UNIVERSITY HOSPITAL AND HEALTH SYSTEM
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street, Jackson MS 39216

CLINICAL PRIVILEGES- PEDIATRIC SEDATION SERVICE APP

Name: _____

☐ Initial Appointment
☐ Reappointment

Department _____
Specialty Area_____

All new applicants must meet the following requirements as approved by the governing body effective: 8/7/2013

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document. Site-specific services may be defined in hospital and/or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional governance (MS Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR PEDIATRIC SEDATION SERVICE APP

To be eligible to apply for core privileges as a pediatric sedation service advanced practice provider, the initial applicant must meet the following criteria:

Current certification as a Certified Registered Nurse Anesthetist, Nurse Practitioner, or Physician Assistant;

Required Previous Experience: Applicants for initial appointment must be able to demonstrate clinical experience as an advanced practice nurse or PA during the past 24 months or demonstrate successful completion of an advanced practice nurse or PA training program within the past 12 months.

Reappointment Requirements: To be eligible to renew core privileges as a Pediatric Sedation Service APP, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience, (inpatients, outpatients, or consultations) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

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CORE PRIVILEGES

PEDIATRIC SEDATION SERVICE APP

□ **Requested**

Assess, evaluate, diagnose, treat, and provide consultation patients of the ages approved by specialty certification. Provide care to patients in the intensive care setting in conformance with unit policies and in accordance with privileges held by the collaborating physician. Initiate emergency resuscitation and stabilization measures on any patient. Order and interpret appropriate diagnostic tests. Perform evaluations. Change or discontinue medical treatment plans. Prescribe, initiate, and monitor all medications which APRNs or PAs are authorized to prescribe in Mississippi. Initiate consultation for and monitor patients during special tests. May write orders in the medical record, including standing orders in collaboration with a physician; may record pertinent data on the medical record, including progress notes and discharge summaries; and may conduct patient/family education and counseling. The core privileges in this specialty include the procedures on the attached procedure list.

PRESCRIPTIVE AUTHORITY

_____I have been approved for the following schedules by the Mississippi State Board of Nursing and have attached a copy of my approved Controlled Substance Prescriptive Authority registration. _____*II*_____*III*_____*IV*_____*V*

_____I **have not** been approved for Controlled Substance Prescriptive Authority.

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SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

If desired, Non-Core Privileges are requested individually in addition to requesting the Core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

See next page for requested non-core privileges for specified provider.

ADMINISTRATION OF SEDATION AND ANALGESIA

☐ **Requested** See Hospital Policy for Procedural Sedation by Non-Anesthesiologists for additional information.

Section One--INITIAL REQUESTS ONLY:

☐ Demonstration of prior clinical privileges to perform procedural sedation along with a good-faith estimate of at least 20 such sedations performed during the previous year (the estimate should include information about each type of procedure where sedation was administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:

_____

_____

-OR-

☐ Successful completion (within six months of application for privileges) of a UMHC-approved procedural sedation training and examination course that includes practical training and examination under simulation conditions.

Section Two--INITIAL AND RE-PRIVILEGING REQUESTS:

☐ Successful completion of the UMHC web based Procedural Sedation Course/Exam initially and at least once every two years **-AND-**

Provision of a good-faith estimate of the number of instances of each type of procedure where sedation is administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:

_____

_____

–AND-

☐ ACLS, PALS and/or NRP, as appropriate to the patient population. **(Current)**

Section Three--INITIAL AND RE-PRIVILEGING REQUESTS:

Controlled Substance Prescriptive Authority Schedules II – V approval from the Mississippi Board of Nursing.

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CORE PROCEDURE LIST

To the applicant: If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, initial, and date. ***Procedures that are not in concert with your collaborating physician's privileges should be stricken from this list.***

- Perform and document a pre-sedation patient assessment and evaluation, including requesting consultations and diagnostic studies
- Assist with administration of accessory drugs, fluids, blood and blood by-products needed to maintain the patient's physiologic homeostasis while sedated, and to institute interventions to correct responses to deep sedation
- Select and apply appropriate non-invasive modalities for collecting and interpreting patient physiological data
- Assist with non-invasive monitoring of patient's physiologic status pre-, intra-, post-sedation
- Evaluate for post-procedural pain
- Assess for patient readiness for discharge per established protocol.
- Provide post-sedation follow-up evaluation
- Respond to emergency situations by providing airway management, administration of emergency fluids or drugs, or using basic or advanced cardiac life support techniques
- Insert peripheral intravenous lines
- Intubation (oral/nasal) to establish an emergency airway or electively under the direction of a supervising physician
- Establishment and maintenance of open airway in non intubated, unconscious and paralyzed patients
- Order respiratory services
- Interpretation of ECG
- Local anesthetic techniques
- Management of anaphylaxis and acute allergic reactions
- Use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry
- Initiation and maintenance of vasoactive drug infusion under physician supervision
- Ventilator management, including experience with various modes (pressure, volume, and flow cycled)
- Blood component transfusion therapy
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods

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ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at University Hospital and Health System, University of Mississippi Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed _____ ***Date*** _____

DIVISION CHIEF'S RECOMMENDATION (AS APPLICABLE)

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Division Chief Signature _____ ***Date*** _____

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DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Department Chair Signature _____ ***Date*** _____

Reviewed:

Revised:8/7/2013