morphine sulfate (MS Contin)
- oxycodone (Oxycontin)
- oxycodone w/ acetaminophen (Percocet, Tylox)
- oxycodone w/aspirin (Percodan)

ADHD

- detroamphetamine (Dexedrine)
- dextroamphamine /amphetamine (Adderall)
- methylphenidate (Ritalin, others)

MEDICATION MANAGEMENT (MM)

POLICY

The nurse practitioner is authorized to manage drugs and devices under the following protocols:

PROTOCOLS

1) The management of drugs or devices includes evaluating, initiating, altering, discontinuing, renewing, Furnishing and ordering of prescriptive and over-the-counter medications.

2) Medication evaluation includes assessment of:
   - Other medications being taken.
   - Prior medications used for current condition.
   - Medication allergies and contraindications, including appropriate labs and exams.

4) The drug or device is appropriate to the condition being treated, and:
   - Accepted dosages per references.
   - Generic medications are ordered if appropriate.

5) A plan for follow-up and refills is written in the patient's chart.

6) The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the nurse practitioner.

7) All other applicable Standardized Procedures in this document are followed during health care management.

8) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

MEDICATION MANAGEMENT WORK PAGE

MM There are some facilities that may want to further direct the authority of the NP in the management of medications. The options to do so are many, so rather than make the Furnishing Standardized Procedure longer, I created this one. Most of it is really common sense and good nursing practice, but laying it out sometimes helps people adjust. Before Furnishing numbers came about, this Standardized Procedure for Medication Management was a mechanism for authorizing NPs to provide medication to their patients. It does not stand alone; it needs to be used with, or integrated into, Furnishing.

DISPENSING MEDICATIONS (DM)

POLICY

The nurse practitioner may dispense pre-packaged prescription drugs and devices, including Schedule II-V controlled substances under the following protocols:

PROTOCOLS

1) The drug or device utilizes required pharmacy containers and labeling. (DM1)

2) All appropriate record keeping practices of the dispensary are performed. (DM2)

3) All State and Federal policies on dispensing Controlled Substance must be followed.

4) All other applicable Standardized Procedures in this document are followed during health care management.

5) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

DISPENSING WORK PAGE

DM In Business and Professions Code 2725.1, Registered Nurses can "dispense" (hand to a patient) nonscheduled drugs and devices upon the valid order of a physician in community and free clinics, some government run clinics, and clinics operated on tribal land. Furnishing nurse practitioners can dispense both Schedule V-II and non scheduled drugs and devices in these clinics *pursuant to a standardized procedure.* If you aren't dispensing you don't need this. If you aren't dispensing controlled substances you don't need it either. In the past I have thought that this could be stretched to include private offices, but I don't think so now.

DM1 Be sure you are complying with pharmacy laws[1].

DM2 There are regulations on how drugs are to be stored and maintained, and there is always the paperwork to do.

[1] "Nurse Practitioners: Laws and Regulations", rev. 2/2010 www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf

COMPLIMENTARY SAMPLES (CS)

POLICY

The nurse practitioner is authorized to sign for the request and receipt of complimentary samples of prescription drugs and devices under the following protocols:

PROTOCOLS

1) The list of Authorized Pharmaceutical Samples for Nurse Practitioner Signature is kept in _____ (CS1)

2) Each written request shall contain the name and address of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the name of the nurse practitioner receiving the samples, the date of receipt, and the name and quantity of the dangerous drugs or devices provided. These records shall be preserved by the supplier. (CS2)

3) A review of this process will be part of the review of all the Standardized Procedures. (CS3)

4) All other applicable Standardized Procedures in this document are followed during health care management.

5) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

COMPLIMENTARY SAMPLES WORK PAGE

CS Furnishing nurse practitioners being able to sign for drug samples is convenient for many offices and clinics. What might not be so convenient is the paperwork and remembering to periodically review it for accuracy – both of which are required. Recall there is no requirement that you take the responsibility of requesting and receiving samples.

CS1 How it works is that a physician has to provide a written request for samples to the drug rep. Then, a Furnishing nurse practitioner who is functioning pursuant to a standardized procedure may sign for the (future) requests and receipt of the sample – provided it is identified in the standardized procedure. You need to figure out how this is going to work on a practical/logistical level. Talk to the physician(s). Are there any specific drugs or categories of drugs that you shouldn't sign for? It's really up to the physician and the drug rep to compile the list of drugs you can sign for.

CS2 This is right out of Business and Professions Code 4061[1]. I think it's up to the supplier to make sure it's all there but you should know about it.

CS3 You have to state the review process. Protocols 4) and 5) could suffice as this standardized procedure will be caught in the overall review process. Just a reminder: When you do the review, the authorizing list should also be checked and signed off for new or discontinued items.

[1] "Nurse Practitioners: Laws and Regulations", rev. 2/2010
www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf

AUTHORIZATIONS (AU)

POLICY

The nurse practitioner is authorized, under the following protocols, to:

- Assess Worker's Compensation injuries and illnesses.
- Certify Disability.
- Manage Home Health and Personal Care Services.
- Order Restraint and Seclusion.

PROTOCOLS

1) Workers' Compensation. The Doctor's First Report of Occupational Injury or Illness, co-signed by the nurse practitioner, for a workers' compensation claim can be for a period of time off from work not to exceed three calendar days. The treating physician is required to sign the report and to make any determination of any temporary disability. (AU1)

2) Certify Disability. The nurse practitioner has performed a physical exam and collaborated with a physician and surgeon. (AU2)

3) Home Health or Personal Care Services. Approval, signing, modifying, or adding to a plan of treatment or plan of care is after consultation with the treating physician and surgeon. (AU3)

4) Restraint and Seclusion. The nurse practitioner must be knowledgeable and competent in the Hospital Conditions of Participation for Patients' Rights including the Interpretive Guidelines. Ordering physical or chemical restraint, and/or seclusion, is in strict accordance with the protocols adopted in the Resources section of this document which include the extent of implementation and which meets the intent of the acute medical and surgical hospitals Conditions of Participation for Rights. (AU4)

5) All other applicable Standardized Procedures in this document are followed during health care management.

6) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

AUTHORIZATIONS WORK PAGE

AU There are situations when the practice of NPs crosses lines regulated by other governing bodies. When that happens someone has to hammer out how the needs of each entity will be met. Sometimes the inter-jurisdictional outcome takes the form of requiring a standardized procedure authorizing the NP to perform the function, and sometimes not. Sometimes there are specific limitations (Workers Comp) and sometimes not (Durable Medical Equipment). And sometimes we thought we needed a standardized procedure (Supervising Medical Assistants in clinics) and it turns out we didn't.

What I've done here is bundle together the authorizations that require a standardized procedure and have additional rules. You could put these in Health Care Management or create a separate standardized procedure for each authorization. By the way, providing veterans with disabilities parking placards, medical exam of school bus drivers, and treating STD partners are examples of actions that did not lead to the requirement of a standardized procedure.

AU1 This language is from the BRN advisory on cosigning Workers' Comp reports[1]. Of note is that, "The reviewing or supervising physician and surgeon of the…nurse practitioner shall be deemed to be the treating physician." It is the treating physician's responsibility to submit the First Report to the employer and insurance company within five working days from the date of the initial examination.

AU2 This is right out of the Business and Professions Code 2835.7[2]. FYI: "Collaboration" is not defined.

AU3 Again this language is straight from Business and Professions Code 2835.7.

AU4 In the past I have not included these kinds of authorizations because the Workbook is geared more toward general outpatient care, and because I am not remotely familiar with the scope of practice they imply. That said, since there is a growing trend of having other agencies impact NP standardized procedures, and more NPs are using the Workbook in inpatient facilities, I decided to include this example. If you are doing this work please read the BRN's advisory on the topic of Restraint and Seclusion, meet all the requirements, and adopt medical procedures for doing so. (See Resources) A similar area is NPs in long term care settings. There is a comprehensive BRN advisory on this topic as well.

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[1] "Nurse Practitioners Cosign Workers Compensation Claimant Report", rev. 12/2004 www.rn.ca.gov/pdfs/regulations/npr-b-40.pdf

[2] "Nurse Practitioners: Laws and Regulations", rev. 2/2010 www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf

RESOURCES

RESOURCES (RE)

In House Protocols:

- Formulary
- List of Scheduled Drugs
- Pain Management Protocol
- Schedule II Patient Specific Protocol for _____
- Medical Procedure for _____

Examples of References:

- Current Medical Diagnosis and Treatment, Lange Series, 2013.
- 5 Minute Clinical Consult, 2013. 5minuteconsult.com
- American Academy of Family Physicians. aafp.org/online
- National Heart, Lung and Blood Institute Guidelines. nhlbi.nih.gov/guidelines
- Epocrates. epocrates.com
- Nurse Practitioner Prescribing Reference (NPPR). empr.com

RESOURCES WORK PAGE

RE Let me begin by saying that I understand stating references and having a Resources section is debatable. The prompt to do so comes from Guideline b3: "State any specific requirements which are to be followed by the registered nurses in performing particular standardized procedure functions", and the BRN interpretation of the Guideline. In the BRN example of a process protocol[1] it states "the standardized procedure protocols developed for use by the nurses are designed to describe the steps of medical care for given patient situations." In the same advisory it states:

> "Standardized procedures which reference textbooks and other written resources in order to meet the requirement of Title 16, CCR Section 1474 (3), [this is Guideline (b3)], must include book (specify edition) or article title, page numbers and sections. Additionally, the standards of care established by the sources must be reviewed and authorized by the registered nurse, physician and administrator in the practice setting. A formulary may be developed and attached to the standardized procedure. Regardless of format used, whether a process protocol or disease-specific, the standardized procedure must include all eleven required elements as outlined in Title 16, CCR Section 1474."

Aside from the fact that coming up with references can be tedious and is perhaps archaic, the real issue is whether or not they are a liability. The argument against listing references is that you don't want to be in the position of having provided good care only to find, in some unforeseen litigation, that the care you provided was not supported by an outdated text referenced in your standardized procedures. Another argument is that the parameters you've diligently established addressing the other Guidelines, plus meeting the special requirements of Furnishing, Authorizations, and so forth, adequately meets Guideline b3 and the intent of the law. If that's how you and your MD and admin team interpret things, omit the general references to Resources in this document while keeping the references to the specific medical procedures you need. The problem for me, however, is that while I may not necessarily agree with the BRN interpretation of how NPs meet Guideline b3, especially calling for chapter and verse, neither am I in a position to ignore it in this Workbook. So you, dear reader, as usual, will have to decide for yourself. What I can offer you are possible ways to manage Resources if you are heading in that direction.

You begin to establish Resources by listing the medical references that would support the steps you take to reach a medical diagnosis and develop a treatment plan – be it pharmaceutical or a medical procedure. The idea is to include resources that you really would and do refer to in your day-to-day practice, and that would substantiate your management plans. Include resources that will address your diagnoses, procedures, and prescription medication recommendations. Textbooks are still in use, but so are web based protocols - and there are many out there. When the Guidelines (and this Workbook) were

[1] "An Explanation of Standardized Procedure Requirements for Nurse Practitioner Practice, 12/1998 www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf

first written, we didn't have evidence based medicine or smart phones or tablets, and "internet website" wasn't even in our lexicon. I could go on about the ramifications of information technology and standardized procedures but I won't. Suffice it to say, whatever the format, you undoubtedly have go-to resources and this is where you would list them. Remember the idea is to be thorough but not over the top.

And what about chapter and page number? I don't know what to say. One can certainly make the case that by listing commonly accepted texts and web sites, and having addressed all the general Guidelines and the specifics for Furnishing, you have narrowed the field adequately. Having a formulary and a list of scheduled controlled substances further defines your scope for Furnishing, listing procedures provides constraint on that function, and the description of your role in Health Care Management sets a perimeter around the diagnoses you can make. That certainly seems like enough. On the other hand, if you're feeling inclined, include at least chapters (required if you are <u>not</u> using a formulary). I've seen folks type them all out; they say it's not such a big deal. I've also been known to photocopy the Table of Contents of texts and highlight chapters.

Whether you choose to list general references or not, you will need some container for the specific lists and medical protocols you are adopting. Documents like your formulary, list of scheduled drugs, pain management protocols, patient specific protocols for Schedule II, and any other special medical procedures or algorithms you are adopting need an accessible home. It could be an appendix attached to this document or a separate notebook labeled something like "In House Protocols" that is referenced here but kept where you can use it. However you want to do it, check your document for consistency in terminology.

Lastly, from what I can gather, the biggest liability issue for nurse practitioners in California is not having any standardized procedures at all. So regardless of how you feel about doing them, please get them done for your own protection. At the end of the day, what you really want is for your judgment to be sound, and your practice appropriate to your limits and acceptable to your medical colleagues, community and peers. You want to provide excellent health care, and meet the intent of the law.