ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG June 27, 2023
June 2023 MEC Meetings

Clinical Service Rules and Regulations

None

Credentials Committee –

- Standardized Procedures – (Summary of Changes for each SP Attached; Copies of SPs sent to Commissioners)
  -Discharge Ambulatory Surgery RN SP
  -Management of Benign and Malignant Breast Conditions SP
  -Neurosurgery SP

- Privileges List - None

Discharge Ambulatory Surgery RN SP

Summary of changes:

- 3.B.3: Added additional physician consultation parameters: "Any new concerns about the patient's clinical condition, including shortness of breath, SpO2 sat <92%, and acute changes in oxygenation requirements" and "New or worsening change in mental condition"
- 5A.3: Removed BLS reference as this is a condition of employment
- 5.B.1: Changed her/his to their
- Protocol 1.C: Added additional physician consultation parameters:
    - Any new concern about a patient's clinical condition
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Shortness of breath
    - Pulse oximetry <92% despite titration of oxygen therapy

Zuckerberg San Francisco General Hospital and Trauma Center

COMMITTEE ON INTERDISCIPLINARY PRACTICE

2023

STANDARDIZED PROCEDURE- REGISTERED NURSE

TITLE: Discharge Ambulatory Surgery Registered Nurse

~~Zuckerberg San Francisco General Hospital and Trauma Center~~
~~Committee on Interdisciplinary Practice~~

~~2022~~

~~STANDARDIZED PROCEDURE~~

~~Title: Discharge of Adult and Pediatric Ambulatory Surgery Patients~~

1. Policy Statement
   A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, Registered Nurses, Physicians, Pharmacists, Psychologists, Administrators and other affiliated staff and must conform to the Nurse Practice Act, Business and Professions Code Section 2725.
   B. A copy of the signed procedures will be kept in an operational manual in the Post Anesthesia Care Unit (PACU) and on file in the Medical Staff Office.

2. Functions to be performed
   When an RN provides health care that involves areas of overlapping practice between nursing and medicine, a standardized procedure is required. This standardized procedure includes guidelines stating specific conditions requiring the RN to seek physician consultation.

3. Circumstances under which RN may perform function
   A. Setting
      The Registered Nurse may perform the following standardized procedure function in the Post Anesthesia Care Unit (PACU) and Pre-Op consistent with their experience and training.

   B. Scope of supervision required
      1. The RN is responsible and accountable to the PACU and Surgicenter Nurse Manager and Perioperative Medical Director or physician designee.

2. Overlapping functions are to be performed in areas that allow for a consulting physician to be always available to the RN by phone or in person, including, but not limited to, the clinical area.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
   a. When the ambulatory surgery patient fails to meet discharge criteria.
   b. Any new concerns about the patient's clinical condition, including shortness of breath, SpO2 sat <92%, and acute changes in oxygenation requirements.
   ~~a.~~c. New or worsening change in mental condition.
   d. Experiences emergency conditions such as unstable vital signs that require prompt medical intervention.
   ~~b.~~

4. List of Protocols:
   Protocol #1 Discharge of Adult and Pediatric Ambulatory Surgery Patients

5. Requirements for the Registered Nurse
   A. Experience and education
      1. Active California Registered Nurse license
      2. Graduate of an approved RN program
      ~~3. Active BLS~~

   B. Special Training
      1. The RN has successfully completed ~~her/his~~ their orientation to the PACU and/or Surgicenter with a completed orientation checklist on file.
      2. The RN has learned the criteria contained in the Standardized Protocol defined in Protocol #1 Discharge of Adult and Pediatric Ambulatory Surgery Patients.

   C. Evaluation of the RN's competence in performance of the standardized procedure.
      1. Initial:
         After completion of the standardized procedure training, the PACU/Pre-Op Nurse Manager or designee will assess the RN's ability to perform the procedure:
            a. Clinical Practice
               - Successful completion of the PACU/Pre-Op RN orientation program.
               - Successful completion of the PACU/Pre-Op Standardized Procedure training. The RN is assessed, and documentation reviewed on three (3) discharge patients in accordance with the standardized procedure.

2. Annual:
   The PACU/Pre-Op Nurse Manager or designee will evaluate the RN's competence via the annual performance appraisal and skills competency review along with feedback from colleagues and/or physicians. Direct observation and/or chart review may be used.
3. Follow-up:
   RNs with elements requiring increased proficiency, as determined by the initial or annual review will be re-evaluated by the PACU/Pre-Op Nurse Manager or designee at appropriate intervals until acceptable skill level is achieved. Feedback from colleagues, physicians, direct observation and/or chart review may be used to determine competency.

6. Development and approval of standardized procedure
   A. Method of development
      Standardized procedures are developed collaboratively by the registered nurses, nurse managers, physicians, and administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.
   B. Approval
      All standardized procedures must be approved by the CIDP, Credentials Committee, Medical Executive Committee and Joint Conference Committee prior to use.
   C. Review schedule
      The standardized procedure will be reviewed every three years (and as practice changes) by the PACU/Pre-Op Nurse Manager, Perioperative Medical Director and staff.
   D. Revisions
      All changes to the standardized procedures are to be approved by the CIDP, Credentials Committee, Medical Executive Committee and Joint Conference Committee.

Protocol #1
Title: Discharge of Adult and Pediatric Ambulatory Surgery Patients

A. Definition
   1. Patients may be discharged from the Pre-Op or PACU when the physician performing the procedure writes a discharge order indicating the patient may be discharged by the Registered Nurse when all discharge criteria have been met.
   2. Additionally, patients cared for by an anesthesiologist must have a postoperative note written by an anesthesiologist prior to discharge.

B. Database
   1. Subjective Data
      a. Patient is awake, alert and oriented and has returned to their baseline pre-operative level of consciousness
   2. Objective Data
      Meets Discharge Criteria when:
      a. Minimum time passed from the end of the procedure by sedation/anesthesia type received

Minimum Time period has passed since the end of procedure	**Type of Sedation/Anesthesia the patient received**
30 minutes	Moderate Sedation or Monitored Anesthesia Care (MAC)
60 minutes	General, spinal, regional or epidural anesthesia

      b. Two hours is the minimum time elapsed for monitoring any patient receiving a reversal agent (Naloxone or Flumazenil) to detect potential re-sedation (Hosp Policy 19.08 – Moderate and Deep Sedation).
      c. The patient has, at most, mild nausea and/or dizziness.
      d. The patient is alert and oriented to person, place and time and can verbalize appropriately or has returned to their preoperative level of consciousness.
      e. Vital signs are within 20% of preoperative levels
      f. Supplemental oxygen has been discontinued for a minimum of 30 minutes prior to discharge.
      g. Mobility: Able to ambulate with minimal assistance or returned to preoperative mobility status.

h. Pain is no greater than mild to moderate (*NRS* </= 5) with or without PO medication or 30 minutes after IV/IM narcotics.
i. Wound site is dry or appropriate for type of surgery.
j. Neurovascular status of operative extremity is appropriate for postoperative state (if applicable).
k. Urologic, gynecologic, hernia procedures and/or spinal and epidural anesthesia- Patients must void, unless a physician orders differently.
l. Blocks:
    1. Upper extremity blocks - patients may be discharged with partial motor and sensory return. They must understand how to protect their extremity and have a sling in place.
    2. Lower extremity blocks - Patients will be given crutches or assistive devices to ambulate safely. Crutch teaching is done by the RN and a return demonstration by the patient should be performed with the assistance of two staff members for safety needs.
    3. All block patients will receive written block instructions in their discharge teaching.
m. Escort: Patients should have a responsible adult escort to accompany them from the hospital or they may be discharged using an approved transport service.
n. Housing - In cases where the patient is unhoused, they should have shelter and transportation arranged via Social Services.

C. Diagnosis
Physician consultation is required for the following:
1. Failure to meet discharge criteria
2. Vital signs unstable (not within 20% of preoperative level)
3. Any new concern about a patient's clinical condition
4. New or worsening change in mental status
5. Acute change in oxygenation requirements
6. Shortness of breath
~~2.~~7. Pulse oximetry <92% despite titration of oxygen therapy
~~3.~~8. In situations where a responsible adult escort is not present and/or the patient refuses to wait for transportation/escort, the service physician may evaluate the patient in consultation with the Anesthesia attending and, if appropriate, write an order for the patient to be discharged independently.

D. Plan
Education of patient and family or guardian and postoperative follow-up

1. If discharge medications have been ordered, the patient has been educated regarding these medications or prescriptions given.
2. Printed postoperative discharge instructions along with medication reconciliation and instructions on nerve blocks have been reviewed with the patient and escort, using an interpreter as appropriate.
3. The patient has received a postoperative follow-up appointment with the appropriate Provider and clinic when applicable.

E. Record Keeping
Nursing documentation in the clinical record is complete, reflecting that all discharge criteria are met and that teaching/instructions has been provided.

STANDARDIZED PROCEDURES

Discharge of Adult and Pediatric Ambulatory Surgery Patients
Based upon Discharge Criteria

The following registered nurses are authorized to discharge adult and pediatric ambulatory surgery patients under this standardized procedure:

Approved by:

Gerard F. Padilla, RN MS Date
Nurse Manager, PACU/SC

Patty Coggan, RN MSN Date
Nursing Director, Perioperative Services

Romain Pirracchio, MD Date
Chief of Anesthesia

Nandini Palaniappa, MD Date
Medical Director, Perioperative Services

Management of Benign and Malignant Breast Conditions SP

Summary of Changes

- III.B.1: Updated clinic name
- V.A.4: Deleted BLS
- VI.A.2: Deleted OPPE requirement
- VI.3: Deleted language regarding PA supervision
- Protocols 1 and 2 re: Record Keeping: Removed "The medical record of any patient cared for by a PA for whom the supervising physician and surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days. (This language is no longer necessary – reflects change secondary to SB697.)

Community Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Management of Benign and Malignant Breast Conditions

I. Policy Statement

A. It is the policy of the Community Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the ZSFG 5M Obstetric, Midwifery & Gynecology Clinic (5M OMG), 3M Breast Surgery & Oncology Clinic and on file in the Medical Staff Office.

C. The Breast and Cervical Cancer Initiative is a Public Health initiative implemented in 1997. One goal of the initiative is to assure access to breast and cervical cancer diagnosis and treatment for low income women in San Francisco with particular attention to the elderly, the homeless, and other underserved populations in San Francisco. This Standardized Procedure covers clinical care provided by a Nurse Practitioner and/or Physician Assistant in 5M Breast Clinic and 3M Breast Surgery & Oncology Clinic, and addresses breast care due to the complexities associated with breast care/cancer care. Pap smear screening is a fundamental function of primary care and covered by NP/PA practice and is not addressed in this SP. The goal of the Initiative is to increase access to underserved women for both breast and cervical cancer screening/care.

II. Functions To Be Performed

Each practice area will vary in the functions that will be performed, such as primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination ever ten years (6 year recertification cycle prior to 2014, 10 year recertification cycle starting in 2014 and thereafter). Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (documents supervising agreement between supervising physician and PA).

The NP/PA conduct physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care, assists in surgery, performs invasive procedures and furnishes medications/issues drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is at ZSFG 5M Obstetric, Midwifery Gynecology Clinic and 3M Breast Surgery & Oncology Clinic.

B. Supervision
   1. Overall Accountability:
      The NP/PA is responsible and accountable to the Medical Director of 3M Breast Surgery & Oncology Clinic.
   2. A consulting physician, which will be one of the Breast Clinic Attending's in 3M will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
      a. Acute decompensation of patient situation
      b. Problem that is not resolved after reasonable trial of therapies.
      c. Unexplained historical, physical, or laboratory findings for example, including but not limited to: breast mass rapidly increasing in size, lack of response of abscess to usual antibiotic treatment, complex presentation of bloody nipple discharge, unusual family/genetic history.
      d. Upon request of patient, affiliated staff, or physician.
      e. Problem requiring hospital admission or potential hospital admission.

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IV. Protocols
   1. Management of Benign and Malignant Breast Conditions
   2. Furnishing Medications/Drug Orders
   3. Procedure: eConsult Review

V. Requirements for the Nurse Practitioner /Physician Assistant

A. Basic Training and Education
   1. Active California Registered Nurse/ Certified Nurse-Midwife/Physician Assistant license.
   2. Successful completion of a program, which conforms to the Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.
   3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
   4. Possession of a National Provider Identifier or must have

submitted an application.

5. Copies of licensure and certificates must be on file in the Medical Staff Office.
6. Furnishing Number.
7. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Practice Agreement
8. Board Certification will be grandfathered for all staff hired prior to January 2003.

B. Specialty Training

1. Specialty requirements: Physician Assistant, ANP, FNP, Women's Health Practitioner, Geriatric Nurse Practitioner or PNP.
2. Six months of experience in providing health care to women which includes but is not limited to clinical breast examination.
3. Knowledge and use of guidelines set forth by nationally recognized organizations such as the National Comprehensive Cancer Network (NCCN) and the American College of Obstetricians and Gynecologists (ACOG).

VI. Evaluation

A. Evaluation of NP/PA Competence in performance of standardized procedures.

1. Initial: at the conclusion of the standardized procedure training, the Medical Director or designated physician/peer will assess the NP/PA's ability to practice.
   a. Clinical Practice
      - Length of proctoring period will be three months.
      - The evaluator will be the 3M Medical Director or other designated physician/peer.
      - The method of evaluation in clinical practice will be 5 chart reviews for each protocol and clinical consultation and direct observation during the proctoring period.

2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician/peer, at appropriate intervals.

3. Biennial Reappointment: Medical Director, and/or designated physician/peer must evaluate the NP/PA's clinical competence with 5 chart reviews and for each protocol as listed in the procedure protocols.

VII. Development and Approval of Standardized Procedure

A. Method of Development
   1. Standardized procedures are developed collaboratively by the Nurse Practitioners, Physician Assistants, Nurse Midwives, Pharmacists, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval
   1. The CIDP, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to their implementation.

C. Review Schedule
   1. The standardized procedure will be reviewed every three years by the NP/PA and the Medical Director and as practice changes.

D. Revisions
   1. All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.

Protocol #1: Management of Benign and Malignant Breast Conditions

A. DEFINITION

This protocol covers the procedures related to the management of benign and malignant breast conditions. Scope of care includes management of symptoms related to breast changes and referral for appropriate diagnostic testing and treatment as indicated from ZSFG 5M Breast Clinic, ZSFG 3M Breast-Oncology Clinic and the ZSFG AVON Breast Center.

B. DATA BASE

1. Subjective Data
   a. Ongoing/Continuity: review of symptoms and history relevant to the disease process or presenting complaint.
   b. Pain history to include onset, location, and intensity.
   c. Risk assessment- family history of cancer.

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Laboratory and breast diagnostic imagining procedures including, but not limited to mammography, breast ultrasound, MRI, fine needle aspiration, ultrasound core biopsy, stereotactic biopsy, MRI guided biopsy and CT bone scans, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the ZSFGMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g. stable, unstable, and uncontrolled).

D. PLAN

1. Treatment
   a. Initiation or adjustment of medication
   b. Referral to specialty clinics and supportive services, as needed.
   c. Referral to cancer risk counseling and testing.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies

c. Unexplained historical, physical or laboratory findings for example, including but not limited to: breast mass rapidly increasing in size, lack of response of abscess to usual antibiotic treatment, complex presentation of bloody nipple discharge, unusual family/genetic history.
d. Upon request of patient, NP, PA, or physician
e. Problem requiring hospital admission or potential hospital admission.

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. self-breast exam, diet, exercise).
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.

4. Follow-up
   Track patients who are high risk who are breast cancer gene mutation positive, have a strong family history of breast or ovarian cancer, have family history of any cancer.

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). ~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.~~

Protocol #2*:* Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license. All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. A copy of the Certificate must be attached to the Physician Assistants Practice Agreement document. Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, scope of practice of the NP/PA, as well as Service Chief or Medical Director, have determined the following formulary/ies will be used: ~~:~~San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program). This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

1. Subjective Data
    a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
    b. Pain history to include onset, location, and intensity.

2. Objective Data
    a. Physical exam consistent with history and clinical assessment of the patient.
    b. Describe physical findings that support use for CSII-III medications.
    c. Laboratory and imaging evaluation, as indicated, relevant

to history and exam.

d. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.

D. PLAN

1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the EMR or in the Medication Administration Record (MAR). The protocol will include the following:
      1. location of practice
      2. diagnoses, illnesses, or conditions for which medication is ordered
      3. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      1. name of medication
      2. strength
      3. directions for use
      4. name of patient
      5. name of prescriber and title
      6. date of issue
      7. quantity to be dispensed
      8. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings.

d. Upon request of patient, NP, PA, or physician
e. Failure to improve pain and symptom management.
f. Problem requiring hospital admission or potential hospital admission.

3. Education
   a. Instruction on directions regarding the taking of the medications in patient's own language.
   b. Education on why medication was chosen, expected outcomes, side effects, and precautions.

4. Follow-up
   a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the electronic medical record (EMR) as appropriate ~~he medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days~~

Protocol #3: Procedure: eConsult Review- Nurse Practitioner/PA review eConsults to the 5M Breast Clinic.

A. DEFINITION

eConsult review is defined as the review of new outpatient consultation requests via the online eConsult system. A new outpatient is defined as a patient that has neither been consulted upon by the specialty service, admitted to the specialty service nor seen in the specialty clinic within the previous two years.

1. Prerequisites:
    a. Providers reviewing eConsults will have six months experience with patients in the specific specialty area provided at Zuckerberg San Francisco General Hospital and Trauma Center or elsewhere before being allowed to do eConsults independently.
    b. Providers reviewing eConsults will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
    c. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
    d. Providers reviewing eConsults will have expertise in the specialty practice for which they are reviewing.
2. Educational Component: Providers will demonstrate competence in understanding fundamentals of breast care in order to facilitate screening, triaging and prioritizing of patients in the eConsult system.
3. Proctoring: A review of at least 20 of the eConsult consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.
4. Ongoing reappointment: Review of 5 consultations every 2 years.

B. DATA BASE

1. Subjective Data
    a. History: age appropriate history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems relevant to the presenting disease process as provided by the referring provider on the electronic referral. eConsult review will be confined to data found in the submitted eConsult form. Data contained in the paper or electronic medical record, but not in the eConsult, is specifically excluded from the eConsult review. The

reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

b. Pain history to include onset, location, intensity, aggravating and alleviating factors, current and previous treatments.

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient as provided by the referring provider.
   b. Laboratory and imaging evaluation as obtained by the referring provider relevant to history, physical exam, and current disease process will be reviewed. Further evaluation will be requested from the referring provider if indicated.

C. DIAGNOSIS

A diagnosis will not be determined at the time of eConsult review. Differential diagnosis will be provided at the time the patient is seen in clinic by the consulting provider. Assessment of the subjective and objective data as performed by the consulting provider in conjunction with identified risk factors will be evaluated in obtaining a diagnosis.

D. PLAN

1. Review of eConsult

   a. Algorithms or referral guidelines developed and approved by the Medical Director in conjunction with the NP/PA will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.
   b. All data provided via the eConsult consultation request will be reviewed and assessed for thoroughness of history, adequacy of work up, and urgency of condition.
   c. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient conditions requiring Attending Review

   a. Acute decompensation in patient condition
   b. Unexplained historical, physical or laboratory findings
   c. Upon request of the referring NP, PA, or physician
   d. Problem requiring hospital admission or potential hospital admission

e. When recommending complex imaging studies or procedures for the referring provider to order
f. Problem requiring emergent/urgent surgical intervention
g. As indicated per the algorithms or referral guidelines.

3. Education
   a. Provider education appropriate to the referring problem including disease process, additional diagnostic evaluation and data gathering, interim treatment modalities and lifestyle counseling (e.g. diet, exercise).

4. Scheduling of Appointments
   a. Dependant upon the urgency of the referral, the eConsult will be forwarded to the scheduler for either next available clinic appointment scheduling or overbook appointment scheduling.

5. Patient Notification
   a. Notification of the patient will be done by the referring provider if the appointment is scheduled as next available. If the appointment is scheduled as an over book within two weeks of the eConsult, the consulting scheduler is responsible for notifying the patient.

E. RECORD KEEPING

All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the EMR upon scheduling or after a period of six months.

During the proctoring period, the eConsult consultation request will be printed and the provider recommendations will be written on the print out. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into the EMR and forwarded to the scheduler.

Neurosurgery SP

Summary of Changes

- IV. Protocol #7: added "external ventricular drain (EVD)"
- V. 7: Replaced "delegation of service agreement (DSA)" with "practice agreement"
- VI. a.i-iii: Reformatted numbering
- VI. 3: Deleted OPPE
- VI. 3: Updated PA supervision to reflect SB697

- All Protocols re: Record Keeping: Removed "The medical record of any patient cared for by a PA for whom the supervising physician and surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days. (This language is no longer necessary – reflects change secondary to SB697.)
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- Protocol 2.B.2: Added "Controlled substance schedule"
- Footer: Updated date and page numbers

Community Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Neurosurgery

I. Policy Statement

A. It is the policy of the Community Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse –Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Trauma Program Office (3B7) and on file in the Medical Staff Office.

II. Functions to be performed

Each practice area will vary in the functions that will be performed, such as a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every ten years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (documents supervising agreement between supervising physician and PA).

The NP/PA conducts physical exams, diagnoses and treats illness, orders and interpret tests, counsels on preventative health care, assists in surgery, performs invasive procedures, and furnishes medications/issue drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Functions

A. Setting
   1. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center. Inpatient settings include ICU, inpatient units. Outpatient settings include Emergency Department, Neurosurgical Clinic, Traumatic Brain Injury Clinic, and Concussion Clinic.
   2. Role in each setting may include admissions, transfers, discharges, as well as neurosurgical patient evaluation, management and care in the emergency department, all inpatient units, and outpatient clinics.

B. Supervision
   1. Overall Accountability
      The NP/PA is responsible and accountable to: Chief of Neurosurgery.
   2. A consulting physician, who may include attendings, chief residents and fellows, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:

a. Acute decompensation of patient situation
b. Problem that is not resolved after reasonable trial of therapies.
c. Unexplained historical, physical, or laboratory findings.
d. Upon request of patient, affiliated staff, or physician.
e. Initiation or change of medication other than those in the formulary(ies).
f. Problem requiring hospital admission or potential hospital admission.
g. Ordering special studies and radiology procedures if required by service: CT Scans, CT Myelogram, MRI, Angiograms, Floroscopic placement of Drains and/or surgical markers.

IV. Scope of Practice

Protocol #1	Health Care Management – Acute/Urgent Care
Protocol #2	Furnishing Medications/Drug Orders
Protocol #3	Discharge of Inpatients
Protocol #4	Procedure: Clinical Clearance of Cervical Spine Precautions
Protocol #5	Procedure: Surface Trauma and Wound Care
Protocol #6	Procedure: Removal of an Intracranial Pressure Device
Protocol #7	Removal of CSF from External Ventricular Drain (EVD) /Administration of Intracranial Medications
Protocol #8	Ordering Transfusion
Protocol #9	eConsult

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
1. Active California Registered Nurse/ Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
5. Copies of licensure and certificates must be on file in the Medical Staff Office.

6. Furnishing Number.
7. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center ~~Delegation of Service Agreement (DSA~~Practice Agreement~~.~~ (PA). Copies of PA must be kept at each practice site for each PA.

B. Specialty Training
1. Specialty requirements
   a. Successful completion of Trauma Nurse Core Course (TNCC) within 1 year of hire.
   b. Audit of Advanced Trauma Life Support Course (ATLS) within 1 year of hire, or when next ZSFG ATLS course is available.
   c. NP specialty certification as a ANP, FNP, ACNP or AG ACNP
   d. National Certification as a Physician Assistant
2. Amount of previous experience in specialty area expected for this position.
   a. Two years experience as a Registered Nurse or Nurse Practitioner in an emergency department or intensive care unit in an acute care hospital within six months of hire
   b. Two years experience as a PA in an emergency department or intensive care unit in an acute care hospital within six months of hire.

VI. Evaluation

A. Evaluation of NP/PA Competence in performance of standardized procedures. For minor procedures, please refer to the Minor Procedure Protocol.
1. Initial: At the conclusion of the standardized procedure training, the Medical Director, supervising physician, and other supervisors as applicable will assess the NP/PA's ability to practice.
   a. Clinical Practice
      i. Length of proctoring period will be three months. The term may be shortened or lengthened (not to exceed six months CCSF probationary period) at the discretion of the supervising physician. Included in this proctoring period will be 40 chart reviews (20 inpatients, 20 outpatients), and direct observations of cases. At the end of the proctoring term, the NP/PA will be generally supervised by Chief of Service, c~~C~~urrent service attending, Neurosurgery f~~F~~ellow and s~~S~~enior residents~~Chief~~

~~of ____, _____ Service Attending, ___ Fellow and Senior[DJ(1] ____ Residents~~.

ii. The evaluator will be the Chief of Neurosurgery or Clinical Supervising Physician designee.
iii. The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
   a) All cases are presented to the evaluator
   b) Evaluator reviews and co-signs orders and progress notes
   c) Co-signatures by a licensed physician must be concurrent to patient care
   d) Medical record review is conducted for in-patient medication ordering and out-patient discharge medication
   e) Medical Record review may be conducted retrospectively by the Clinical Supervising Physician
   f) Forty cases (20 inpatients, 20 outpatients) must be evaluated to complete proctoring
   g) Procedural skills are incorporated into the competency assessment orientation

2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director and supervisor at appropriate intervals until acceptable skill level is achieved.

~~Ongoing Professional Performance Evaluation (OPPE)~~
~~Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.~~

3. Biennial Reappointment
   Medical Director, and/or designated physician must evaluate the NP/PA's clinical competence. The number of procedures and chart reviews will be done as noted in the specific procedure protocols.

~~Physician Assistants:~~
   ~~a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are 1) Examination of the patient by Supervising Physician the same day as care is given by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within~~

~~thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (c) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

VII. Development and Approval of Standardized Procedure

A. Method of Development
   1. Standardized procedures are developed collaboratively by the Nurse Practitioners/Physician Assistants, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval
   1. The CIDP, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to its implementation.

C. Review Schedule
   1. The standardized procedures will be reviewed every three years by the NP/PA and the Medical Director and as practice changes.

D. Revisions
   1. All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.

Protocol #1 Health Care Management – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions. Settings to include; Emergency Department, Inpatient Units, and Outpatient Clinics.

B. DATA BASE

1. Subjective Data
   a. Screening history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history allergies, current medications, treatments and review of symptoms.
   b. Ongoing/Continuity: review of symptoms and history relevant to the presenting complaint and/or disease process.
   c. Pain history to include onset, location and intensity.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes, may include statement of current status of disease (e.g. stable, unstable or uncontrolled).

D. PLAN

1. Therapeutic Treatment Plan
   a. Diagnostic tests for purposes of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   c. Referral to physician, specialty clinics, and supportive services, as needed.
   d. NP/PAs may also cosign Doctor's First Report of Occupational Injury or Illness (DFR) for a workers' compensation claim to receive time off from work for a period not to exceed three (3) calendar days. The "treating physician" must still sign the DFR and must be the one to make any determination of temporary disability.
   e. The pronouncement of cardiac death on admitted inpatients.

2. Patient Conditions Requiring Attending Consultation:
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical, or laboratory findings
   d. Upon request of patient, nurse practitioner, physician assistant, or physician
   e. Initiation or change of medication other than those listed in or approved by the formulary(ies)
   f. Problem requiring hospital admission or potential hospital admission
   g. Uncommon, unfamiliar, unstable, and complex patient conditions
   h. Notification of the date and time of cardiac death
   i. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling.
   b. Anticipatory guidance and safety education that is risk factor important.

4. Follow-up
   As indicated and appropriate to patient health status, and diagnosis.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record. ~~For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

Protocol #2: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the

patient in accordance with a standardized procedure. A “drug order” is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of a DEA number. All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistants Practice Agreement. Nurse practitioners may order Schedule II - V controlled substances when in possession of a DEA number. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies that will be used are: Zuckerberg San Francisco General Hospital and Trauma Center, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows ZSFG Administration policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (policy no. 13.5).

B. DATA BASE

1. Subjective Data
   a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medications, allergies, current treatments, and substance abuse history.
   b. Pain history to include onset, location, and intensity.

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Describe physical findings that support use for Controlled Substance Schedule/CSII-III medications.
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.

D. PLAN

1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
   c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the electronic record, or in the Medication Administration Record (MAR). The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, number of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      i. name of medication
      ii. strength
      iii. directions for use
      iv. name of patient
      v. name of prescriber and title
      vi. date of issue
      vii. quantity to be dispensed
      viii. license no., furnishing no., and DEA no. if applicable

2. Patient Conditions Requiring Consultation
   a. Problem which is not resolved after reasonable trial of therapies.
   b. Initiation or change of medication other than those in the formulary.
   c. Upon request of patient, NP, PA, or physician.
   d. Failure to improve pain and symptom management.

3. Education

a. Instruction on directions regarding the taking of the medications in patient's own language.
b. Education on why medication was chosen, expected outcomes, side effects, and precautions.

4. Follow-up
   a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. RECORD KEEPING
All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record as appropriate. ~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.~~

Protocol #3: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from Zuckerberg San Francisco General Hospital and Trauma Center. All patients discharged will have approval of an attending physician.

B. DATA BASE
1. Subjective Data
   a. Review: heath history and current health status

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Review medical record: in-hospital progress notes, consultations to assure follow-through.
   c. Review recent laboratory and imaging studies and other diagnostic tests noting any abnormalities requiring follow-up.
   d. Review current medication regimen, as noted in the MAR (Medication Administration Record).

C. DIAGNOSIS
Review subjective and objective data and medical diagnoses, ensure appropriate treatments have been completed, and identify clinical problems that still require follow-up. Appropriate follow-up appointments and studies have been arranged.

D. PLAN

1. Treatment
   a. Review treatment plan with patient and/or family.
   b. Initiation or adjustment of medications per Furnishing/Drug Orders protocol.
   c. Assure that appropriate follow-up arrangements (appointments/studies) have been made.
   d. Referral to specialty clinics and supportive services, as needed.

2. Patient Conditions Requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA or physician.
   c. Referral to Specialty Services not provided by DPH.

3. Education
   a. Review inpatient course and what will need follow-up.
   b. Provide instructions on:
      -follow-up clinic appointments
      -outpatient laboratory/diagnostic tests
      -discharge medications
      -signs and symptoms of possible complications

4. Follow-up
   a. Follow-up appointments
   b. Copies of relevant paperwork will be provided to patient.

E. RECORD KEEPING

All information from patient hospital stay will be recorded in the medical record (discharge summary, discharge order sheet, and progress notes).

~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.~~

Protocol #4: Procedure: Clinical Clearance of Cervical Spine Precautions

A. DEFINITIONS:

Cervical Spine Injury refers to a bony injury of the first through seventh cervical vertebrae. Cervical spine injury usually identified by plain film x-rays or cervical spine CT scan. For the purposes of this protocol, the patient with significant neck pain, sensory and/or motor deficits will be considered to have a spine/spinal cord injury until proven otherwise.

Cervical Spinal Cord Injury refers to an injury to the spinal cord from the first through the eighth spinal root or to the cord itself, as in cord compression. Injuries to the cervical spinal cord are usually identified by physical examination during the trauma resuscitation and may be confirmed through MRI. Such findings would include sensory and/or motor changes in the dermatomes consistent with the level of injury.

Appropriate Mentation refers to the patient's ability to clearly and competently participate in an examination of the cervical spine and spinal cord function. This implies a Glasgow Coma Scale Score of 15 and the absence of drug/alcohol intoxication. In addition, there should be no evidence of head injury which would render an examination invalid.

1. Location to be Performed: For purposes of this protocol, the procedure may be completed in the Emergency Department, Inpatient Units, and Outpatient Clinics at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of Procedure:
    a. Indications:
    Patients who have sustained blunt trauma mechanism consistent with potential axial spine injury. Patients who meet ALL of the following criteria may be candidates for clinical exam clearance of the cervical spine:
        i. Appropriate mentation, cooperative and communicative (no language barrier)
        ii. No clinical evidence of CNS or focal neurological injury
        iii. No subjective complaints of shoulder, neck, or interscapular pain
    b. Precautions
    Patients at risk should always remain in a rigid cervical collar.
    c. Contraindications
        i. Inappropriate mentation
        ii. Clinical evidence of CNS or focal neurological injury
        iii. Distracting Injury
        iv. Intoxication or under the influence of drugs
        v. Complaints of shoulder, neck or interscapular pain

B. DATA BASE

1. Subjective Data
    a. The patient may complain of pain in the neck, specifically with tenderness to palpation of the cervical spine. The patient may also present with clear motor/sensory deficits.

2. Objective Data
    a. Physical exam appropriate to the procedure to be performed.
    b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
    c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
    d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
    a. Patient consent obtained consistent with hospital policy, before procedure is performed.
    b. Time out performed per hospital policy.
    c. Diagnostic tests/imaging for purposes of disease identification.
    d. Referral to physician as needed.

2. Patient Conditions Requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Unexplained physical findings
    c. Uncommon, unfamiliar, unstable, and complex patient conditions
    d. Radiologic abnormalities
    e. Midline cervical tenderness on palpation
    f. Neurological deficit found on physical examination
    g. Upon request of patient, NP, PA, or physician

3. Education
    a. Discharge information and instructions.
    b. The patient should be educated regarding the need for rigid immobilization, imaging, and treatment.

4. Follow-up
    a. As appropriate for procedure performed.
    b. The patient with suspected cervical trauma will be referred to the Spine Service of the day.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. ~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days~~.

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Prerequisites: Direct instruction, onsite training of procedure by the Chief of Neurological Surgery or clinical Supervising Physician designee. Cervical spine clearance will be based upon the Guidelines set forth by the Eastern Association for the Surgery of Trauma.
Proctoring Period a. A minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation. 1. Three procedures needed every 2 years. 2. Three chart reviews needed every 2 years.

Protocol #5: Procedure: Surface Trauma and Wound Care

A. DEFINITION
This protocol covers the initial assessment and management of wounds.

1. Location to be performed: Emergency Department, Inpatient Units, and Outpatient Clinics at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of procedure/minor surgery:
    a. Indications
    Patients presenting for assessment and treatment of lacerations, abrasions and avulsions.
    b. Precautions (require physician consultation)
    Coagulopathy
    Potential for Foreign Bodies within Wound
    Malnutrition
    Diabetes
    Immunocomprimised State
    Peripheral Vascular Disease

3. Contraindications
    a. Vascular compromise or cases where direct pressure does not stop bleeding
    b. Wounds requiring large area of debridement or excision prior to closure
    c. Wounds with bone fragments involved
    d. Wounds with tendon, ligament, vessel or nerve involvement
    e. Head laceration where galea is disrupted
    f. Facial lacerations with cosmetic consideration (e.g. eyelids and vermillion borders)
    g. Lacerations penetrating into joints
    h. Patients requiring conscious sedation
    i. Children under the age of 10
    j. Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
    k. Wounds requiring repair of cartilage
    l. Through and through lip lacerations

B. DATA BASE
1. Subjective Data
    a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, and allergies.

2. Objective Data
    a. Physical exam appropriate to the procedure to be performed. Physical exam of the wound including a description of its location, extent, depth and appearance of discharge, erythema, swelling or ecchymosis
    b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
    c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
    d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of subjective and objective data to identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan
    a. Patient consent obtained consistent with hospital policy before procedure is performed.
    b. Time out performed per hospital policy.
    c. Diagnostic tests for purposes of disease identification.
    d. Laboratory tests performed for purposes of disease identification.
    e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    f. Referral to physician, clinic, and supportive services, as needed.

2. Patient Conditions Requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Unexplained historical, physical or laboratory findings
    c. Uncommon, unfamiliar, unstable, and complex patient conditions (Coagulopathy, Potential for Foreign Bodies within Wound, Malnutrition, Diabetes, Immunocompromised State, Peripheral Vascular Disease)
    d. Inability to approximate wound edges
    e. Persistent or uncontrolled bleeding
    f. Scalp wounds involving the galea
    g. Upon request of patient, NP, PA, or physician

h. Initiation or adjustment of medication other than those in the formularies.
i. Problem requiring hospital admission or potential hospital admission.

3. Education
Discharge information and instructions.

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. ~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days~~.

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Perquisites: Completion of wound management course approved by the Chief of Neurosurgery. Individual standardized protocol training and proctoring by the Chief of Neurosurgery or Clinical Supervising Physician designee until competency is met.
Proctoring a Minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation. 1. Three procedures needed every 2 years. 2. Three chart reviews needed every 2 years.

Protocol #6: Procedure: Removal of an Intracranial Pressure Device

A. DEFINITION

Intracranial pressure device discontinuation is defined as the removal of a Camino Bolt and/or EVD.

1. Location to be Performed

   For purposes of this procedure, the protocol will be completed in the ICU at Zuckerberg San Francisco General Hospital Medical Center.

2. Performance of Procedure/minor Surgery:
   a. Indications

      Removal will be determined by the Neurosurgical team and in accordance with the Attending Neurological Surgeon.
   b. Precautions

      Coagulopathy
   c. Contraindications

      Coagulopathy

      Elevated Intracranial Pressure

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, and allergies.

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
      i. Normal coagulation values
      ii. Normal intracranial pressures (≤ 15mmHg) for 24 hours
      iii. Afebrile (≤ 38.5) or with a documented source for febrile state
      iv. No evidence of medical treatment for elevated intracranial pressures for 48 hours
      v. No evidence of infection or discharge from the bolt insertion site
      vi. Evidence of inaccurate device readings as determined by the Neurological Surgery Attending Physician
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of subjective and objective data to identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained consistent with hospital policy before procedure is performed.
   b. Time out performed per hospital policy.
   c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient Conditions Requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Development of uncontrolled bleeding or cerebrospinal fluid leak.
   c. Change in neurological exam following device discontinuation.
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.

3. Education
   a. Instruct patient on procedure prior to performance (As patient may be unable to comprehend provide nursing instruction prior to performance)
   b. Discharge information and instructions.

4. Follow-up
   a. As appropriate for procedure performed.
   b. Check suture/exit site for drainage 1-2 hours post removal
   c. Obtain report from nursing staff regarding level of consciousness post removal

E. RECORD KEEPING
   a. Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. ~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.~~
   b. The ICP reading before device removal will be documented in the above note

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Prerequisites

Completion of standardized procedure training on site.
Proctoring Period a. Minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation. 1. Completion of three procedures every 2 years. 2. Three chart reviews needed every 2 years.

Protocol #7: Procedure: Removal of CSF from External Ventriculard Drain (EVD)/Administration of Intracranial Medications.

A. DEFINITION

CSF Sampling from an EVD (external ventricular drain) is defined as removal of CSF for the purpose of culture, gram stain, cell count, and/or chemistry from a catheter located within the intraventricular space. Administration of intracranial medications is defined as injection of a specific medication and dosage as determined by the Infectious Disease Service (for antibiotics) or Neurosurgical team (for Tissue Plasminogen Activator (tPA) and/or Normal Saline) into the intracranial space via an appropriate catheter.

1. Location to be Performed:
   For purposes of this procedure, the protocol will be completed in the inpatient units at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of Procedure:
   a. Indications
      Removal of CSF from an EVD will be determined by the Neurosurgical team and in accordance with the Attending Neurosurgeon. Administration of intrathecal antibiotics for the purpose of treatment of meningitis or ventriculitis will be determined in accordance with the Neurosurgical team/Attending and the Infectious Disease Service. Administration of intracranial tPA for the purpose of blood clot disruption will be determined in accordance with the Neurosurgical team/Attending. It may be indicated for a patient with a diagnosis of intracerebral hemorrhage, in whom a clot is causing hydrocephalus or increased intracranial pressure. NS may be administered with either of these, or by itself for the purpose of unclogging the catheter.
   b. Precautions
      Increased Intracranial Pressures
      Medication Allergies
      Immunocompromised State
      Coagulopathic state
   c. Contraindications
      Resistance met upon injection
      Absent waveform or Intracranial Pressure Measurement

B. DATA BASE
   1. Subjective Data
      a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, and allergies.

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
      i. Review of medication dosages
      ii. Laboratory review of microbiology results and white count if applicable, coagulation factors if applicable
      iii. Assessment for febrile (≤ 38.5) state
      iv. Evaluation of the EVD insertion site for evidence of infection
      v. Performance of a neurological examination
      vi. Patient evaluation for signs of meningitis; including but not limited to; severe frontal/occipital headache, neck stiffness, light sensitivity, fever, rash
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of subjective and objective data to identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained consistent with hospital policy before procedure is performed.
   b. Time out performed per hospital policy.
   c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient Conditions Requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA, or physician
   c. Initiation or adjustment of medication other than those in the formularies.
   d. Resistance met upon withdraw of CSF and/or administration of sterile preservative free normal saline or antibiotics
   e. Noted leakage of fluid from the EVD catheter/tubing

f. Presence of air noted within the EVD catheter/tubing
g. Evidence of infection at the EVD insertion site
h. Change in neurological status following CSF withdraw or antibiotic administration
i. Development of rash, hives, fever, tachycardia or change in respiratory status following antibiotic administration
j. Loss of waveform following drain manipulation

3. Education
Instruct patient to report symptoms of severe headache, fever, chills, numbness, tingling or weakness of extremities, impaired balance, incoordination, development of rash, hives, or shortness of breath

4. Follow-up
a. Assess EVD for evidence of effective functioning; presence of ICP waveform, active CSF drainage
b. Assess EVD and tubing for signs of loss of integrity including; leakage, breakage, presence of air
c. Assess for signs of site infection
d. Assess for symptoms of meningitis
e. Follow-up laboratory results on CSF samples and if appropriate catheter tip cultures and toxicology values
f. Assess for changes in neurological status

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. ~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.~~

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites Completion of standardized procedure training on site
Proctoring Period a. Minimum of 3 successful observed demonstrations b. Minimum of 3 chart reviews
Reappointment Competency a. Evaluation will be performed by Supervising Physician and/or his or her designee b. Ongoing competency evaluation. 1. Completion of three procedures every 2 years.

2. Three chart reviews needed every 2 years

Protocol #8: Ordering Blood Transfusions

A. DEFINITION
Ordering the administration of whole blood or blood components i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate.

1. Location to be performed: Emergency Department, Inpatient Units, and Outpatient Clinics.

2. Performance of procedure:
   a. Indications
      1. Anemia
      2. Thrombocytopenia or platelet dysfunction
      3. Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means.
   b. Precautions
      1. Blood and blood components must be given according to ZSFG guidelines.
      2. Emergency exchange transfusion orders are not covered by this standardized procedure – these must be countersigned by the responsible physician.
      3. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.
   c. Contraindications
      1. Absolute: none
      2. Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenia purpura (TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.

B. DATA BASE
   1. Subjective Data
      a. History and review of symptoms relevant to the presenting complaint and reason for transfusion.
      b. Transfusion history, including prior reactions, minor red cell antibodies and allergies.

   2. Objective Data

a. Physical exam relevant to the decision to transfuse.
b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
c. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of subjective and objective data to direct transfusion therapy and identify contraindications to transfusion.

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent must be obtained before writing transfusion orders.
   b. Outpatients must be provided with post-transfusion instructions. (ZSFG Form).
   c. Appropriate post-transfusion laboratory studies are ordered to assess therapeutic response.
   d. Referral to physician, specialty clinics and supportive services as needed,

2. Patient Conditions Requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions, post-transfusion orders for outpatients.

4. Follow-up
   As appropriate for patient condition and reason transfusions were given.

E. RECORD KEEPING
Patient visit, consent forms, and other transfusion-specific documents(completed transfusion report and “blood sticker” will be included in the medical record and other patient data bases, as appropriate. ~~The medical Record of any patient cared for by a PA for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.~~

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Successful completion of the Zuckerberg San Francisco General Hospital Transfusion Training course. b. Successful completion of Transfusion Training course test on blood ordering and informed consent. c. Must have an 80% test score on both examinations.
Proctoring Period: a. Read and Sign the ZSFG Administrative Policy and Procedure 2.3 “Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options”. b. Read ZSFG Transfusion Guidelines in Laboratory manual. c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.
Reappointment Competency Documentation: a. Completion of the two education modules and completion of the two examinations with a passing score of 80%. b. Performance of 1 transfusion order per year and 1 medical record review per year. c. Review of any report from the Transfusion Committee. d. Evaluator will be the medical director or other designated physician.

PROTOCOL #9: eConsult Review

A. DEFINITION

eConsult review is defined as the review of new outpatient consultation requests via the online eConsult system. A new outpatient is defined as a patient that has neither been consulted upon by the specialty service, admitted to the specialty service nor seen in the specialty clinic within the previous two years.

1. Prerequisites:
   a. Providers reviewing eConsults will have six months experience with patients in the specific specialty area provided at Zuckerberg San Francisco General Hospital and Trauma Center or elsewhere before allowed to review eConsults independently.
   b. Providers reviewing eConsults will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
   c. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
   d. Providers reviewing eConsults will have expertise in the specialty practice for which they are reviewing.

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.

3. Proctoring: A concurrent review of the first 20 eConsult consultation decisions will be performed by the Chief of Service or designee in the first three months.

4. Reappointment: 5 chart reviews will be needed for reappointment every 2 years.

B. DATA BASE

1. Subjective Data
   a. History: age appropriate history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems relevant to the presenting disease process as provided by the referring provider on the electronic referral. eConsult review will be confined to data found in the submitted eConsult form. Data contained in the paper or electronic medical record, but not in the eConsult, is

specifically excluded from the eConsult review. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

b. Pain history to include onset, location, and intensity, aggravating and alleviating factors, current and previous treatments.

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient as provided by the referring provider.
   b. Laboratory and imaging evaluation as obtained by the referring provider relevant to history, physical exam, and current disease process will be reviewed. Further evaluation will be requested from the referring provider if indicated.

C. DIAGNOSIS

A diagnosis will not be determined at the time of eConsult review. Differential diagnosis will be provided at the time the patient is seen in clinic by the consulting provider. Assessment of the subjective and objective data as performed by the consulting provider in conjunction with identified risk factors will be evaluated in obtaining a diagnosis.

D. PLAN

1. Review of eConsult
   a. Algorithms or referral guidelines developed and approved by the Chief of Service will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.
   b. All data provided via the eConsult consultation request will be reviewed and assessed for thoroughness of history, adequacy of work up, and urgency of condition.
   c. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient Conditions Requiring Attending Review
   a. Upon request of the referring NP, PA, or physician
   b. Problem requiring hospital admission or potential hospital admission
   c. When recommending complex imaging studies or procedures for the referring provider to order
   d. Problem requiring emergent/urgent surgical intervention
   e. As indicated per the algorithms developed by the Chief of Service

3. Education
    a. Provider education appropriate to the referring problem including disease process, additional diagnostic evaluation and data gathering, interim treatment modalities and lifestyle counseling (e.g. diet, exercise).

4. Scheduling of Appointments
    a. Dependant upon the urgency of the referral, the eConsult will be forwarded to the scheduler for either next available clinic appointment scheduling or overbook appointment scheduling.

5. Patient Notification
    a. Notification of the patient will be done by the referring provider if the appointment is scheduled as next available. If the appointment is scheduled as an over book within two weeks of the eConsult, the consulting scheduler is responsible for notifying the patient.

E. RECORD KEEPING

All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the medical record upon scheduling or after a period of six months.