

Privileges for: AHP - Authorized

Request

- ST. ELIZABETH - EDGEWOOD
- ST. ELIZABETH - FLORENCE
- ST. ELIZABETH - FT. THOMAS
- ST. ELIZABETH - GRANT CO. (Surgical & other invasive procedures requiring general anesthetic are not offered)

**SCOPE OF PRACTICE FOR ALLIED HEALTH PROFESSIONALS - Authorized**

The allied health professional (AHP) - "Authorized" category includes the registered nurse, registered nurse first assistant, surgical assistant-certified and registered orthopedic technician.

The allied health professional will remain under the direct in-person supervision of the employer physician. The AHP will be involved in the care of patients of only the employer physician.

**DEPARTMENT APPROVAL**

\_\_\_\_\_ Approved                      \_\_\_\_\_ Disapproved

\_\_\_\_\_  
Department/Section Chair Signature

\_\_\_\_\_  
Date

**Nursing Administration Approval**

\_\_\_\_\_  
Sr. V.P. of Nursing or Designee Signature

\_\_\_\_\_  
Date

**SPECIFIC PRIVILEGES**

Please see Registered Nurse, Registered Nurse First Assistant, Surgical Assistant or Registered Orthopaedic Tech

**REGISTERED NURSE**

- \_\_\_\_\_ Make rounds with the employer physician.
- \_\_\_\_\_ Perform clerical functions with the employer physician in attendance and with immediate countersignature by the employer physician.
- \_\_\_\_\_ Record verbal orders with immediate countersignature by the employer physician as permitted by state law.
- \_\_\_\_\_ Provide patient education or post discharge instructions as directed by the employer physician.
- \_\_\_\_\_ Dressing applications / changes
- \_\_\_\_\_ Suture removal

**REGISTERED NURSE FIRST ASSISTANT**

**EDUCATION, CREDENTIALS, LICENSES, EXPERIENCE:**

- Current Kentucky RN license
- Successful completion of RNFA program and internship that meets AORN's Standards for RN Fist Assistant
  - Program criteria
  - Basic Cardiac Life Support (BCLS)
  - Current CNOR (Certified Nurse Operating Room) required
  - CRNFA (Certified RN First Assistant) certification preferred
  - Knowledge of aseptic technique when functioning in the perioperative setting
  - Two years of operating room experience in both the scrub and circulating roles as an RN

- \_\_\_\_\_ Assist in transporting the patient post-operatively
- \_\_\_\_\_ Assist in positioning, skin preparation and draping of the patient
- \_\_\_\_\_ Provide patient counseling and education
- \_\_\_\_\_ Place access catheters and tubes for diagnostic, therapeutic or interventional purposes under the direct supervision of surgeon in the Operating Room.

Privileges for: **AHP - Authorized**

**Request**

- \_\_\_\_\_ Provide hemostasis and wound exposure, handle tissue appropriately to reduce the potential for injury
- \_\_\_\_\_ Suture tissue and apply dressings to the wounds, excepting facial wounds, traumatic wounds requiring suturing in layers and infected wounds
- \_\_\_\_\_ Use surgical instrumentation, including advanced technology, consistent with their design and purpose
- \_\_\_\_\_ Assist the surgeon with dissection and retraction

**SURGICAL ASSISTANT - Certified**

**MINIMUM CRITERIA**

**Certified by the Kentucky Board of Medical Licensure as a "Kentucky Certified Surgical Assistant"**

- \_\_\_\_\_ Assist employer surgeon with surgical procedures in the operating room and emergency department. (Operating Room not available at GRANT CO.)
- \_\_\_\_\_ Dressing applications/changes
- \_\_\_\_\_ Suture removal

**REGISTERED ORTHOPAEDIC TECH**

**MINIMUM CRITERIA**

- 1. Must have completed a two year proctorship in an orthopedic practice**
- 2. Must be sponsored by two orthopedic surgeons**
- 3. Must sit for and pass the examination by the American Society of Orthopedic Professionals**

- \_\_\_\_\_ Dressing applications/changes
- \_\_\_\_\_ Suture removal
- \_\_\_\_\_ Casting and bracing
- \_\_\_\_\_ Provide patient education or post discharge instructions as directed by the employer physician.

**I agree that the use of my electronic signature below indicates my intent to sign this document as if it were my original handwritten signature.**

**Last 4 digits of S.S.N.** \_\_\_\_\_

\_\_\_\_\_  
**Sponsoring Physician's Signature**

\_\_\_\_\_  
**Date**

**I agree that the use of my electronic signature below indicates my intent to sign this document as if it were my original handwritten signature.**

**Applicants Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_