

Standardized Protocol for Assessment and Management of Acute and Chronic Patients: Anesthesia Pre-Op Clinic

Protocol for the Management of Acute and Chronic Illness and Injuries prior to the administration of anesthesia

Policy Statement

It is the policy of Laguna Honda Hospital that all standardized procedures are developed collaboratively and approved by the Interdisciplinary Practices Committee whose membership consists of Nurse Practitioners, Clinical Nurse Specialists, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

All standardized procedures are to be kept in the Standardized Procedure section of the nursing department policies and procedures. A copy of the procedures will be kept in an operational manual in the Outpatient Clinics' Office and on file in the Medical Staff Office.

Functions To Be Performed

Each practice area will vary in the functions that will be performed, such as primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

The NP conduct physical exams, diagnoses and treats illness, order and interpret tests, counsel on preventative health care, assists in surgery, performs invasive procedures and furnish medications/issue drug orders as established by state law.

Circumstances Under Which NP May Perform Function

Setting

Location of practice is the Anesthesia Pre-Op Clinic including visits to any other part of the hospital where preoperative patient evaluations are required.

Supervision

- Overall Accountability: The NP is responsible and accountable to the Medical Director (and/or designee) and the anesthesia attending assigned to supervise the Pre-Op Clinic.
- A consulting physician (Anesthesia attending) will be available to the NP, by phone, in person, or by other electronic means at all times.

- Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
 - a. Acute decompensation of patient situation
 - b. Problem that is not resolved after reasonable trial of therapies.
 - c. Unexplained historical, physical, or laboratory findings.
 - d. Upon request of patient, affiliated staff, or physician.
 - e. Initiation or change of medication other than those in the formulary (ies).
 - f. Problem requiring hospital admission or potential hospital admission.
 - g. Acute, severe respiratory distress.
 - h. An adverse response to respiratory treatment, or a lack of therapeutic response.

Scope of Practice – Protocols

- Pre-Op Screening of Adults

Requirements for the Nurse Practitioner

Basic Training and Education

- Active California Registered Nurse license.
- Successful completion of a program, which conforms to the Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.
- Degree needed: ANP, FNP.
- Maintenance of Board Certification (NP).
- Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
- Possession of a National Provider Identifier or must have submitted an application.
- Copies of licensure and certificates must be on file in the Medical Staff Office.
- Furnishing Number and DEA Number if applicable.

Evaluation

Evaluation of NP Competence in performance of standardized procedures.

Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and other supervisors, as applicable will assess the NP's ability to practice.

Clinical Practice

- Length of proctoring period will be one month. The evaluator will be the Chief of Outpatient Clinics, or designee. The method of evaluation in clinical practice will be presentation of all cases to either the Chief of Outpatient Clinics or designated physician during the proctoring period.

- Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief of Outpatient Clinics, and/or designated physician, at appropriate intervals.
- Biennial Reappointment: Chief of Outpatient Clinics, and/or designated physician must evaluate the NP's clinical competence. Evaluation will be the review of 5 medical records and one direct observation of an adult assessment.

Development and Approval of Standardized Procedure

Method of Development

Standardized procedures are developed collaboratively by the Nurse Practitioners, Clinical Nurse Specialists, Pharmacists, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

Approval

The Interdisciplinary Practices, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to its implementation.

Review Schedule

The standardized procedure will be reviewed every two years by the NP and the Chief of Outpatient Clinics and as practice changes.

Revisions

All changes or additions to the standardized procedures are to be approved by the Interdisciplinary Practices Committee accompanied by the dated and signed approval sheet.

Protocol #1: Pre-Op Screening of Adults

Clinical Definition

This protocol covers the assessment and management of adults prior to the administration of anesthesia. This will include a directed history and physical.

Data Base

Subjective Data:

- Screening: appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems.
- Historical information relative to the presenting illness (past health history, family history, occupational history, personal/social history, review of systems;
- Status of relevant symptom(s), e.g. present or stable

Objective Data:

- Physical examination appropriate to the disease process;
- Review of appropriate laboratory / diagnostic studies

Diagnosis

- Assessment of data from the subjective and objective findings identifying risk factors and disease processes may include a statement of current status of disease (e.g. stable, unstable, and uncontrolled). Medical clearance for anesthesia will be provided.

Management

Diagnostic

- Appropriate screening tests, and/or diagnostic tests for purposes of disease identification
- Referral to specialty clinics and supportive services, as needed

Patient conditions requiring Attending Consultation

- With emergent conditions requiring prompt medication attention;
- With acute decompensation of the patient situation;
- When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings;
- Upon request of the patient, Nurse Practitioner, or Physician;
- When ordering expensive and/or unusual diagnostic studies;
- When prescribing medications not within the clinical expertise of the Nurse Practitioner
- Patient conditions that may require physician consultation in addition to the ones mentioned in the General Policy including:
 - Significant abnormal lab values
 - New carotid bruits
 - New cardiac murmurs or other cardiac symptoms
 - Current uncompensated heart failure
 - New ECG changes

- Other acute conditions which will benefit from treatment and stabilization prior to surgery.
- Patients evaluated for surgery who have unusual and/or unanticipated findings.

Patient / Family Education

- In verbal and/or written format, the Nurse Practitioner explains to the pertinent party or parties involved the diseased process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up. Information will be provided, as appropriate for pre-op, operative, and post-op care.

Follow-up and referral

- Performed in accordance with the standard of practice and/or with the consulting physician's recommendation.

Record Keeping

- Patient contacts and visits are to be documented in accordance with standard practice and institutional policy.
- All information relevant to patient care will be recorded in the medical record.