Medical Directive Title:

Physician Assistant Medical Directive in Acute Care General Surgery

Name and Signature of authorizing Physician(s):

See attached list.

System(s)/Service(s) who verified the need for development of the medical directive:

Department of General Surgery

Professional Groups consulted:

Chief Diagnostic Imaging
Chief Emergency
Chief Cardiology
Chief Pediatrics
Chief Laboratory
Surgery Program Steering Committee
Pharmacy & Therapeutics Committee
Professional Practice Committee
Medical Advisory Committee

To which professional group(s) the medical directive applies:

PAs working in Acute Care Surgery Model in the division of General Surgery who are certified under the Physician Assistant Certification Council of Canada (PACCC) and have successfully completed a Canadian Medical Association (CMA) accredited Physician Assistant Program. **The PA works under the supervision of a registered physician. The PA supports the supervising physician, who maintains primary responsibility for patient care as the principle decision-maker.**

Contact person (position) for clarification of the medical directive:

- Physician Assistant
- Division Head of General Surgery

The directive was developed by the PA and General Surgeon PA Medical Directive Lead and reviewed by *Program Director of Surgery and Peri-Operative Services, Division Head of General Surgery,* and all members of the Division of General Surgery.

Description of Medical Directive:

This medical directive was developed to define the practice of physician assistant(s) (PAs) working in the Acute Care Surgery Model in the division of General Surgery.

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) PAs to accept an order or delegation to a controlled act(s) from a physician within their level of competence and (ii) nurses/allied health to accept an order as outlined in this medical directive from a physician. When nurses/allied health 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 (a) the appropriateness of carrying out the task/treatment and (b) whether the task/treatment is within their scope of practice and level of competence. This order may be relayed to nurses/allied health by the PA in verbal or written form.

Goals of Medical Directive:

1a. Consultations: To enable PAs to provide surgical consultation to patients referred to the attending general surgeon.

1b. Orders and Diagnostic Tests: To enable PAs to order clinically indicated laboratory tests, diagnostic imaging procedures to aid in diagnosis of clinical conditions, as well as to evaluate and monitor clinical outcomes of treatment interventions.

1c. Therapeutic Interventions: To enable PAs to order and perform clinically indicated non-pharmacological and pharmacological interventions.

1d. Telephone Orders: To enable PAs to accept a verbal order or telephone order from any authorized prescriber.

1e. Procedures: To enable PAs to complete procedures as directed by the attending physician.

1f. Referrals: To enable PAs to integrate interdisciplinary expertise into a patient's plan of care.

1g. Discharges: To enable PAs to discharge a patient home, after consultation with the attending physician with appropriate documentation, follow up, and support resources as required.

Client Conditions:

This medical directive applies to all adult and pediatric (≥8 years old or ≥30 kg) patients referred or admitted to the General Surgery service, under a supervising physician who has reviewed and approved this medical directive. The patient condition must meet the indication(s) as outlined in sections 1a-1g. The patient or substitute decision maker(s) must consent to the plan of care and to receiving care from a PA.

Clinical Criteria/Client Situation:

1a. CONSULTATIONS

The PA is authorized to provide general surgery consultation to patients referred to an attending general surgeon, who has approved this medical directive. The PA may perform a preliminary assessment of emergency department or ward consultations as directed by an attending surgeon. After consultation with and approval of the attending surgeon the PA may admit patients to hospital on behalf of an attending surgeon for observation, surgical or non-surgical intervention. The PA will document a consultation note.

Prior to implementing this medical directive the PA is required to perform an assessment of the patient's status including:

- History of present illness and physical examination;
- Past medical/surgical history and pertinent family history;
- Current medications and allergies; and
- Current and previous investigations and laboratory results.

The PA may put an instrument, hand or finger: beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body. The term instrument will refer to the following: otoscope, tongue depressor, swabs for culture and sensitivity, nasal speculum and packing, rectal thermometer, Foley catheter, vaginal speculum, and all wound care or resuscitation instruments carried on surgical trays sanctioned by Trillium Health Partners.

The PA may communicate the diagnosis and management plan to the patient or his/her delegate. The PA may communicate patient information to friends/family members with consent from the patient. The PA may also communicate patient information, with implied consent from the patient, to other health care providers within the patient's circle of care when seeking consultation or transfer of care.

1b. ORDERS AND DIAGNOSTIC TESTS

The PA may implement this medical directive for patients referred to an attending general surgeon, who has approved this medical directive. The PA will order diagnostic investigations as clinically indicated and communicate the results of such investigations to patients and the attending general surgeon.

The PA may implement this medical directive to:

- Confirm and/or rule out medical diagnoses;
- Assess and/or monitor a patient's ongoing illness;
- Evaluate success of prescribed treatments; and/or
- Screen for comorbid conditions.

Biochemistry:

Diagnostic Order	Indications
Electrolytes, Creatinine.	Persistent vomiting/diarrhea, abdominal pain, SOB, chest pain, change in patient condition. To assess and monitor renal function, hydration status, electrolyte imbalances.
Troponin	Chest pain, shortness of breath (SOB), ECG changes.
Arterial/Venous Blood Gases (A/VBGs)	Chest pain, SOB, dyspnea, respiratory rate > 30/min, decreased LOC, oxygen saturations <80%, cyanosis.
Random/fasting blood glucose, Point of Care blood glucose	Monitor glycemic control in appropriate diabetic patients or other patient with unstable blood glucose, decreased LOC.
Liver Enzymes (ALT, AST, ALP, un/conjugated, bilirubin)	Abdominal pain, jaundice. To assess and monitor liver enzymes in patients with pancreatitis, post cholecystectomy, post liver resection, with history of ethanol abuse.
Lipase	Abdominal pain. To rule out pancreatitis.
Calcium, Magnesium, Phosphate	To assess and monitor patients receiving total parenteral nutrition (TPN), post-op liver resection, patients with high output ostomy or fistula, ileus, electrolyte imbalances.
CEA, CA-125, CA 19-9	Pre and post-operative to monitor treatment of colon cancer, gynecologic cancer, and pancreatic cancer.
Albumin	To assess nutritional status.
Serum Drug Level	To monitor blood level of certain drugs, example: digoxin, tobramycin, gentamicin, vancomycin, anti-convulsants, etc.
Hepatitis Screen	To screen for hepatitis. (HBsAg, Anti-HBs, Anti-HBc, HCV antibody)

Hematology:

Diagnostic Order	Indications
CBC	Fever, vomiting, abdominal pain/distension, tachycardia, chest pain, SOB, hypotension. To asses and monitor patients for bleeding, leukocytosis, etc.
INR/PTT	Persistent bleeding, to assess pre-operative/pre-procedure risk of bleeding, liver function, to monitor patients on warfarin/coumadin, IV heparin.
Group & Screen	Low hemoglobin, pre-transfusion, pre-operative patients that may require transfusion intra-operatively or post-operatively.
HIT Screen	Thrombocytopenia, decreased in platelets >50% in patients on/previously on heparin.

Microbiology:

Diagnostic Order	Indications
Urinalysis, R&M, C&S	Dysuria, frequency, urgency, urinary retention, pyuria, hematuria, fever, leukocytosis.
Blood Culture & Sensitivity (C&S)	Fever greater than or equal to 38-38.5C to rule out sepsis, follow-up from previous positive blood cultures.
Sputum C&S	Productive cough, fever, leukocytosis.
Stool C&S, *C.difficile* Toxin	Watery diarrhea, diarrhea in patients with risk factors for *C.difficile* infection.
Wound & Drainage Fluid C&S	Purulent drainage.

Diagnostic Imaging:

The PA may implement this medical directive to order the following diagnostic imaging investigations in consultation with the attending surgeon. The PA is **not** authorized to order a CT scan on patients under the age of 40 or on patients who are pregnant. The PA will implement this directive according to the clinical indications below and will consult the attending surgeon prior to ordering CT scans of the Head**,** Chest, Abdomen and Pelvis as well as V/Q scans. The clinical indication for the examination will be included with the order. The PA will be available to speak with a radiologist when the latter requests a review of pertinent clinical information. The indications for ordering a CT scan will match clinical program specialty.

Regarding contrast-enhanced CT scans, special consideration will be given to patients with impaired renal function and patients with allergy to contrast. Alternative imaging options will be discussed. If the patient with contrast allergy requires a contrast-enhanced CT scan pretreatment may be warranted and given according to hospital clinical practice guidelines, CPG 19-2: Radiopaque Contrast Media. Enhanced CT scan is relatively contraindicated in patients with renal insufficiency (GFR <30mL/min or Creatinine >100). Glucophage/Metformin will be held prior to CT scan and creatinine will be reassessed 48 hours post CT scan prior to restarting. Acetylcysteine/Mucomyst and IV fluids will be considered prior to contrast-enhanced CT scan in patients with renal insufficiency.

Diagnostic Order	Indications
Chest X-Ray (CXR) PA/Lateral/Portable	Acute dyspnea/respiratory distress. Significant abnormality in air entry where an effusion, fluid overload, pneumothorax, atelectasis or consolidation/infiltrate is suspected based on physical exam. Follow up of previous abnormal CXR.
Abdominal X-Ray (AXR) 1-3 views	Vomiting, abdominal distension/pain, obstipation. Follow up AXR for conservative management of bowel obstruction. 1 view to verify NGT placement.
Abdominal/Pelvic Ultrasound (US)	Abdominal pain, pelvic pain, jaundice, post-operative abdominal pain and/or fever, leukocytosis, to rule out abscess, follow up to previous abnormal US.
Kidney, Ureter, Bladder Ultrasound	Urinary retention, obstructive symptoms, hematuria.
Venous Doppler	Clinical signs of DVT.
CT Head (no contrast)	Acute change in neurological status, focal neurological findings, decreased LOC, head trauma and/or fall. To rule out fracture, epidural or subdural hemorrhage, or cerebrovascular accident (CVA).

V/Q Scan CT PE Protocol/ Angiography	Acute onset dyspnea, pleuritic chest pain, cough, hemoptysis, orthopnea, wheezing, tachycardia, and/or clinical signs/symptoms of DVT. To rule out pulmonary embolus (PE). *If patient has impaired renal function or contrast allergy V/Q scan will be considered.*
CT Abdo/Pelvis (contrast)	Acute onset abdominal pain, peritonitis, leukocytosis and/or fever in the post-operative patient to assess for complications such as abscess(es), anastomotic leak, fistula, obstruction. To assess pancreatitis. To rule out metastatic disease.
MRCP	Biliary dilatation, jaundice/elevated bilirubin, choledocholithiasis, cholangitis.
Upper GI Series/ Small Bowel Follow Through (SBFT)	To define anatomy of small bowel, to rule out stricture, obstruction, dysmotility. Use of barium versus gastrografin will be made based on clinical indication and any upcoming radiologic investigations.
Fistulograms, Drain Checks	To define anatomy of fistula, percutaneous or cholecystostomy drain tract(s).

Cardiac Investigations:

ECG	Chest pain, SOB, pre-operative screening, to identify/rule out abnormal rhythms, conduction defects, myocardial infarction (MI), pericarditis, etc. To monitor drug effects, cardiac pacemaker function.
Echocardiogram	Evaluate left ventricular and cardiac valve function. Assess new murmurs/rubs, pericardial fluid accumulation. Rule out endocarditis. Upon consultation with cardiology.

1c. THERAPEUTICS INTERVENTIONS

The PA may implement this medical directive for patients referred to an attending physician, who has approved this medical directive. The PA will order therapeutic interventions as clinically indicated and communicate the results of such interventions to patients and the attending physician.

Pharmacologic Orders:

The PA is authorized to order on admission all pre-admission medications if the drug, dose and frequency of administration are clinically indicated and contained in the hospital formulary. If the drug is non-formulary, a pharmacy substitution may be used or the patient may be allowed to use their own medication while an inpatient. The PA will consult the attending physician regarding continuation/discontinuation of home anticoagulants.

During the course of a patient's hospitalization, the PA may prescribe and/or initiate titration of medications included in the medical directive (see list below), as clinically indicated. Medication dose will be based on product monograph, hospital formulary and patient co-factors. References that are available for consultation include but are not limited to: Compendium of Pharmaceuticals and Specialties (CPS), Lexi-Comp Online, Rx Files Drug Comparison Charts, hospital protocols and clinical practice guidelines. The PA will consult standard references to define contraindications, precautions and potential side effects and drug interactions when implementing the medical directive for ordering medications. Patient co-factors include: weight, age, renal function, previous response to specific or similar medications, concurrent medications, drug allergies/sensitivities, co-morbid conditions, physical examination and results of relevant laboratory, imaging or other diagnostic tests, as well as ongoing response to the relevant medication.

All controlled substances, including narcotics and benzodiazepines cannot be prescribed by the PA. The PA is not authorized to document verbal, telephone or e-mail orders for narcotics or other controlled substances. For all non-controlled medications not listed in the medical directives, the PA is authorized to accept and document telephone, verbal, or email orders from any authorized prescriber.

Medications: Generic/Trade Name
Analgesics/NSAIDS: Ibuprofen (Advil®, Motrin®) – po Acetaminophen (Tylenol®) Ketorolac (Toradol®) – IV, for maximum 48 hours Naproxen (Naprosyn®, Aleve®) Celecoxib (Celebrex®)
Antibiotics: Ceftriaxone Metronidazole (Flagyl®) Ciprofloxacin (Cipro®) Cloxacillin Moxifloxacin (Avelox®) Levofloxacin (Levaquin®) Amoxicillin/Clavulanic Acid (Clavulin®) Piparcillin/Tazobactam (Tazosin®) Cefazolin (Ancef®) Cephalexin (Keflex®) Clindamycin Nitrofurantoin (Macrobid®) TMP-SMX (Bactrim®) (Septra®) Vancomycin
Antihistamines: Diphenhydramine (Benadryl®)
Anti-fungals: Fluconazole (Diflucan®) Nystatin Clotrimazole 1% (Canesten®) Topical
Anti-emetics: Dimenhydrinate (Gravol®) Ondansetron (Zofran®)
Anti-Hyperglycemic Agents: As per pre-printed order set for insulin.
Anti-platelets & Anti-thrombotic Agents: Aspirin (ASA) Heparin – for DVT Prohphylaxis Dalteparin (Fragmin®) – or formulary LMWH for DVT Prophylaxis Warfarin (Coumadin®) – post-operative titration for patients taking warfarin pre-admission
Acid Suppression: Ranitidine (Zantac®) Pantoprazole (Pantoloc®) Pantoprazole (Pantoloc®) Infusion – for 48 to72 hours
Sedatives: Zopiclone (Imovane®)

Stool Softeners & Laxatives: Docusate (Colace®) Lactulose Senna (Senokot®) Milk of Magnesia (MOM) Bisacodyl (Dulcolax®) Go-Lytely/ Peg-Lyte Pico Salax PEG 3350 (Restoralax®)
Prokinetics: Metoclopramide (Maxeran®) – for 24 to 48 hours Erythromycin Pinaverium (Dicetel®) Domperidone (Motilium®)
Topicals: Anusol® Cream Hydrocortinsone Cream 0.5-1% Zinc Oxide (Zincofax®)
Other: Loperamide (Imodium®) Octreotide (Sandostatin®) t-PA (Cathflo®) Thiamine Furosemide (Lasix®) Multivitamins Ferrous fumarate Oral Potassium Replacement (K-Elixer, K-dur) Tamsulosin (Flomax®) 4% nebulized lidocaine

Non-Pharmacologic Orders:

Therapeutic Intervention	Indications
IV Fluids: 0.9% NaCl, RL, 2/3 + 1/3, D5W 0.9% NaCl or D5W 0.45% NaCl, +/- 20-40 mEq KCl/L at 25-150 mL/hr IV Bolus: 0.9% NaCl 0.5 – 1L Discontinuation of IV: Saline lock(SL) IV, to keep vein open (TKVO), Discontinue IV	Fluid resuscitation for patients with clinical evidence of dehydration including low urine output, low blood pressure, and tachycardia, and all patients who are NPO.
Packed Red Blood Cells (PRBC) 1-2 units	Patients with low hemoglobin <70 mmHg or Hgb 70-90 mmHg and symptomatic.
Albumin 5%, 25%	100-500 mL IV over 1 hour
Voluven	250-500 mL IV
Percutaneous drain, percutaneous cholecystostomy tube	Drainage of intra-abdominal abscess. Drainage of gallbladder.

PICC line	Patient to receive TPN, prolonged IV antibiotics.
Discharge from SOU (Surgical Observation Unit)	In consultation with MRP, after acute issues have stabilized and patient no longer requires 24 hour observation.
Oxygen Therapy	Post-operatively to maintain saturations >90%, in patients with COPD maintain saturations of 88-92%.
Enemas	Indication: Constipation. Contraindication: Recent anastomosis of left colon or rectum within 7 days.
TED Stockings	Patient at increased risk for developing DVT, LE edema.

Diet Advance Criteria:

Diet	Indications
NPO	Patients scheduled for surgery/procedure, or requiring NG tube/bowel rest.
Clear Fluid Diet (CF)	Patients with normal bowel function as demonstrated by flatus and/or bowel movement.
Full Fluid Diet (FF)	Patients tolerating clear fluid diet.
Low Residue Diet	Patients tolerating a FF diet with recent bowel obstruction, stricture or ileostomy.
Regular Diet/ Diet as Tolerated (DAT)	Patients tolerating a clear/full fluid diet with no diet restrictions.

1d. TELEPHONE ORDERS

For specific orders not covered by the medical directives, the PA is authorized to accept and document telephone, verbal, or email orders from any authorized prescriber. The PA will document the name of ordering physician, time, and medical directive in the chart. Regulated health care professionals are able to accept telephone and verbal orders enacted through this medical directive by the PA, for patients admitted to the PA's supervising physician who has approved this medical directive. The PA is not authorized to document verbal, telephone or e-mail orders for narcotics or other controlled substances.

1e. PROCEDURES

Consent: The PA may initiate the consent discussion for major surgery, explain the surgical intervention to the patient, the associated risks and benefits of the procedure, alternative treatment options, and address any questions or concerns. It is the accountability of the attending surgeon to obtain consent prior to performance of any surgical intervention. The PA is authorized to assist in the operating room as directed by the attending surgeon. The PA may apply cautery in the operating room as directed by the attending surgeon.

The PA is authorized to perform a procedure on tissue below the dermis or below the surface of a mucous membrane, and administer a substance via injection as delegated by the attending physician. It is the PA's responsibility to obtain informed consent from a capable patient or his/her delegate prior to performing any procedure.

It is the responsibility of the PA and the physician that prior to performing any procedure, the PA is supervised, educated, and evaluated on proper technique to ensure competency, see Appendix B: Physician Assistant Procedure List. The PA is accountable for getting a physician signatory to the medical directive and documenting this on the procedure list. This list is not intended to be inclusive of all procedures a PA is permitted to perform under this medical directive but represents those procedures that might be considered to be of higher risk. Any of the signatories may attest to the competency of the PA to perform these procedures.

The PA is authorized to perform the following procedures as directed by the attending surgeon:

Procedure	Indications
Peripherally Inserted Central Catheter (PICC) Removal	No further clinical indication for PICC line.
Removal of Central Line	No further clinical indication for central line.
Percutaneous Drain Removal	Resolution of abscess, low outputs, serous drainage.
Jackson Pratt (JP) Drain Removal	Low outputs, serous drainage.
Cutaneous Suture/Staple Insertion with Local Anesthesia	Wound healing via primary intention.
Staple/Suture Removal	Post-operative day 7-14, evidence of wound infection.
Abscess Incision & Drainage	Subcutaneous abscess amenable to drainage.
Wound Care: Open, clean, debride and apply dressing to the wound	Signs of wound infection.
Insertion and Removal of Foley Catheter	Insertion: pre/peri-operative, urinary retention. Removal: No further clinical indication.
Nasogastric Tube (NGT) Insertion and Removal	Insertion: Persistent nausea/vomiting, abdominal pain/distension, and obstipation for conservative management of small bowel obstruction. Removal: Low outputs, evidence of normal bowel function, resolution of small bowel obstruction. Contraindication(s): Severe facial trauma, significant epistaxis/nasal deformity, patient refusal, recent gastric or esophageal surgery.

1f. REFERRALS

The PA may request physician consultation independently as clinically indicated, after consultation with the supervising physician. The PA will clarify the appropriateness and urgency of the consultation. Indications for referrals to allied health professionals are listed below:

Allied Health Professions	Indications
Dietician	Management of nutritional needs for malnourished patients, calorie counts, patients requiring TPN and/or tube feeds, etc. Patient education for low fibre diet, diabetic diet, new ostomy diet, etc.
Speech Language Pathology (SLP)	Difficulty swallowing, aspiration, prolonged intubation, history of stroke, etc.
Social Work (SW)	Psychosocial assessment/counselling, discharge/disposition planning, family meetings, etc.
Physiotherapy (PT)	Chest physiotherapy, mobilization, ambulation, discharge planning, etc.
Occupational Therapy (OT)	Post-operative ADLs/IADLS, geriatric cognition, home safety assessment, discharge planning, etc.
Community Care Access Centre (CCAC)	Home care: Jackson Pratt (JP) drain care, percutaneous drain care, IV antibiotics, best practice wound care, staple removal, PICC care, etc.
Wound Care & Enterostomal Therapy	Assessment and management of complex wounds, for initiation of VAC wound therapy, stoma care, etc.
Respiratory Therapy (RT)	Oxygen management, ABGs, bedside spirometry.

1g. DISCHARGES

After consultation with and approval from the attending physician, the PA may:

- Discharge a patient home according to multidisciplinary plan of care when the patient no longer has any acute issues that warrant continued hospitalization;
- Transfer a patient to other wards/services within the facility when patient can best be managed on a less acute service. (Example: Slow Stream Rehab, Palliative);
- Transfer a patient to other wards/services within the facility when the patient's acuity exceeds abilities of current environment. (Example: Critical Care);
- Arrange for CCAC homecare follow up upon discharge from hospital.
- Instruct the patient regarding the discharge plan, follow up appointments, prescription medications, wound care and further diagnostic investigations if indicated; and
- Dictate discharge summaries and complete appropriate paperwork, including CCAC forms, work/school notes, and outpatient diagnostic imaging or lab requisitions. Prescriptions for narcotics, as well as all discharge prescriptions require a signature of the attending physician.

Contraindications to implementation:

- Patient does not consent to plan of care; including diagnostic or therapeutic intervention(s), or to receiving treatment from a PA
- Patient exhibits contraindications for specific diagnostic or therapeutic intervention(s) or clinical indication is absent
- When the clinical situation exceeds PA knowledge, skill and ability

Resources available for potential complications (if applicable):

The PA implementing this medical directive will:

- Inform MRP of implementation of medical directive within 24 hours, via face-to-face or telephone discussion or multidisciplinary progress note
- Provide timely reporting of any developments and/or changes in the patient's status that would affect the established medical care plan to the MRP
- Contact the MRP via hospital paging system should the medical directives require clarification or in the event immediate support is required.
- Any unintended outcomes or issues arising from implementing this medical directive will be reported to the MRP as soon as possible for appropriate disposition.

Documentation:

The PA implementing this medical directive will document the following in the patient's health record:

- Patient assessment and necessary clinical information in history & physical, consultation, and/or progress notes section(s)
- Indications for performing investigations and procedures in progress notes and MD order section
- Results of investigations, response to procedure(s) and treatment(s) in progress notes
- Orders given in the MD order section with name/signature/designation, name of medical directive, and signed "as per the supervising physician"

Example: ***IV NS at 100 mL/hr*** ***Name, Signature, Designation***
PA Medical Directive
As per Dr. _____

Education Plan:

The PA has successfully completed a Canadian Medical Association (CMA) accredited Physician Assistant Program, graduating with a Bachelor of Science Physician Assistant Degree. The PA is certified as a Canadian Certified Physician Assistant (CCPA) under the Physician Assistant Certification Council of Canada (PACCC), having successfully completed the Physician Assistant Certification Exam.

Continuing professional development (CPD) is required through the PACCC to maintain the designation of CCPA. The requirements are:

- Minimum of 25 Mainpro credits per year of any combination of Mainpro-M1, Mainpro-M2, or Mainpro-C credits, totaling 250 credits per 5-year cycle.

The PA is responsible for developing learning goals and seeking out opportunities for continuing professional development.

Tracking, Monitoring, and Evaluation Plan:

The PA in Acute Care General Surgery will monitor and track individual practices and seek feedback from physician colleagues to further improve clinical skills and knowledge.

Communication Plan:

Prior to implementation of the medical directive, the PA in Acute Care General Surgery will meet with key administrative individuals, nursing and physician groups, allied health professional groups, hospital committees, and all services impacted by the medical directive. Processes and implications of the medical directive will be discussed and reviewed with professional practice manager and all clinical educators.

Education Plan: **Completed**
Tracking, Monitoring, and Evaluation Plan: **Completed**
Communication Plan: **Completed**

References:

College of Physicians and Surgeons of Ontario (2012). Policy Statement – Delegation of Controlled Acts. Toronto, Ontario.
Sunnybrook Odette Cancer Center. Medical Directive: Physician Assistants (PA) in Oncology (2015).Toronto, Ontario.

Appendix A: Medical Directive Administrative Review/Approval Form

☐ Forward to Chief of Diagnostic Imaging/CT Task Force (for review/recommendations) **Date: March 25, 2015** **Signature:**
☐ Forward to Chief of Emergency (for review/recommendations) **Date: January 22, 2015** **Signature:**
☐ Forward to Chief of Cardiology (for review/recommendations) **Date: January 23, 2015** **Signature:**
☐ Forward to Chief of Pediatrics (for review/recommendations) **Date: January 22, 2015** **Signature:**
☐ Forward to Chief of Laboratory (for review/recommendations) **Date: March 30, 2015** **Signature:**
☐ Approved by Surgery Program and Steering Committee (for review/recommendations) **Date: April 23, 2015**
☐ Approved by Pharmacy & Therapeutics Committee (for review/recommendations) **Date: April 27, 2015**
☐ Approved by Professional Practice Committee (PPC) (for review/recommendations) **Date: April 27, 2015**
☐ Approved by the Medical Advisory Committee (MAC) **Date: June 2015**

Appendix B: Physician Assistant Procedure List – General Surgery

Physician Assistant Procedure List - General Surgery			
Name of Physician Assistant: Review Date:			Able to perform capably, safely, and independently
Procedure	Physician Sign Off	Date of Approval	
Removal of Peripherally Inserted Central Catheter			
Removal of Central Line			
Removal of Percutaneous Drain			
Removal of Jackson-Pratt Drain			
Injection of Local Anesthesia			
Cutaneous Suture/Staple Placement			
Cutaneous Suture/Staple Removal			
Incision and Drainage of Abscess			
Wound Care: Opening, Irrigating, Debridement, and Application of Dressing			
Insertion of Foley Catheter			
Insertion and Removal of Nasogastric Tube			
New Competencies:			