NEPHROLOGY
NURSE PRACTITIONER
ADVANCED PRIVILEGES

Name of Nurse Practitioner (Print)

To be eligible to apply for privileges as a Nurse Practitioner in Nephrology, the applicant must currently possess Nurse Practitioner Core Privileges as a member of the Kaleida Health Medical/Dental Staff.

NEPHROLOGY NURSE PRACTITIONER CORE PRIVILEGES

Provide care, treatment, and services consistent with the Nephrology practice, including the performance of physical exams, diagnosing conditions, the development of treatment plans, health counseling, and prescribing medications in accordance with New York State law for patients within the age group of patients seen by the collaborating physician. Nurse practitioners may write orders that include ongoing orders, discharge orders and admission orders under the physician’s service to the hospital. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative services. The core privileges in this specialty include the procedures on the Nurse Practitioner Core privileges and such other procedures that are extensions of the same techniques and skills.

INITIAL APPLICANTS

To be eligible to apply for privileges as a NP in Nephrology, the applicant must meet the following criteria:

- Completion of a master’s, post-master’s, or doctorate from a nurse practitioner program accredited by the Commission on the Collegiate of Nursing Education or the Nation League for Nursing Accrediting Commission with emphasis on the NP’s specialty area, AND
- Current active licensure to practice as an advanced practice registered nurse in the practitioner category in New York State, AND
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Medical/Dental Staff Bylaws, AND
- Current ACLS certification

REAPPOINTMENT REQUIREMENTS

To be eligible to renew privileges as a NP in Nephrology, the applicant must meet the following criteria:

- An adequate volume of experience with acceptable results for the past 24 months and demonstrated current competence based on results of ongoing professional practice evaluation and outcomes. Experience must correlate to the privileges requested. AND
- Current active licensure to practice as an advanced practice registered nurse in the practitioner category in New York State, AND
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Medical/Dental Staff Bylaws, AND
- Current ACLS certification
ADVANCED PRIVILEGES

Noncore privileges are requested individually in addition to requesting the core. Each individual requesting advanced privileges must meet the specific threshold criteria as applicable by the initial applicant or reappointment. Each time a new privilege is requested, it may be requested by the Nurse Practitioner and recommended by the collaborating physician and forwarded to the Kaleida Health Medical Staff Office to be approved and appended to the advanced list of privileges.

Advanced Privileges – The applicant must provide written documentation of current competence (as noted below) for all procedures requested:

1. A list of requested procedures performed within the educational program, signed by a representative of the program, attesting to competence OR a case list requested procedures performed within the previous 2 years AND
2. A signed statement from the collaborating physicians confirming that he/she has personally observed the applicant successfully perform the procedure(s) and can attest to his/hers competence.

If the above requirements cannot be met, the applicant may request approval to perform the procedure(s) under direct supervision until such time as the above noted attestation can be submitted. This request must be co-signed by the collaborating physician. If the applicant requires direct supervision they must keep a log of the first 10 procedures that they have performed. This log should be submitted for documentation.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Requested</th>
<th>Approved</th>
<th>*Not Approved</th>
<th>With Direct Supervision</th>
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<tr>
<td>Apply, remove, and change dressings and bandages</td>
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<td>Assist patients and families with modality choices (including hemodialysis, peritoneal dialysis, transplant, and conservative management)</td>
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<td>Focus on care that promotes health, prevents kidney disease, prevents and/or manages the complications of acute and chronic disease and prevents disability</td>
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<td>Implement palliative and end-of-life care through evaluation, modification, and documentation according to the patient’s response to therapy, changes in condition, and therapeutic interventions to optimize patient outcomes</td>
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<td>Insert and remove nasogastric tube</td>
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<td>Perform incision and drainage of superficial abscesses</td>
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<td>Place temporary vascular catheters for hemodialysis and plasmapheresis</td>
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<td>Prescribe, administer, and evaluate pharmacologic and non-pharmacologic therapeutic treatment regimens</td>
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<td>Provide care to individuals with varying degrees of kidney impairment</td>
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<td>Start femoral dialysis lines</td>
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Nephrology Nurse Practitioner

Advanced Privileges

__________________________
Name of Nurse Practitioner (Print)

To be completed for reappointment only:

I attest that I have reviewed the Practice Agreement previously submitted.
(check one of the following)

____ No revisions are necessary; the agreement reflects current practices and protocols.
____ Revisions have been made and an updated copy is attached.

THE COLLABORATING PHYSICIAN MUST COMPLETE THIS SECTION by checking one of the following:

____ a) I, as collaborating physician, have personally observed __________________________ (applicant’s name) in the clinical setting and can attest he/she has the cognitive skills appropriate.

____ b) I, as collaborating physician, have not personally observed __________________________ (applicant’s name) in the clinical setting and recommend he/she be given a six (6) month provisional approval with direct supervision at the end of which an attestation as to competence will be required.

Practitioner’s Name (Print) __________________________ Practitioner’s Signature __________________________ Date _________________

Collaborating Physician’s Name (Print) __________________________ Collaborating Physician’s Signature __________________________ Date _________________

Chief of Service Signature __________________________ Date _________________

Chairman, Advanced Practice Professional Committee __________________________ Date _________________