Healthcare

VANTAGE POINT®

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Nonphysician Providers: A Guide to Safer Delegation

The increasing integration of nurse practitioners (NPs) and physician assistants (PAs) into a wide variety of inpatient and outpatient settings has enhanced efficiency and increased patient access to care. Especially in rural areas, nonteaching hospitals and other locations with less physician presence, NPs and PAs perform a myriad of critical functions. Depending upon state scope of practice regulations and position descriptions, these tasks often include prescribing medications, ordering diagnostic tests and taking after-hours calls. However, the relationship between physicians and these highly trained and skilled professionals presents certain complexities, and establishing a safe and effective collaboration requires careful attention to such issues as communication, documentation and extent of practice.

For NPs operating within a collaborative practice model, the following risk management lapses, among others, may occur:

- **Failure to obtain consultations in a timely manner** when establishing a diagnosis.
- **Improper or untimely management of medical complications,** including failure to summon physician backup.
- **Neglecting to discuss medication concerns** with the consulting pharmacist.
- **Lack of communication with the primary or collaborating physician** regarding urgent or critical patient care concerns.

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Risk exposures persist for PAs, as well. Based upon data reviewed from the National Practitioner Data Bank, the average professional liability indemnity payment for PAs is $173,128.[1] Common PA-related errors include:

- **Inadequate patient examination** caused by incomplete physical assessment or failure to ask pertinent questions.
- **Failure to properly diagnose conditions,** due to misinterpreting information and/or overlooking significant signs and symptoms.
- **Failure to refer in a timely manner,** reflecting failure to properly diagnose the condition, lack of knowledge of the course and nature of the disease, and/or underestimation of the urgency of the situation.
- **Negligent misrepresentation,** i.e., neglecting to inform the patient that one is a PA, rather than a physician.

1 See Pasquini, S. "Do Physician Assistants Get Sued? Medical Malpractice, Liability and Lawsuits – A Guide for PAs," posted online at The Physician Assistant Life.

As the patient population expands, NPs and PAs are anticipated to assume a more prominent role, with delegation of clinical tasks becoming a more critical issue. This edition of *Vantage Point®* offers strategies to help administrators and providers accomplish the following goals:

- **Clarify practice guidelines** and organizational expectations.
- **Improve communication** regarding protocol deviations, emergencies and referrals.
- **Strengthen performance evaluations,** record reviews and related documentation.

The strategies provided here offer general guidance. However, as practice statutes differ, organizational leaders and physicians are urged to thoroughly and periodically review all federal, state and local laws regarding NPs and PAs, and also to consult with legal counsel before developing specific practice policies. In addition, leaders should contact an insurance professional or attorney to ensure that appropriate coverage is in place, as some policies may exclude allied healthcare providers unless such coverage is specifically added by endorsement. Finally, all protocols and guidelines pertaining to independent practitioners should be approved by the facility's governing body.

Practice Agreements

By virtue of education and training, NPs and PAs are capable of performing a wide range of services. However, state regulations and restrictions vary, requiring ambulatory care centers, hospitals and other settings to define in writing the nature and extent of allied healthcare provider practice. Depending upon state practice regulations, both NPs and PAs are permitted to diagnose clinical conditions and write prescriptions. Many NPs have independent practice authority under state law. For PA supervision requirements by state, see Physician Assistants Overview.

Practice agreements are an effective means of mutually communicating and enforcing expectations, delineating parameters of care and avoiding costly clinical missteps. The organization's agreement for services to be provided by NPs and PAs must never extend to services prohibited by applicable laws and regulations. The table below highlights some of the recurrent aspects of care typically included within collaborative practice agreements.

Aspects of Care – Practice Agreements

For NPs:	For PAs:
• Taking patient histories, performing physical exams, and ordering laboratory tests and procedures. • Diagnosing, treating and managing diseases. • Prescribing medications, within stated limits. • Coordinating referrals. • Performing certain procedures and minor surgeries, such as lumbar punctures. • Providing patient education and counseling to support healthy lifestyle choices and behaviors.	• Tracking patients' medical histories and symptoms. • Ordering laboratory tests and analyzing results with physicians. • Prescribing appropriate interventions and medications. • Conducting diagnostic and therapeutic procedures. • Advising patients on preventive healthcare. • Treating minor injuries or sicknesses. • Referring patients to specialists as required.

Delegation considerations. Practice agreements are intended to clarify and strengthen the collaborative working relationship between the NP or PA and physicians. Prior to hiring, administrators should have clear criteria for duties and procedures that may be delegated, and avoid the temptation of altering a job description to fit a candidate's limitations. The following questions can help minimize the likelihood of inappropriate delegations:

When delegating duties to NPs, ask:

- Is the task to be delegated within the individual's lawful authority, and is it permitted by organizational protocols?
- Is the collaborating physician privileged to perform the task?
- Has the NP demonstrated sufficient clinical proficiency and competence to perform the task?
- Is the task routinely indicated among the organization's patient population?
- Will there be a licensed physician available for consultation while the task is carried out?

When delegating duties to PAs, ask the above questions, as well as the following:

- Can the task be performed without the exercise of independent medical judgment?
- Are the results of the task reasonably predictable?
- Can the task be performed safely, relying upon specific standing orders or directions?
- Can the task be performed without the need for making complex observations or critical decisions?
- Could the task, if performed incorrectly or contrary to protocol, have life threatening consequences?

For outpatient care, practice guidelines also should consider the size and complexity of the patient population, as well as the immediate availability of a physician or pharmacist.

Sample NP practice agreements, which can be adapted to meet jurisdictional requirements, are available here and here. A sample PA practice agreement is available here. Agreements should be reviewed annually, through consultation with legal counsel, dated and signed by both parties, and made easily accessible to the healthcare team in the event that questions arise requiring clarification.

Prescription and practice safeguards. Prescribing and treating regulations are state-specific, varying with respect to allied health-care providers' authority to:

- Prescribe certain classes of medications.
- Order medical devices.
- Order diagnostic and laboratory tests.
- Perform certain therapies and procedures, such as suturing, intubations, and placement of arterial lines and chest tubes.

Collaborating and/or supervising physicians should maintain a record of the prescribing authority delegated to NPs and PAs. Parameters for prescribing different categories of drugs – such as antibiotics, antivirals, diabetic drugs, hormones, anti-asthmatics and anti-hypertensives – should be delineated. In addition, any prescription authority delegated for medical devices, diagnostic tests and procedures should be expressly noted.

A sample prescriptive authority agreement is available on page 7.

Communication and Consultation

Optimally, physicians and NPs/PAs should work together in same site teams that make decisions collaboratively. In many hospital settings, NPs conduct the team rounds and are responsible for facilitating discussion among physicians, social workers, dieticians, charge nurses and other members of the treatment team. To learn more about the process of creating multidisciplinary care teams, visit the Agency for Healthcare Research and Quality.

Effective team functioning requires timely, accurate communication among members. The following strategies can help reduce potential miscommunication:

Deviations from protocol. In most settings, NPs and PAs generally follow clinical pathways created by medical directors, hospitalists and professional societies. When a change in a patient's status requires a deviation from established protocol, this decision must be communicated to the treatment team and documented in the patient healthcare information record. By participating in daily multidisciplinary rounds, NPs and PAs can convey issues or concerns that may make it necessary to diverge from guidelines.

Emergency care. NPs and PAs are often called upon to manage emergency situations, including urgent care, triage and emergency department treatment. Credentialing protocols should specify the emergency procedures approved for allied healthcare providers. In addition, hospitals and other healthcare settings should promulgate written guidelines defining when an NP or PA must seek physician consultation, as well as when a supervising physician is required to physically attend to a patient in distress. The supervised orientation period for NPs and PAs should emphasize mastering communication protocols and complying with organizational expectations regarding provision of safe and appropriate emergency care.

Referrals. Patients with complex medical problems often require referral to outside specialists. To help NPs and PAs provide sufficient clinical information to physicians and other providers who are assuming care, organizations are encouraged to develop an effective and comprehensive electronic referral system, which should:

- **Utilize standardized electronic referral templates** that interface with the patient healthcare information record.
- **Include both structured and free-text fields** to better facilitate entry of clinical information.
- **Match electronic referral requests** with existing patient/clinical information.
- **Enforce electronic capture** of the primary referral question or reason.
- **Permit institutional monitoring and measurement** of referral-related performance.

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Performance Evaluation and Supervision

Annual performance review of NPs and PAs promotes quality of care and helps ensure that these providers function within the permitted scope of practice. The evaluation process should minimally include clinical performance, documentation, patient satisfaction, attention to patient safety and risk management practices, and compliance with patient assessment and management protocols. The following two components play an integral part in successful performance evaluation:

Performance review. A supervising or collaborating physician should be assigned to evaluate in a methodical, ongoing manner the outcomes of services provided by NPs and PAs, as well as their skill, knowledge and ethical standards. Written supervisory guidelines should focus on the following criteria, among others:

- **Compliance with scope of practice,** as delineated in applicable regulations, privileges granted by the organization, position descriptions and/or contracts.
- **Basic skills and professional competence,** which should be reviewed upon hire, at six months and annually thereafter.
- **Management of patients with complex problems,** including case review of referrals made or consultations requested with other professionals.
- **Response to urgent situations,** including compliance with approved emergency care guidelines.
- **Narcotic/controlled substance prescribing,** if applicable, and adherence to the organizational formulary.
- **Compliance with the organization's policies and procedures,** as well as medical staff bylaws, rules and regulations, including documentation requirements.
- **Continuous availability during assigned work times,** either in person or via reliable communications technology.

A self-evaluation tool to measure PA competencies is available from the National Commission on Certification of Physician Assistants and other professional organizations. In addition, the National Organization of Nurse Practitioner Faculties outlines NP core competencies, including suggested curriculum content.

Patient healthcare information record reviews. Supervising or collaborating physicians also are expected to review selected patient care records for compliance with practice directives and standards of care. In some jurisdictions, frequency of quality reviews is specified by state law. Otherwise, as a general guideline, reviews should be conducted during the probationary period, every six months afterwards, and as part of the annual review or recredentialing process.

Record review techniques will vary depending upon the practitioner's scope of delegated duties, degree of experience and training, and assigned patient load. At a minimum, chart reviews should assess the following competencies:

- Diagnostic descriptions.
- Application of routine standing orders.
- Compliance with clinical guidelines and documentation policies and procedures.
- Explanations for any deviations from clinical guidelines or established policies and procedures.
- Issues and/or concerns – including differential diagnosis, plan and disposition – discussed with the family, physicians and other members of the healthcare team.
- Explanation for referrals to outside healthcare providers.
- Recommendations for care improvement.
- Discussion with the patient and significant others, including documentation of educational efforts made and indication that the patient or the patient's healthcare decision-making surrogate understands the suggested care plan.
- Timely and legible documentation.
- Entry signatures and dates.

When necessary, record reviews should be supplemented by face to-face discussion between reviewing physicians and NPs and PAs. For a sample quality review template, see "Review of Care and Quality Improvement Record" on page 6.

Nonphysician providers are anticipated to assume an increasingly meaningful role within the healthcare delivery system of the future. By specifying their range of duties, fostering a collaborative work environment, and carefully conducting and documenting performance and record reviews, organizations can obtain the full benefit of their knowledge and skills, while minimizing associated liability risk exposure.

Quick Links

Online material:

- Buppert, C. "Reducing Liability Risk When Collaborating With Nurse Practitioners." *Medscape*. September 1, 2017.
- Minemyer, P. "Nurse Practitioner Malpractice Payouts Are On the Rise; Opioid Prescription Liability an Emerging Hot Spot." *FierceHealthcare*. November 15, 2017.
- "Nurse Practitioners and Today's Professional Liability Risks." *Minority Nurse*. December 8, 2017.
- Scope of Practice Laws for Nurse Practitioners and Physician Assistants. ECRI Institute. January 5, 2015.

Organizations:

- American Academy of Physician Assistants (AAPA)
- American Association of Nurse Practitioners™ (AANP)

Review of Care and Quality Improvement Record

This template can be used to record regularly scheduled chart reviews and meetings between supervising/collaborating physicians and nurse practitioners or physician assistants. Quality reviews should occur on a monthly basis for the first six months following hire, then every six months thereafter.

1. Clinical case: ______________________________

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2. Review of history: ______________________________

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3. Review of physical assessment: ______________________________

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4. Differential diagnosis, plan and disposition: ______________________________

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5. Recommendations for improvement: ______________________________

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6. Improvement plan and time line: ______________________________

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Nurse practitioner/physician assistant signature: ____________________ Date: ____________

Primary supervising physician signature: ____________________ Date: ____________

This sample form is for illustrative purposes only. As each practice presents unique situations and statutes may vary by state, it is recommended that you consult with your attorney prior to use of this or similar forms in your organization.

Sample Prescriptive Authority Agreement

PART I: Background Data

Location of incident: ______________________________

Name of supervising or collaborating physician: ______________________________

License number: ______________________________

Address: ______________________________

Name of alternate physician, if applicable: ______________________________

License number: ______________________________

Address: ______________________________

Name of nurse practitioner (NP) or physician assistant (PA) to whom prescribing authority is being delegated: ______________

License number: ______________________________

Address: ______________________________

Practice area (e.g., pediatrics, primary care, OB-GYN, internal medicine): ______________________________

Practice location(s)/unit(s): ______________________________

PART II: Prescribing Parameters

The following types or categories of drugs and devices may be prescribed:

All nonschedule drugs, other than the following: ______________________________

All medical devices and biologicals, other than the following: ______________________________

All respiratory therapies, orthotics and prosthetics, other than the following: ______________________________

All schedule II controlled substances for inpatient or emergency department patients being treated for:

☐ Pain

☐ Sedation

☐ Seizures

☐ Anesthesia (for emergency procedures)

All schedule III-V controlled substances, other than the following: ______________________________

Limitations on schedule III-V controlled substances:

☐ Thirty-day supply, or less.

☐ No refills without prior consultation with the supervising or collaborating physician.

☐ Prescriptions for patients under 2 years of age require prior consultation with supervising or collaborating physician.

PART III: Instructions

Process and rules for communicating information regarding patient care to the supervising/collaborating physician (e.g., direct or telephonic consultation, reporting format, required response time, follow-up): ______________________________

____

Specific instructions for certain drugs or drug classes: ______________________________

____

Follow-up monitoring requirements for specific drugs or classifications of drugs: ______________________________

____

Protocol for handling patient emergencies: ______________________________

____

Protocol for physician/pharmacist consultation and referral of patients: ______________________________

____

PART IV: Quality Assurance (QA)

Prescribing authority QA measures (e.g., chart review frequency, number/percentage of charts to be reviewed): ______________

____

Method of documenting quality review: ______________________________

Interval between meetings with supervising or collaborating physician:

☐ Monthly ☐ Quarterly ☐ Other (specify) ______________________________

PART V: Documents

Title of QA plan and date of last review: ______________________________

Names of applicable clinical practice protocols and date of last review: ______________________________

PART VI: Signatures

The NP or PA listed below acknowledges that he or she:

1. Holds an active license to practice in [*name of state*] and is in good standing in this state.
2. Is not currently prohibited by the State Board of Nursing or the Physician Assistant Board from executing a prescriptive authority agreement.
3. Has disclosed to the undersigned physician any prior disciplinary action by the State Board of Nursing or the Physician Assistant Board.

Signature of supervising or collaborating physician: ______________________________

Signature of NP or PA: ______________________________ Date of agreement: ______________

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