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

PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER CLINICAL PRIVILEGES

Name: _____

Effective From ____/____/_____ To ____/____/_____

☐ Initial Appointment
☐ Reappointment

Department _____
Specialty Area_____

All new applicants must meet the following requirements as approved by the governing body effective: 6/3/15

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 PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS

To be eligible to apply for core privileges as a Psychiatric Mental Health Nurse Practitioner, the initial applicant must meet the following criteria:

Current certification as a Psychiatric Mental Health Nurse Practitioner, Adult Psychiatric Mental Health Nurse Practitioner, or Family Psychiatric Mental Health Nurse Practitioner by the American Nurses Credentialing Center (ANCC), American Academy of Nurse Practitioners (AANP), or an equivalent body as required by licensure;

Required Previous Experience: Applicants for initial appointment must be able to demonstrate clinical experience as Psychiatric Mental Health Nurse Practitioner, Adult Psychiatric Mental Health Nurse Practitioner, or Family Psychiatric Mental Health Nurse Practitioner during the past 24 months or demonstrate successful completion of Psychiatric Mental Health Nurse Practitioner, Adult Psychiatric Mental Health Nurse Practitioner, or Family Psychiatric Mental Health Nurse Practitioner training program within the past 12 months.

Reappointment Requirements: To be eligible to renew core privileges as Psychiatric Mental Health Nurse Practitioner, Adult Psychiatric Mental Health Nurse Practitioner, or Family Psychiatric Mental Health Nurse Practitioner, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and a sufficient 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

PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER CORE PRIVILEGES

☐ **Requested**

Assess, evaluate, diagnose, treat, and provide consultation for common psychiatric disorders and mental health problems (acute and chronic) to patients of the ages approved by specialty certification. May 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 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.

PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER CLINICAL PRIVILEGES

Name: _____

Effective From ____/____/_____ To ____/____/_____

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.***

- Conduct individual, family, and group psychotherapy
- Conduct motivational interviews
- Conduct play therapy
- Conduct psychoeducational interventions
- Diagnose and treat common acute psychiatric problems, illness, and crises
- Histories and physicals, performance of (includes performance of age-appropriate comprehensive and/or problem-focused psychiatric evaluation)
- Manage patients actively withdrawing from substances
- Monitor common health care problems and refer for specialized medical treatment
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Provide crisis intervention therapies
- Provide substance use disorder therapies and treatment
- Psychopharmacological management
- Rehab service ordering
- Respiratory services, ordering of
- Restraints, Chemical and/or physical of agitated patient in accordance with hospital policy

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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***_____

Approved: 6/3/15

Reviewed:

Revised: