

CARLSBAD MEDICAL CENTER

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) JOB DESCRIPTION

NAME OF APPLICANT: _____

SUPERVISING PHYSICIAN: _____

CERTIFICATION: _____

LICENSURE/CERTIFICATION/QUALIFICATIONS:

The CRNA may be eligible for approved functions if the CRNA:

- a. Is currently licensed as a registered nurse by the New Mexico Board of Registered Nursing;
- b. Is certified as a Nurse Anesthetist by the New Mexico Board of Registered of Nursing;
- c. Has successfully completed the National Qualification Exam by the American Association of Nurse Anesthetists (AANA);
- d. Is recertified by the AANA Council on Recertification of Nurse Anesthetists;
- e. Maintains Continuing Education as required for certification;
- f. Has evidence of liability insurance with limits of 1/3.

APPOINTMENT/REAPPOINTMENT

Applicants for initial appointment and reappointment to the AHP Staff will be required to demonstrate sufficient training and experience to ensure competence. This assessment will include information from performance improvement activities which will include an assessment of the CRNA's clinical judgement and skills.

Competence may also be documented by the following:

- a. A letter from an individual with at least equivalent licensure and comparable training and current practice experience who has recently clinically observed the applicant in the functions requested;
- b. a letter from the program direction of the training facility;
- c. Continuing Education programs.

PROCTORING REQUIREMENTS

All provisional appointees shall undergo a period of observation/proctoring to determine clinical/technical competence. Members of the AHP staff requesting additional functions are required to be proctored for those functions. The terms and methods of proctoring are contained in the Allied Health Practitioner Staff Rules and Regulations, Article IV and where applicable, the Medical Staff Policy on Proctoring.

SUPERVISION

A supervising physician shall be a current member in good standing of the medical staff who holds privileges in Anesthesiology. Except in an emergency, the CRNA will collaborate with an anesthesiologist prior to administering an anesthetic with the exception of administration of epidurals for laboring patients. The CRNA will collaborate on labor epidurals on an as needed basis with the anesthesiologist.

NAME OF PRACTITIONER: _____

JOB DESCRIPTION – CERTIFIED REGISTERED NURSE ANESTHETISTS

Please check the appropriate boxes related to those functions that you would like included in your job description.

R = Requested G = Granted D = Denied

GENERAL COGNITIVE

R	G	D	
[]	[]	[]	Perform a pre-anesthetic assessment
[]	[]	[]	Request lab and diagnostic studies
[]	[]	[]	Preanesthetic medications
[]	[]	[]	Perform the post anesthetic evaluation of the patient
[]	[]	[]	Postanesthesia care and discharge

PROCEDURAL FUNCTIONS

General Anesthesia

R	G	D	
[]	[]	[]	Inhalation Anesthesia
[]	[]	[]	Intravenous Anesthesia

Regional Anesthesia

[]	[]	[]	Caudal
[]	[]	[]	Epidural Anesthesia
[]	[]	[]	Extremity Lower
[]	[]	[]	Upper
[]	[]	[]	Intracapsular Nerve Blocks
[]	[]	[]	IV Regional Anesthesia
[]	[]	[]	Periocular Nerve Blocks
[]	[]	[]	Subarachnoid Anesthesia
[]	[]	[]	Topical and Infiltration as in Field Blocks

Invasive Procedures and Monitoring

[]	[]	[]	Arterial Lines-Peripheral Invasive Procedures and Monitoring
[]	[]	[]	Central Venous Lines

NAME OF PRACTITIONER: _____

The procedures listed below require documentation of training and experience.

R	G	D	
[]	[]	[]	Cardiopulmonary Resuscitation Management
[]	[]	[]	Fluid, Electrolyte Management
[]	[]	[]	Mechanical Ventilation/Oxygen Therapy
[]	[]	[]	Perianesthetic Monitoring
[]	[]	[]	Trachael Intubation/Extubation

I certify that I have had the necessary training and experience to perform the job description functions I have requested. I agree to abide by the Allied Health Practitioner Rules and Regulations, the Medical Staff Bylaws, Rules and Regulations and Hospital Policies and will provide only services within the scope of my licensure and/or practice.

Signature: _____ Date: _____

I have reviewed the above described functions and agree to supervise _____ in the performance of the approved functions.

Supervising Physician Signature: _____ Date: _____

APPROVALS

All functions have been individually considered and have been recommended based upon the Practitioner's licensure/certification, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM THE FUNCTIONS AS INDICATED:

Exceptions/Limitations: (Specify)

Department of Surgery _____ Date

Medical Executive Committee _____ Date

Board of Trustees _____ Date



AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

Print Name

Signature

Date