Medical Directive/Delegation of Controlled Acts

Division of Orthopaedic Surgery

(Hospital)

Title: **Physician Assistant in Orthopaedic Surgery**	**Number:**
Activation Date:	**Sponsoring/Contact Person(s):**

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Recipient Patients:

Specific conditions or circumstances that must be met before directives can be implemented

1. The patient must be a registered patient of *(hospital)*, registered to the Emergency Department or an Outpatient clinic and
2. A physician, who has signed as an authorizer of this medical directive is responsible for this patients care, and
3. The patient, or appropriate legal guardian, consents to the plan of care and to receiving care from the Physician Assistant.

Contraindications to directive implementation

The medical directive may not be implemented if:

1. The patient is not a registered patient of *(hospital)*, registered to the Emergency Department or an Outpatient clinic.
2. The patient, or legal guardian for that patient, does not consent to the plan of care, or to receiving treatment from the Physician Assistant, or
3. The patient is not under the care of an authorizing physician.

Authorized Implementers:

Name:	**Title:** **Canadian Certified Physician Assistant (CCPA)**
Signature:	**CAPA Number:**

Guidelines for Implementing the Order/Delegation:

It is the policy of *(hospital)* to support the use of Medical Directives and/or delegation of controlled acts in accordance with the Regulated Health Professions Act and the regulatory colleges of health professionals. Within this framework the Division will utilize Physician Assistants to provide exemplary clinical care, improve patient safety, enhance the patient experience, provide continuing medical education to future health care workers and support research.

This Medical Directive authorizes the performing of a History, Physical Examination and Clinical Treatment by the Physician Assistant (PA) in the Division of Orthopaedic Surgery. It is incumbent upon the PA to practice within the scope of their training and practice, as well as the training and practice of the attending staff.

The PA working within the Division of Orthopaedic surgery may perform a history, physical assessment and treatment procedures as ordered on the appended Order Tables and Medication Tables, provided that the Physician Assistant has met the education requirements and demonstrated competence.

Documentation and Communication:

Documentation

Treatments that have been implemented and the patient's response to therapy, if applicable, will be documented in the clinical record as per hospital documentation standards.

The following will be documented on the appropriate MD order sheet/section of the clinical record:

a. The name of the medical directive
b. The orders given
c. The name, signature and designation of the Physician Assistant implementing the order

The following will be documented in the clinical record:

a. The patient assessment,
b. The directive implementation,
c. Treatments that have been implemented and,
d. The patients' response to therapy, if applicable.

Communication Path

The Physician Assistant will contact the authorizing physician if clarification of any aspect of the medial directive is required. The MRP responsible for the patient will be notified of the completion of treatments and the patient's response to treatment. Any untoward events resulting from this medical directive will be relayed to the authorizing physician as soon as reasonably possible.

This medical directive will be communicated to:

1. All Orthopaedic Surgery Division medical staff, full and part time status
2. All Emergency Department and Critical Care Unit medical staff, full and part time status
3. All Emergency Department and Critical Care Unit nursing staff, full and part time status
4. All Nursing staff on (*unit location)*, full and part time status
5. All operating room staff on (*unit location)*
6. All orthopaedic staff in (*unit location)*, full and part time status
7. Members of the (*unit location)*
8. The Department of Diagnostic Imaging
9. The Department of Laboratory Medicine
10. Health Data Resources
11. Pharmacy
12. Occupational Therapy

13. Physical Therapy
14. Social Work
15. Speech Language Pathology

Review and Quality Monitoring Guidelines:	**Appendix Attached: Yes ☒ No ☐** **Title: Appendix D**

Procedure Log

All PAs must complete the procedure log prior to performing the procedures independently, at the discretion of the attending orthopaedic staff. During the first three months of practice, the PA is expected to perform all procedures under supervision.

Administrative Approvals (as applicable):	
Administrative	**Signature:**
Divisional	**Authorized By:**
Professional Leader	**Authorized By:**
Medical Advisory Committee	**Approval Date:**
Other:	

Approving Physicians/Authorizers:	
Authorizing Physicians with Signature	

Appendix A:

Medical Directives of Physician Assistant in Orthopaedic Surgery: Hospital Procedures

According to the Regulated Health Professions Act, members of a health profession have the authority to accept an order or delegation to a controlled act(s) and that are deemed appropriate by their regulatory college from a health care provider who is authorized to perform the controlled act(s).

This medical directive provides authority both for (i) physician assistants (PAs) to accept an order or delegation to a controlled act(s) from a physician within their level of competence and (ii) nurses to accept an order as outlined in this medical directive from a physician. When nurses accept an order under this medical directive, they are not directly accepting the order from the PA but are carrying out the physician's order set out in this medical directive based on their own assessment of (i) the appropriateness of carrying out the task/treatment and (ii) whether the task/treatment is within their scope of practice and level of competence. This order may be relayed to the nurse by the PA.

Group 1 activities are those that the PA may perform either prior to or after discussion with the MRP/clinical fellow/senior resident.

Group 2 activities are those that the PA must discuss with the MRP/clinical fellow/senior resident prior to performing.

All PAs in their probationary 3 month period are required to discuss all Group 1 activities with the MRP/clinical fellow/resident team.

Please note that for all radiologic tests, the MRP must be specified when ordering the test so that Medical Imaging has an MRP of record to contact for urgent findings.

Procedure	Group 1	Group 2	Indications	Contraindications
1) Acute, Non-Traumatic Chest Pain	The PA may implement an order for, or perform, venipuncture for all or some of the following: - CBC, diff, glucose, electrolytes, urea, creatinine, CK, VBGs, D-Dimer, Troponin, PT/ INR, digoxin level if on such medication. The PA may implement an order for, or administer, supplemental oxygen. The PA may implement an order for, or perform, 12 Lead EKG. The PA may implement an order for CXR	The PA may implement an order for ABGs following discussions with the MRP. The PA may implement an order for obtaining CT-PA following discussions with the MRP.	**For Supplemental Oxygen:** If O_2 Sat less than 94% R/A, HR is greater than 120 bpm or the patient exhibits: palpitations, chest pain, shortness of breath, lightheadedness, dizziness, syncope, or diaphoresis then 100% O_2 via non rebreather mask. **For CXR:** Patients presenting with Dyspnea and other symptoms consistent with pneumonia, pneumothorax, PE, foreign body inhalation or have a known pulmonary disease **For CT PA:** Patients presenting with dyspnea with a high index of suspicion for PE	**For CXR:** Known or suspected pregnancy **For CT PA:** Poor renal function Allergy to contrast Known or suspected pregnancy
2) Admission Orders		The PA may implement and perform admission orders following discussion with MRP.	Following discussion with MRP.	
3) Advanced diagnostic imaging: CT Scan, Ultrasound,	The PA may implement an order for CT scan to investigate significant	The PA may implement an order for advanced diagnostic imaging and interventional	As per clinical demands +/- MRP approval as outlined As per Interdepartmental	Known or suspected pregnancy if a CT is contemplated.

and MRI, Interventional radiology	musculoskeletal injury in an acute, traumatic setting.	radiology after discussion with the MRP if it is in compliance with the Interdepartmental Agreement with Diagnostic Imaging in a non-acute setting.	Agreement On the Emergency Frequent Request Roster of EDIS	Known or suspected renal failure if injected dye is part of the protocol. Allergy to contrast material. MRI contraindications per the Department of Diagnostic imaging published list as written on the MRI requisition. Patient refusal.
4) **Bracing**	The PA may apply and remove a brace on a patient when clinically indicated.		Immobilize a fracture or unstable joint	Patient refusal.
5) Casting	The PA may apply and remove a fiberglass or plaster cast on a patient when clinically indicated.		Immobilize a fracture or unstable joint	Patient refusal.
6) **CCAC**	The PA may implement orders for initiation and re-initiation of CCAC services via RM&R. Including but not limited to PSW, OT/PT, Stoma, Wound Care, Nursing, IV Abx, prior to discussion with MRP.		Where appropriate indications for each exist.	
7) Chest Tubes		The PA may write orders	**For Removal:**	

		regarding chest tube management. Additionally, following discussion with the MRP or consulting service and obtaining patient consent the PA may remove chest tubes.	As per MRP/consulting service.	
8) Closed Reduction	The PA may assist in performing a closed reduction of a displaced fracture, dislocation or deformity.	The PA may perform a closed reduction of a displaced fracture or dislocation after discussions with the MRP.	Fractures that are displaced, shortened, angulated or unstable.	Undisplaced fractures, displaced fractures not affecting function, fractures where open reduction is indicated (e.g. severe comminution), a reduction that cannot be maintained or fractures produced by traction forces.
9) Compartment Pressure Checks	The PA may assist in compartment pressure checks using the Stryker compartment pressure monitor.	The PA may perform compartment pressure checks using the Stryker compartment pressure monitor following discussions with the MRP.	Patients with a high clinical suspicion for compartment syndrome. As above plus: Patients who are unresponsive Patients who are uncooperative (e.g. developmentally delayed, or intoxicated patients) Patients with peripheral nerve deficits attributable to other causes (e.g. tibial fracture with peroneal nerve	Patient refusal Application of monitor on areas with overlying cellulitis (relative contraindication)

			injury)	
10) Consultations	The PA may implement an order for consultations for inpatient and outpatient services. Including but not limited to: medicine, geriatrics, palliative care, medical oncology, radiation oncology, radiology (including interventional), wound care, stoma nurse, APS, psychiatry, gastroenterology.	The PA may implement and perform orders suggested by consulting specialties after discussion with MRP.	As indicated for each specialty.	
11) Diabetes or Suspected Diabetes	The PA implement an order for, or perform, venipuncture for all or some of the following blood tests and/or urine tests prior to discussing the patient's case with their respective Most Responsible Physician: - CBC, diff, glucose, electrolytes, urea, creatinine, lactate, ketones. - Blood culture x 2 if febrile - Urine R&M and C&S PAs may implement an order for CXR		Adult patient with established or suspect new onset diabetes **For Portable CXR:** Patients presenting with disease or complications suspected to be of diabetic origin	Patient refusal **For Portable CXR:** Known or suspected pregnancy
12) Diet	The PA may implement		Where appropriate	

	orders for diet including but not limited to: NPO, clear fluids, full fluids, low residue, soft diet and diet as tolerated.		indications for each exist.	
13) Digital Nerve Blocks	The PA may assist in the application of a Digital Web Space, Transthecal or Wrist Nerve Block.	The PA may perform the application of a Digital Web Space, Transthecal or Wrist Nerve Block following discussions with the MRP.	Lacerations beyond the mid-proximal phalanx, nail bed injuries, foreign bodies in the digit, finger fractures and finger and/or nail bed infection.	Infection of the tissues through which the needle will pass, compromised blood supply and an allergy to the anaesthetic. Epinephrine should not be used for digital nerve blocks, especially in patients at risk for digit infarction or ischemia (peripheral vascular disease or diabetes mellitus)
14) Discharge		The PA may implement and perform discharge orders. Including but not limited to: discharge summaries and electronically signing off, leave of absence letters and prescriptions in association with MRP, following discussion with MRP.	Following discussion with MRP.	
15) Dyspnea	The PA may implement an order for, or perform, all or some of the following blood tests and X rays prior to discussing the		Patient with entrance complaint of subjective or objective dyspnea	Patient refusal or under the age of 18 years **For Portable CXR:**

	patient's case with their respective Most Responsible Physician: - CBC, electrolytes, urea, creatinine, glucose, troponins, Serum Pregnancy Test (if female), INR, urine analysis. The PA may implement an order for a CXR The PA may implement an order for, or perform, 12 Lead ECG. The PA may implement an order for or perform intravenous access with Normal Saline at a rate of 100 mL/h or Saline lock. Large bore access if BP less than 90 or HR greater than 100 mmHg or postural change greater than 20 mmHg **NB.** If patient has Pulmonary Edema and/or elevated JVP with clinical suspicion of CHF then Saline lock only is authorized. **These treatments should be immediately reported**		**For Portable CXR:** Patients presenting with dyspnea of unknown, suspected pulmonary origin, or known cardiac disease **Guidelines:** 12 Lead ECG to be presented immediately to Most Responsible Physician for review if suggestive of arrhythmia, ischemia of any type, or if patient is symptomatic with abnormal vital signs **For Supplemental Oxygen:** If O_2 Sat less than 92% R/A, HR is greater than 120 bpm or the patient exhibits: palpitations, chest pain, lightheadedness, dizziness, syncope, or diaphoresis then O2 via an appropriate delivery mechanism. If O_2 Sat less than 90% R/A then adjust Fi O_2 to maintain O_2 greater than 92%.	Known or suspected pregnancy

	to the MRP			
16)Electromyography and Nerve Conduction Studies		The PA may order and interpret needle electromyography and nerve conduction studies following discussions with the MRP	To aid in the diagnosis of peripheral nerve and muscle pathology, including but not limited to peripheral neuropathy, entrapment neuropathy, radiculopathy and muscle disorders.	Severe coagulopathy, blood dyscrasia, implanted cardiac defibrillator.
17) Emergency Department Consults	The PA may implement the following medical directives in the setting of consults in the Emergency Department. - Ordering and performing the drawing of blood - Ordering x-rays - Ordering and administering tetanus - Ordering and administering antibiotics (cephalosporins, aminoglycosides, penicillins, macrolides, sulpha combinations, tetracyclines and other unclassified antibiotics)	The PA may implement the following the following medical directives in the setting of consults in the Emergency Department following discussions with the MRP. - Performing the aspiration of joint fluid - Assist in the reduction of a displaced or dislocated/subluxed fracture or joint - Ordering CT scans and MRI scans - Discharging a patient whom responsible care has been transferred to the orthopaedic service	As per individual Medical Directives outlined in this document	
18) Foley Catheter	The PA may implement or perform an order for the insertion and removal of a foley catheter prior to discussion with MRP.		**For Insertion** Pre-operatively Accurate Ins and Outs Difficulty voiding **For Removal**	**For Insertion:** Urethral Trauma Pelvic Fractures **For Removal:**

			When the indications for insertion no longer exist.	Epidural Subsequent pelvic surgery.
19) Hospital Ward Consults	The PA may implement the following medical directives in the setting of consults in the hospital inpatient ward. - Ordering and performing the drawing of blood - Ordering x-rays - Ordering and administrating therapeutic medication as outlined in Appendix C.	The PA may implement the following the following medical directives in the setting of consults in the hospital inpatient ward following discussions with the MRP. - Performing the aspiration of joint fluid - Assist in the reduction of a displaced or dislocated/subluxed fracture or joint - Ordering CT scans and MRI scans	As per individual Medical Directives outlined in this document	
20) Incision and Drainage		The PA may implement and perform an order for incision and drainage after discussion with MRP.	Fluctuant and/or purulent abscess.	Anatomical challenges Patient refusal.
21) Joint Aspiration and Injection		The PA may perform a joint aspiration and/or joint injection after discussion with MRP.	**For Aspiration:** High clinical index of suspicion for septic joint. **For Injection:** As part of a patient's treatment plan for osteoarthritis, gouty arthritis, and other inflammatory joint pathology.	**For Aspiration:** Patient refusal. **For Injection:** Active infection (e.g. cellulitis, Tuberculosis) Patient refusal Bleeding dyscrasias, Charcot joint, Joint prosthesis (relative contraindication)

22) JP Drain		The PA may implement an order for the removal of a JP drain after discussion with MRP and/or consulting services.	As per MRP and/or consulting services.	
23) MOHLTC Provincial Medical Directive for the use of Tamiflu during an Influenza Outbreak	The PA may implement the MOHLTC Provincial Directives for Prescribing Tamiflu		As per MOHLTC Directive	Known or suspected pregnancy Patient refusal.
24) NG Tubes	The PA may order an X-ray following insertion to ensure appropriate placement and auscultation of stomach with air flush.	The PA may implement an order for the insertion and removal of an NG tube after discussion with MRP.	**Insertion** **Indications:** Administration of medications **Removal** When indications for placement no longer exist.	**Insertion:** Severe facial trauma Esophageal Stricture Total gastrectomy Esophageal surgery
25) Outpatient Clinic Prescriptions	The PA may write a prescription for physical therapy, massage therapy, joint bracing, orthotics or orthosis in an outpatient clinic setting.	The PA may write a prescription for non-opioid analgesics (Acetaminophen, NSAIDs), non-benzodiazepine muscle relaxants and neuropathic pain medication following discussions with the MRP.	**For Group 1:** Patient clinically appropriate for mobilization or rehabilitation. Patient requiring the use of bracing, orthotics or orthosis for return to function. **For Group 2** For the management of acute nociceptive (somatic, visceral) and/or neuropathic pain.	**For Group 2:** Patients with known history of gastric, kidney or liver disease (relative contraindication).

26) PICC lines		The PA may implement an order for the insertion and removal of a PICC line following discussion with MRP.	**Insertion** TPN, bloodwork, following discussion with MRP **Removal** When indications for insertion are no longer valid. Following discussion with MRP	**Insertion** Skin infection at site, known central vascular occlusions, dialysis fistula, ipsilateral radical mastectomy and lymphedema, sepsis, bleeding disorder
27) Rehab and LTC	The PA may implement orders for initiation and re-initiation via RM&R for rehab and LTC prior to discussion with MRP.		When appropriate indications for each exist, following discussion with interdisciplinary specialties and families where applicable.	
28) Sepsis	In the event that a patient is suffering from known or suspected sepsis, the PA may implement an order for, or perform all or some of the following: - CBC, electrolytes, BUN/Cr, Arterial Blood Gases, glucose, INR and PTT, Blood cultures x 2, urine analysis and C&S, wound cultures. The PA may implement an order for a CXR. The PA may implement an order or perform 12-lead ECG	Following discussion with the MRP, the PA may order an ultrasound, CT, or drainage procedure for further evaluation and management of the sepsis.	Fever Unwell patient	Patient refusal

	The PA may implement an order for or perform intravenous access with Normal Saline at a rate of 75-150 mL/h or Saline lock. Large bore access if BP less than 90 or HR greater than 100 mmHg or postural change greater than 20 mmHg			
29) Splinting	The PA may apply and remove a fiberglass or plaster splint on a patient when clinically indicated.		Immobilize a fracture or unstable joint	Patient refusal.
30) Suturing above the fascia		The PA may perform a procedure below the dermis, including probing, cleansing, removal of a foreign body and suturing of the wound. Order and administer the following local anaesthetic agents: - Lidocaine Plain 1% or 2% solution - Bupivacaine 0.25% or 0.5% solution - Lidocaine with epinephrine 1% or 2% solution Order and administer the following topical anaesthetic	Wound requiring primary closure	Allergy or sensitivity to local anaesthetic agents L.E.T. and lidocaine with epinephrine is contraindicated in/on the following: mucous membranes, digits, nose, ear, penis and burns

		agents: - L.E.T. (lidocaine 4.3%, epinephrine 0.05%and tetracaine 0.5%)		
31) Traction	The PA may apply skin traction to the patient with fractures and dislocations. The PA may assess a halo traction device for maintenance.	The PA may assist in the application of the following to the patient following discussions with the MRP. - Thomas Splint - Pelvic Binder - Halo Traction Device	For fractures, dislocations and/or instability that cannot be treated by means of casting.	Skin traction that requires greater than 10 lbs. of sustained force may not be applied due to increased risk of skin disruption and irritation.
32) VAC and Wound Dressing	The PA may implement and perform an order for simple wound dressing application and changes.	The PA may implement and perform an order for the application and removal of negative pressure wound therapy (VAC) following discussion with MRP or consult service	**For Simple Wound Dressing** Sterile management of an active wound site. **For Negative Pressure Wound Therapy** Post-operative and dehisced surgical wounds Pressure ulcers Diabetic/neuropathic ulcers Traumatic wounds Skin flaps and grafts Venous insufficiency ulcers Explored fistulae	**For Simple Wound Dressing:** Visible bowel **For Negative Pressure Wound Therapy:** Malignancy in the wound Untreated osteomyelitis Non-enteric and unexplored fistulas Necrotic tissue with eschar present.
33) Wound Debridement		The PA may implement and perform an order for wound	Necrotic tissue	Visible bowel

		debridement after discussion with MRP.		
34) Wound Packing		The PA may implement and perform an order for wound packing after discussion with MRP.	Purulent discharge from wound site. As per MRP	Visible bowel
35) Other		Procedures and orders not discussed above may be carried out by the PA following discussion with, and at the discretion of, the MRP		

Appendix B:

Medical Directives of Physician Assistant in Orthopaedic Surgery: Operating Room

It is the policy of (*hospital)* to support the use of medical directives and/or delegation of controlled acts in accordance with the Regulated Health Professions Act and the regulatory colleges of health professionals. Within this framework the Division will utilize Physician Assistants to provide exemplary clinical care, improve patient safety, enhance the patient experience, provide continuing medical education to future health care workers and support research.

According to the *Regulated Health Professions Act*, members of a health profession have the authority to accept an order or delegation to a controlled act(s) and that are deemed appropriate by their regulatory college from a health care provider who is authorized to perform the controlled act(s).

This Medical Directive authorizes the performing of specific duties and procedures in the operating room by the Physician Assistant (PA). It is incumbent upon the PA to practice within the scope of their training and practice, as well as the training and practice of the attending staff.

The PA, working within the Operating Room may perform procedures as ordered on the appended Order Tables, provided that the Physician Assistant has met the education requirements and demonstrated competence.

Procedure	Group 1	Group 2	Indications / Contraindications	Competency Verification
1. Importing/loading of digital imaging	The PA may implement an order for importing/loading of digital imaging for surgical navigation prior to discussion with MRP.		**Indications:** Patient confirmed to undergo surgical procedure **Contraindications:** Patient not confirmed to undergo surgical procedure.	
2. Marking and confirming of a surgical site		The PA may implement an order for confirming and marking a surgical site after discussion with MRP.	**Indications:** Patient confirmed to undergo surgical procedure **Contraindications:** Patient not confirmed to undergo surgical procedure. Patient allergy to marking materials. Patient refusal.	Marking must be verified and confirmed by MRP or fellow.
3. Positioning of the patient	The PA may position a patient in the operating room prior to discussion with MRP if discussion regarding positioning occurred previously for the same operative procedure.	The PA may implement an order for positioning of a patient in the operating room after discussion with MRP.	**Indications:** Patient confirmed to undergo surgical procedure. **Contraindications:** Patient not confirmed to undergo surgical procedure. Positioning may exacerbate pre-existing patient injury. Patient refusal.	Positioning for each surgical procedure must be verified three times by an attending staff surgeon, fellow or senior surgical resident.
4. Conducting the surgical brief		The PA may conduct a surgical	**Indications:** Patient confirmed to undergo	Surgical brief must be verified three times by an

		brief after discussion with MRP.	specific surgical procedure. **Contraindications:** Patient not confirmed to undergo surgical procedure. Patient deemed not fit for surgery as per anaesthesia. Patient refusal.	attending staff surgeon, fellow or senior surgical resident.
5. Conducting the surgical timeout	The PA may implement an order to conduct the surgical timeout prior to discussion with MRP.		**Indications:** Patient confirmed to undergo surgical procedure. **Contraindications:** Patient not confirmed to undergo surgical procedure. Patient deemed not fit for surgery as per anaesthesia. Patient refusal.	Surgical timeout must be verified three times by staff attending surgeon, fellow or senior surgical resident.
6. Sterile Surgical Prepping	The PA may implement an order to conduct surgical sterile prepping prior to discussion with MRP.		**Indications:** Patient confirmed to undergo surgical procedure. Induction / intubation completed. **Contraindications:** Patient not confirmed to undergo surgical procedure. Patient deemed not fit for surgery as per anaesthesia. Patient refusal.	The PA must complete and show proof of completion of the appropriate corresponding LMS module for “Skin Prepping Protocols”
7. Sterile scrubbing, gowning and gloving		The PA may perform scrubbing, and gloving following	**Indications:** The PA instructed by MRP to scrub into OR.	The PA must complete sterile scrubbing, gowning and gloving session provided by

		instruction to scrub by MRP, fellow or senior surgical resident.	**Contraindications:** PA not instructed by MRP to scrub into OR.	Medical Education.
8. Draping a patient	The PA may perform draping of a patient prior to discussion with MRP.		**Indications:** Patient confirmed to undergo surgical procedure. Induction / intubation completed. **Contraindications:** Patient not confirmed to undergo surgical procedure. Induction/intubation not completed.	Draping technique must be verified three times by a staff attending surgeon, fellow or a senior surgical resident.
9. Assisting with surgical procedure		The PA may implement orders for assisting with a surgical procedure as per ongoing discussions (pre-operative or intra-operative) with MRP	**Indications:** As instructed by MRP. Senior surgical resident, fellow or staff attending surgeon must be in attendance in the OR suite. **Contraindications:** Not instructed by MRP.	Verification is based on each attending staff surgeon/fellow/senior surgical resident – PA relationship
10. Using Electrocautery		The PA may implement orders for using cautery intra-operatively after discussion with MRP.	**Indications:** Hemostasis must be achieved. Superficial tissue destruction / dissection. **Contraindications:** Not instructed by MRP.	Verification of use of electrocautery is based on staff attending surgeon/ fellow/senior surgical resident – PA relationship.

			Considerations: Patients with permanent pacemaker or ICD may require interrogation in the pacemaker clinic pre and post exposure to electrocautery.	
11. Camera Operation	The PA may implement orders for operating a camera intra-operatively prior to discussion with MRP.		**Indications:** Surgical procedure requires use of camera (eg. Laparoscopy). **Contraindications:** Surgical procedure does not require use of camera.	Operation of camera must be verified three times by staff attending surgeon, fellow or senior surgical resident.
12. Application or removal of extremity traction/splints		The PA may implement orders for the application or removal of extremity traction/splints following discussion with the MRP	**Indications:** Application – For fractures, dislocations and/or instability that cannot be treated by means of casting. Removal – When extremity traction/splint no longer indicated. **Contraindications:** Surgeon preference.	Procedure must be verified by staff attending surgeon, fellow or senior surgical resident.
13. Application/removal of external fixator frame/pin		The PA may implement orders for the application or removal of	**Indications:** Application – For the skeletal stabilization of open/closed fractures with severe soft-tissue	Procedure must be verified by staff attending surgeon, fellow or senior surgical resident.

		external fixator frame/pin following discussion with the MRP	compromise, limb shortening or when internal fixation not indicated at that time. Removal – When external fixator frame/pin no longer indicated. **Contraindications:** Surgeon preference.	
14. Intraoperative compartment pressure measurement		The PA may implement orders for the intraoperative measurement of compartment pressure following discussion with the MRP	**Indications:** Assessment of compartment pressures for the evaluation and documentation of possible compartment syndrome. **Contraindications:** Relative contraindication on areas with overlying cellulitis.	Compartment pressure measurements must be verified by staff attending surgeon, fellow or senior surgical resident.
15. Skin closure with staples.	The PA may implement orders for skin closure with staples prior to discussion with MRP.		**Indications:** Linear incisions requiring primary closure with good edges for approximation. **Contraindications:** Cellulitis or suspected infection. Severely contaminated wounds. Fascia not intact. Patient allergy.	Skin closure with staples must be verified three times by staff attending surgeon, fellow or senior surgical resident.
16. Skin closure with glue		The PA may implement orders for skin closure with glue after	**Indications:** Small linear incisions requiring primary closure with good edges	Skin closure with glue must be verified three times by staff attending

		discussion with MRP.	for approximation. Incisions under low tensions. Surgeon preference. **Contraindications:** Cellulitis or suspected infection. Severely contaminated wounds. Jagged or stellate incisions. High moisture areas (eg. axillae/perineum/hands/feet) Fascia not intact. Patient allergy. Surgeon preference.	surgeon, fellow or senior surgical resident.
17. Skin closure with steri-strips	The PA may implement orders for skin closure with steri-strips prior to discussion with MRP.		**Indications:** Incisions requiring primary closure under low tension. Can also be used as an adjunct to suture or staple closures in high-tension wounds, May be used as reinforcement for wounds after early suture or staple removal. Surgeon preference. **Contraindications:** Cellulitis or suspected infection. Severely contaminated wounds. Jagged or stellate incisions. Areas of high tension or repetitive motion. High moisture areas (eg. axillae/perineum/hands/feet) Fascia not intact. Patient allergy. Surgeon preference.	Skin closure with steri-strips must be verified three times by staff attending surgeon, fellow or senior surgical resident.

18. Suturing above the fascia		The PA may implement an order for suturing above the fascia after discussion with the MRP. The PA may perform a procedure below the dermis, including probing, cleansing, removal of a foreign body, and suturing of a wound or incision	**Indications:** Incision requiring primary closure. Securing drains. Stoma creations. **Contraindications:** Cellulitis or suspected infection. Fascia not intact.	Suturing above the fascia must be verified three times by an attending staff surgeon, fellow or senior surgical resident. Completion of a CME suturing course is an asset.
19. Incising above the fascia		The PA may implement an order for incising above the fascia after discussion with the MRP.	**Indications:** Incision for a surgical procedure. **Contraindications:** Prosthesis (expander or Implant) immediately under skin or poor soft tissue coverage. Fascia not intact.	Incising above the fascia in the operating room must be verified three times by an attending staff surgeon, fellow or senior surgical resident.
20. Applying post-operative dressing	The PA may implement an order for applying post-operative dressing prior to discussion with MRP.		**Indications:** Surgical incision requiring post-operative dressing. **Contraindications:**	Applying post-operative dressing must be verified three times by an attending staff surgeon, fellow or senior surgical

			Surgeon preference.	resident.
21. Application of post-operative negative pressure wound therapy dressing		The PA may implement an order for applying post-operative negative pressure wound therapy **(**VAC) dressing following discussion with MRP.	**Indications:** Risk reduction of post-operative wound infection, seroma formation and wound dehiscence. **Contraindications:** Malignancy in the wound. Untreated osteomyelitis. Non-enteric and unexplored fistulas. Necrotic tissue with eschar present.	Applying post-operative negative pressure wound therapy must be verified three times by an attending staff surgeon, fellow or senior surgical resident.
22. Application of post-operative splints/orthoses		The PA may implement an order for applying post-operative splints/orthoses following discussion with MRP.	**Indications:** To immobilize a bone or joint. **Contraindications:** Surgeon preference.	Applying post-operative splints/orthoses must be verified by an attending staff surgeon, fellow or senior surgical resident.
23. Escorting patient to the post-operative area and giving sign-over	The PA may escort patients to the post-operative area and give sign-over to the appropriate teams.		**Indications:** Following completion of surgical procedure, anaesthesia confirmation and bed availability. **Contraindications:** Anaesthesia team has not given approval to proceed to recovery. Bed is unavailable.	Escorting patient to the post-operative area and giving sign-over must be verified three times by attending staff surgeon, fellow or senior surgical resident.

Appendix C:

Medical Directives of Physician Assistant in Orthopaedic Surgery: Medications

According to the *Regulated Health Professions Act*, members of a health profession have the authority to accept an order or delegation to a controlled act(s) and that are deemed appropriate by their regulatory college from a health care provider who is authorized to perform the controlled act(s).

This medical directive provides authority both for (i) physician assistants (PAs) to accept an order or delegation to a controlled act(s) from a physician within their level of competence and (ii) nurses and allied health professionals to accept an order as outlined in this medical directive from a physician. When nurses or allied health professionals accept an order under this medical directive, they are not directly accepting the order from the PA but are carrying out the physician's order set out in this medical directive based on their own assessment of (i) the appropriateness of carrying out the task/treatment and (ii) whether the task/treatment is within their scope of practice and level of competence. This order may be relayed to the nurse or allied health professional by the PA.

To implement these directives the Physician Assistant must complete the requirements of Section No 1 and be in compliance with all hospital and departmental policies. The most responsible physician must be a signatory of these directives.

Group 1 medications may be initiated either before or after discussion with the most responsible physician at the professional judgment of the Physician Assistant. All cases must be discussed with the Attending Physician while the patient is in hospital.

Group 2 medications must routinely be discussed with the most responsible physician prior to initiation. There are limited exceptions when a group 2 drug becomes Group 1 if the safety of the patient is jeopardized by any delay (see medications list).

Renal dosing: The notation "(RF)" after a Group 1 drug requires that the PA consider dosage adjustment. The PA can consult an online database for Drug Dosing in Renal Impairment (link) before initiating therapy. In dialysis patients, all medications must be discussed with the most responsible physician prior to initiation (i.e., the drugs assume Group 2 status).

For all new graduate Physician Assistants still on probation and all Physician Assistant trainees all medications are classified Group 2.

The medication history, potential for drug allergy, prior use of analgesics and antimicrobials, and the possibility of pregnancy must be explored prior to implementing this directive.

Therapeutic Indication or Therapeutic Drug Class	**MEDICATIONS & DOSAGE RANGES** ***(RF)*** = consider renal dosage adjustment	
1) Allergy Therapy After implementation of an appropriate history and physical examination and applying due consideration to any appropriate investigations available the PA may order. ***Epinephrine may be ordered as a Group 1 drug if in the professional opinion of the PA any delay would be deleterious for the patient. Dosage for anaphylaxis: 0.1 to 0.5 mg IM Q 10 min*** **In the event that this Directive is used by a staff PA, there must be a mandatory review by the Program Co-Directors (Medical Director and Patient Care Manager) to investigate the circumstances from an operational and systems perspective.**	**Group 1** ***Betamethasone valerate*** (Topical) 0.1% cream or ointment Applied once or twice daily to affected areas Do not apply to face ***Diphenhydramine*** (Benadryl) 25-50 mg PO/IV Q6H or PRN ***Ranitidine (RF)*** 150 mg PO twice daily 50 mg IV Q8-12H	**Group 2** ***Epinephrine*** ***Hydroxyzine*** ***Methylprednisolone*** (Solu Medrol®) Up to 2 mg/kg IV; may repeat Q4-12H ***Prednisone*** Up to 1 mg/kg PO once daily ***Prednisolone*** (Pedipred® oral solution) Up to 1 mg/kg PO once daily

2) Analgesics / Antipyretics After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for alleviating pain or fever. ***The PA cannot prescribe narcotics as per Federal Law.***	***<u>Group 1</u>*** ***Acetaminophen*** Up to 1000 mg PO/PR Q6-8H/PRN ***Not to exceed 4g/day** ***Diclofenac (Voltaren®, Solaraze®)*** 1% top. 2 g (upper extremities)/4 g (lower extremities) q6hr **** Not to exceed 8 g/day to any single joint of upper extremities; 16 g/day to any single joint of lower extremities*** 3% top. 0.5 g BID ***Diclofenac (Pennsaid®)*** 1.5% (16.05mg/mL; dropper bottle) Apply 40 gtt on each painful knee QID 2% (20mg/pump actuation) Apply 40 mg (2 pump actuations) on each painful knee BID	**<u>Group 2</u>** ***ASA*** 325-650 mg PO or 650 mg PR Q4-6H PRN ***To be held for 5 days prior to surgical intervention unless otherwise specified or indicated by MRP*** ***Ibuprofen*** 200-400 mg PO Q4-6H or PRN ****Contraindicated in Kidney Failure*** ****Relative contraindication during post-operative*** ***Celocoxib (Celebrex®)*** 200-400mg PO Q12-24H PRN ****Contraindicated in Kidney Failure*** ****Relative contraindication during post-operative period and risk of leaks*** ***Naproxen*** 250-500 mg PO Q8-12H or PRN (usual max 1,000 mg per day) ****Relative contraindications during post-operative period and risk of leaks*** ***Pain only: Indomethacin*** Up to 50 mg PO Q6H ***Ketorolac (RF)*** Up to 30 mg IV Q6H or PRN (max 120 mg/day)

3) Anticoagulation After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order anticoagulation.	**Group 1** **DVT Prophylaxis:** **Enoxaparin (RF)** 40 mg SC daily or 40 mg SC BID (patients >100kg)	**Group 2** **Therapeutic anticoagulation:** ***Apixaban*** ***Dabigatran*** ***Enoxaparin (therapeutic dose)*** ***Heparin (therapeutic dose)*** ***Rivaroxaban*** ***Warfarin***
4) Antimicrobial Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for an infectious disease.	***Antibiotics:*** ***Group 1:*** ***Amoxicillin*** 500 mg PO Q8H ***Ampicillin (RF)*** 1-2 g IV Q4-6H ***Amoxicillin-clavulanate*** (Clavulin®) 500 mg PO Q8-12H or 875 mg Q12H ***Cefazolin (RF)*** 1 g IV Q8H 2 g IV once daily for outpatient treatment (with probenecid) ***Metronidazole*** 500 mg PO Q8-12H or 500 mg IV Q12H ***Clindamycin*** 150-450 mg PO Q6H 600-900 mg IV Q8H	**Group 2** ***Ceftriaxone*** 1 g IV once daily Up to 2 g Q12H for meningitis, endocarditis, osteomyelitis ***Ciprofloxacin (RF)*** 500-750 mg PO Q12H 400 mg IV Q12H ***Clarithromycin*** 250-500 mg PO Q12H ***Cloxacillin*** 500-1,000 mg PO Q4-6H 1-2 g IV Q4-6H ***Co-trimoxazole (RF)*** Trimethoprim/Sulfamethoxazole (TMP/SMX): 2 tabs PO or 10 mL IV Q12H ***Levofloxacin (RF)***

	Adjuncts: **<u>Group 1</u>** ***Probenecid*** 1 g / PO once prior to IV dose of cefazolin or ceftriaxone ***Tobramycin*** ***Gentamicin***	750 mg PO/IV once daily ***Nitrofurantoin (RF)*** 50-100 mg PO up to QID ***Adjuncts:*** **<u>Group 2</u>** ***Piperacillin-tazobactam*** ***Vancomycin*** ***<u>Antivirals:</u>*** ***Acyclovir*** ***Famciclovir*** ***Oseltamivir*** ***Valacyclovir*** ***<u>Antifungals:</u>*** ***Nystatin*** ***Fluconazole***
5) Antinauseants / Antiemetics After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for nausea.	**<u>Group 1</u>** ***Dimenhydrinate*** (Gravol®) 25-50 mg PO Q4-6H PRN 50-100 mg PR Q4-6H PRN 12.5 to 50 mg IV Q4-6H PRN ***Ondansetron*** 4 mg PO/IV Q6H PRN	**<u>Group 2</u>** ****Prochlorperazine*** ****Metoclopramide (RF)*** 10 mg PO/IV QID or Q4-6H PRN ****Contraindicated in immediate post-op period***

6) Blood Products After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may write the order 'as per Dr. _____' (most responsible physician). ***Prior to initiation, the order must be discussed with the most responsible physician.*** ***The PA must have successfully completed the current prescribed course provided by the (hospital) Blood Bank.***		**<u>Group 2</u>** All blood product(s) <u>Indications:</u> 1. Discussion with and approval by MRP. 2. Must fall within the published (*hospital)*guidelines as documented on the intranet. 3. Must have documented and a signed order on the patient record to hospital standards. 4.Unless circumstances do not permit the patient must have read, or had an opportunity to read, the hospital information package for transfusion patients <u>Contraindications:</u> 1. Known prior adverse reaction to blood products of any nature or known antibody issue. 2. Failure to achieve any of the above 4 indications. ***It is the Canadian legal standard that the MRP or his physician delegate must:*** 1). Discuss risk benefits with the patient in person. 2). Sign the blood consent form.
7) Cardiovascular Therapy After implementation of a complete history and physical examination and applying due consideration to	***EC ASA*** (antiplatelet therapy) 81-325 mg PO once daily ***Furosemide*** 20-40 mg PO/IV; may repeat as necessary ***Nitroglycerin lingual spray*** 0.4 to 0.8 mg (1-2	***Calcium gluconate*** ***Diltiazem*** ***Furosemide >40 mg*** ***Magnesium sulfate***

appropriate investigations available, the PA may order for suspect disease of cardiovascular origin. ***If the patient has an acute STEMI and a physician is not in attendance, the PA may activate the Code STEMI Team but then must immediately inform the most responsible physician.***	sprays) stat; may repeat x 2 at 5-min intervals With SPB >100mmHG ***Nitroglycerin Transdermal Patch*** 0.2 to 0.8 mg applied once daily (remove QHS to allow 10-12 h drug-free period) With SPB >100mmHG	***Metoprolol***
8) Corticosteroid Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order the following corticosteroid therapeutic interventions.	**Group 1** ***Hydrocortisone*** 1-2 mg/kg IV ***Prednisone*** Up to 1 mg/kg PO once daily ***Prednisolone*** (Pedipred® oral solution) Up to 1 mg/kg PO once daily	**Group 2** ***Methylprednisolone*** (Solu Medrol®) Up to 2 mg/kg IV; may repeat Q4-12H ***Stress corticosteroids post-op***
9) Diabetes Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order	**Group 1** The PA may resume the patient's home dosage of both insulin and non-insulin antihyperglycemic agents.	**Group 2** ***Glucose / Dextrose Chewable Tablet or Gel*** 3-4 chew tabs or 1 tube of gel PO stat; may repeat after 15-20 min if BG still < 4 mmol/L ***Dextrose 50% Injection (50 mL syringe)*** 12.5 g (25 mL of D50W) IV slow bolus; may repeat

the following interventions for management of blood glucose.		***Dextrose 10% IV Infusion (500 or 1000 mL bag)*** 12.5 g (125 mL of D10W) infused IV as rapidly as possible (e.g., over 10 min); may repeat ***Insulin*** SC or IV ***Non-insulin antihyperglycemic agents***
10) Fluid & Electrolyte Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order fluid and electrolyte therapy. **For patients in the pre-operative or post-operative period who are unable to intake adequate p.o. fluids. Electrolytes should be checked prior to starting any solution.**	**<u>Group 1</u>** ***Any plain IV solution*** (no KCl) routinely stocked ***Potassium chloride ORAL*** if serum K **< 3.2 mmol/L** 8 to 40 mmol oral SR tab (K-Dur, Slow-K) 20-40 mmol (15-30 mL) oral liquid **Magnesium Sulfate** if serum Mg **< 0.7 mmol/L** Magnesium sulphate 2 g in 100 mL IV solution over 1 hour via central or peripheral venous access. **Calcium gluconate** if serum Ca **< 2.20 mmol/L** CL SALT NOT USED Calcium gluconate: 1 g in 50 mL IV solution, 2 g in 100 mL IV solution over 1 hour **Phosphate** Potassium/Sodium if ser P **< 0.87 mmol/L** **AND** serum **K < 3.5 mmol/L with peripheral IV**	

	access Potassium phosphate 15 mmol in 500 mL IV solution over 4 hours. Do not give additional K replacement as 15 mmol of potassium phosphate provides 22 mmol of K. **AND** serum **K ≥ 3.5 mmol/L** Sodium phosphate 15 mmol in 100 mL IV solution over 2 hours via peripheral or central venous catheter. **OR** Phosphate Novartis effervescent tablet 1000 mg PO/NG x 1 dose.	

11) Gastrointestinal Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for disease of suspect GI origin.	***Acid Suppressants / Antacids:*** **<u>Group 1</u>** ***Antacid*** Magnesium & aluminum hydroxide (Gelusil®) 15-30 mL PRN ***Pantoprazole*** <u>Acid suppression</u>: 40-80 mg PO/IV per day (given once or twice/day) ***Ranitidine (RF)*** 150 mg PO twice daily50 mg IV Q8-12H ****Contraindicated in patients with known or suspected C.diff infection*** The PA may also order and implement a bowel regiment as outlined by the (*hospital)* Bowel Order Sets.	***Laxatives:*** ****contraindicated in the early post-operative period for GI surgery*** **<u>Group 2</u>** ***Lactulose*** 15-30 mL once or twice daily ***Magnesium Citrate*** 75 to 300 mL PO; repeat as necessary ***Magnesium hydroxide*** 30-60 mL PO; repeat as necessary ***Na Phosphate*** (Fleet Enema)130 mL PR; repeat as necessary ***Polyethylene Glycol*** 17 g PO once or twice daily ***Sennosides*** 2-4 tabs PO once or twice daily ***Antidiarrheals:*** **<u>Group 2</u>** ***Diphenoxylate*** 2 tabs (5 mg) PO 3-4 times a day ***Loperamide*** 2 tabs PO stat; then 1 tab PO after each loose BM (max 8 tabs per day)
12) Local Anaesthesia After implementation of a	**<u>Group 1</u>** ***Bupivacaine 0.25% or 0.5%***	

complete history and physical examination and applying due consideration to indications, contraindications and appropriate investigations available, the PA may order or use for local anesthesia.	Via SC infiltration (for dose, see CPS) ***EMLA*** (2.5%prilocaine, 2.5%lidocaine) Apply topically with occlusive dressing 1 hour before procedure ***LET Solution*** (lidocaine 4%, Epinephrine 1:1000, Tetracaine 0.5%) Apply topically avoiding mucous membranes and open wounds ***Lidocaine 1% or 2% with or without epinephrine*** 1:100,000 or 1:200,000 Via SC infiltration (see CPS) ***Lidocaine Viscous 2%*** 5-15 mL orally (may swish & spit / swallow) PRN (max 60 mL per day) ***Lidocaine Topical Solution 4%*** Apply 2.5 to 10 mL topically to oropharyngeal, tracheal and bronchial areas pre-procedure	
13) Neuropathic Pain Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for neuropathic pain	**<u>Group 1</u>** **Capsaicin (Capzasin®)** 0.025-0.1% cream – top. TID to QID for 3-4 weeks ***Not to exceed 4 applications/day**	**<u>Group 2</u>** Calcium Channel Alpha-2-delta Ligands ***Gabapentin (Neurontin®)*** 300 mg PO Q8-24H up to 1200mg Q8H ***Decrease dosage to twice per day in renal impairment** ***Pregabalin (Lyrica®)*** 75-600 mg/day PO divided Q8-12H ***not to exceed 300mg in patients with creatinine**

		clearance less than 60 ml/min
14) Ophthalmologic Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for ophthalmologic disease.	**<u>Group 1</u>** ***Lacrilube®*** eye ointment Instill into affected eyes up to Q6-8H ***Tears Naturale®*** eye drops 1-2 drops into affected eyes up to Q2H	
15) Outpatient Medications for Maintenance Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order the continuation of medications in hospital that were being taken by the patient as treatment for pre-existing conditions. ***The PA cannot prescribe narcotics or controlled or targeted drugs as per Federal Law.*** ***The PA must not prescribe any medication deemed in***	**<u>Group 1</u>** The PA may prescribe (without prior discussion with a physician) any medication that the patient was taking as an outpatient and that requires continuation while the patient is being assessed and treated in Hospital.	

their professional opinion to be causing the presenting complaint. ***The PA must not prescribe oral medications for a patient deemed at significant risk of requiring anaesthesia or deep conscious sedation.***		
16) Respiratory Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for respiratory disease. ***Any nebulizer therapy must be in compliance with the current (hospital) policy (Infection Prevention & Control).***	**Group 1** ***Budesonide (Pulmicort®)*** 400–2400 µg/day divided BID ***Ipratropium*** MDI: 4-8 puffs Q15-20 min x 3 for acute asthma Then 2 puffs QID or PRN NEBULIZER: 500 mcg/2 mL inhalation sol PRN ***Salbutamol*** MDI: 4-8 puffs Q15-20min x 3 for acute asthma Then 2 puffs QID or PRN NEBULIZER: 2.5 to 5 mg inhalation sol PRN ***Naloxone (Narcan®)*** 0.4-4 mg IV/IM/SC; repeat q2-3min PRN ***Not to exceed 10 mg (0.01 mg/kg)**	
17) Sedative / Hypnotics for Sleep	**Group 1** Melatonin 1-3 mg PO qhs prn (max 5 mg) Zopiclone 3.75-7.5 mg PO qhs prn	

18) Skeletal Muscle Relaxant After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order for skeletal muscle spasms	**Group 1** ***Methocarbamol (Robaxin)*** *1500 mg PO q6hr for 48-72 hours then decrease to 4-4.5 g/day divided q4-8hr* ***Not to exceed 8 g/day***	
19) Wound Therapy After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order wound therapy.	**Group 1** **Any hospital approved ward stock antiseptic skin cleansing agent(s)** **Hydrogen Peroxide 3% solution** Apply to affected areas to cleanse wounds or ulcers as needed **Polysporin cream or ointment** Apply to affected areas BID-TID **Tetanus & Diphtheria Toxoids (Td Adsorbed)** Booster dose in patients aged 7 yrs or older:0.5 mL IM once	**Group 2** **Surgifoam** Apply as directed to achieve homeostasis **Tissue Glue** Apply as directed **Surgicel** Apply as directed to achieve homeostasis

20) Miscellaneous After implementation of a complete history and physical examination and applying due consideration to appropriate investigations available, the PA may order the miscellaneous medications listed here following discussions with the MRP	**<u>Group 2</u>** ***Tamsulosin*** ***Tranexamic acid*** ***Vitamin K***
Life Threatening Medical Emergency, <u>Unsupervised</u> In the unlikely circumstance that a fully certified staff PA, for whatever reason, finds themselves asked to see a life-threatening illness and the most responsible physician is not available <u>and</u> it is the professional judgment of that PA that any further delay significantly and imminently jeopardizes the life of that patient, the PA is authorized to take whatever action is deemed appropriate to maintain the life of the patient and may intervene with any of the above listed medications (Group 1 or 2) and act within the full current ACLS guidelines as sanctioned by the Ontario Heart & Stroke Foundation. **In the event that this Directive is used by a staff PA, there must be a mandatory review by the Program Co-Directors (Medical Director and Patient Care Manager) to investigate the circumstances from an operational and systems perspective and to elicit any learning that may pertain.**	Prescribing and actions must be in complete compliance with the latest ACLS Provider and ACLS Advanced algorithms.
Any order not described above may be written by the PA, following discussion with MRP: "XYZ, as per verbal order from DR. MRP."	

Appendix D:

Procedure Log

SUPERVISING PHYSICIAN: **START DATE:**

PHYSICIAN ASSISTANT: **END DATE:**

Criteria	**Physician Sign Off-For each directly supervised procedure/skill** (Minimum of 5)				
PROCEDURE OR SKILL	**#1**	**#2**	**#3**	**#4**	**#5**
Administration of local anesthesia					
Admit patients from Ambulatory setting to Inpatient Orthopaedic Unit					
Application of sling					
Application of Thomas splint					
Appropriate referrals for Consulting services including other Allied Health Professionals					

	Appropriate usage of E-Sheet for order entry (outpatient)						
	Consulting other medical specialties and co-signing other medical specialties suggested orders						
	Dispenses appropriate medications/prescription						
	Educates patients regarding treatment plan including risks/benefits						
	Managing Wound Infections						
	Obtains Complete History - New patient						
	Obtains Informed consent for a procedure						
	Order, consent for transfusion						
	Ordering appropriate diagnostic imaging tests						
	Ordering cultures; understands indications						
	Performs appropriate physical exam for patient complaint						
	Perform drain removal						
	Perform dressing placement/change/removal						
	Performs Focused History - Follow-up patient						

Perform splint/cast application: Elbow						
Perform splint/cast application: Hand/Wrist						
Perform splint/cast application: Long Leg						
Perform splint/cast application: Short leg/foot/ankle						
Suture placement/removal						
Understands criteria for certain patient dietary restrictions						
Understands criteria for ordering catheter and drain placement (PICC, pleural catheter, peritoneal catheter)						
Diagnosis and Management of:						
Ankle Fractures						
Bursitis						
Carpal Fractures						
Carpal Tunnel Syndrome						
Clavicle Fractures						
Elbow Dislocation						
Epicondylosis of the Elbow						

Femur Fractures						
Foot Fractures						
Hand Fractures						
Hip Dislocation						
Hip Fractures						
Humeral Fractures						
Knee Dislocation						
Ligamentous Injury						
Meniscus Injury						
Osteoarthritis						
Patellar Dislocation						
Pelvic Fractures						
Radial/Ulnar Fractures						
Rib Fractures						
Rotator Cuff Tear						
Scapular Fractures						

Septic Arthritis						
Shoulder Dislocation						
Tarsal Fracture						
Tendon Strain/Rupture						
Tibia/Fibular Fractures						
Vertebral Fractures						
Diagnosis and Initial Management of:						
Anemia						
Bowel Dysfunction (Constipation/Diarrhea)						
DVT (suspected/proven)						
Dyspnea						
Electrolyte Imbalance						
Fatigue						
GERD						
Nausea/Vomiting						
Pain						

Peripheral neuropathy						
Rash						

Other	**#1**	**#2**	**#3**	**#4**	**#5**