

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG August 22, 2023
July/August 2023 MEC Meetings

Clinical Service Rules and Regulations

- Emergency Medicine RR Updates – Summary of Changes and R&R with Tracked Changes attached.
- Pediatrics Service Rules and Regulations – Summary of Changes and R&R with Tracked Changes attached.

Credentials Committee –

- Standardized Procedures - SPs with Tracked Changes and Summary of Changes attached.
 - CPC
 - FCM
 - Medicine



Department of Public Health

London Breed
Mayor

Gabriel Ortiz, MD, PhD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes for **July 2023**

Document Name:	<i>ZSFG Emergency Department Rules and Regulations</i>
Department:	<i>Department of Emergency Medicine</i>
Date of last approval:	<i>2021</i>
Summary of SP updates:	
Update #1:	<p><i>Addition of new MD Leadership role: Assistant Medical Director of Emergency Department</i></p> <p>The Assistant Medical Director, in collaboration with the Chief and Vice Chief Medical Director, of the ZSFG Emergency Department provides clinical administration and oversight of the ZSFG Emergency Department. The Assistant Medical Director, in consultation with the Chief, Vice Chief Medical Director and related nursing and operational leaders, is responsible for ensuring that services provided are in accord with the institution’s mission, vision, values and goals. The Assistant Medical Director supports the Emergency Department Chief and Vice Chief Medical Director in providing the medical and administrative leadership necessary to deliver patient-centered care as well as assists with the oversight of availability, timeliness and appropriateness of clinical services offered to each Emergency Department patient while working to improve overall departmental performance.</p> <p>Works closely with ZSFG Chief and Vice Chief Medical Director in the following:</p> <ul style="list-style-type: none"> • Chair special projects as designated by the Emergency Department Chief and Vice Chief Medical Director and attends hospital or group meetings as required by the project • Assist in leading initiatives for improving efficiency and improving flow. • Participate in strategic planning and long-term operations as appropriate • Assist in identifying staffing needs and support recruitment and retention efforts • Assist in interviewing potential new staff and working with Chief and

	<p>Vice Chief\Medical Director in completing the credentialing process</p> <ul style="list-style-type: none"> • Ensure that the policies, procedures and clinical activities within Emergency Medicine meet all regulatory requirements including those of California Department of Public Health (CDPH), Center for Medicaid and Medicare Services (CMS), and the Joint Commission (TJC) • Develop and help implement clinical resource management initiatives and practice guidelines • Collaborate with directors of other departments to update interdepartmental policies • Ensure E*Drive is updated with those clinical policies • Assist in orienting new Physicians and Advanced Practice Providers as needed • Completion of or agreement to participate in Lean training (e.g. lean Bootcamp and A3 Thinking) • Attend monthly Emergency Department physician meetings and provide updates to the faculty when requested to by the Chief and Vice Chief\Medical Director • Attend weekly ED Executive leadership meetings • Attend weekly DMS (Daily Management System) meetings with Nursing Leadership • Represent ED Physician leadership at monthly NP meetings • Participate in hospital committees designed to improve ED care and perform committee responsibilities as assigned • Participation in Hospital and ED Process Improvements and Quality Improvement efforts • Serve on the Case Review Committee (CRC) • Review sentinel events and aggregate data of patients, indicators, and monitors on an as-needed and ongoing basis • Perform other duties as assigned by the Emergency Department Chief and Vice Chief\Medical Director
<p>Update #2:</p>	<p>5. Attending schedules</p> <ul style="list-style-type: none"> – Schedule requests from part-time faculty must be submitted at two months ahead of time. – Part-time faculty must work a minimum of fourthree shifts per
<p>Update #3:</p>	<p>6. Request for changes and schedules are made in the following ways</p> <ul style="list-style-type: none"> - Medical students, interns and residents must notify the medical education coordinator at least 24 hours prior to any scheduled trade. — Attendings must notify the Assistant to the Chief prior to a traded shift.



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<p>Update #4:</p>	<p>H. APPROPRIATE DRESS</p> <p>Emergency Department medical staff and members will <u>dress appropriately at all times.</u></p> <ol style="list-style-type: none"> 1. The dress of medical staff should evoke a sense of confidence and respect from the patients. 2. Men or women may wear matching top and bottom ZSFG scrub suits. 3. Men may also wear slacks with a tie and white coat. 4. Women may wear a dress, skirt and blouse, or slacks and white coat.
<p>Update #5:</p>	<p>Patients who meet trauma criteria from hospitals outside <u>the jurisdiction of of Zuckerberg San Francisco General Hospital and Trauma Center</u> should be referred to the <u>transfer coordinator-attending physician on the trauma service</u> for acceptance of transfer.</p> <p>In addition, trauma patients outside our jurisdiction should be referred to the transfer line “when the ED is on diversion” as refusing to accept these patients when we are not on diversion could be an EMTALA violation, and we are accepting multi-system trauma patients outside our jurisdiction when we are not on diversion.</p>
<p>Update #6:</p>	<p>Removed duplicate section (Sick Calls and Missed Shifts)</p>
<p>Update #7:</p>	<p>The section on use of medical interpreters has been updated to clarify current process. Certified interpreters should always be used unless there is an extenuating circumstance.</p> <p>Exceptions may include when a patient is incapacitated and their surrogate is unavailable or cannot be contacted due to clinical acuity and need for emergent intervention. There may also be times when interpreter services cannot provide timely language interpretation support. However, staff should always do their best to communicate with patients in their preferred language whenever possible.</p> <p>Section also contains an updated description of patient’s right to refuse a certified interpreter and how this declination should be documented in the medical record as a best practice.</p>

ZSFGH EMERGENCY DEPARTMENT
RULES AND REGULATIONS
2023~~1~~

**EMERGENCY DEPARTMENT
RULES AND REGULATIONS
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I. EMERGENCY DEPARTMENT ORGANIZATION

A. SCOPE OF SERVICE

Emergency Department at Zuckerberg San Francisco General Hospital encompasses the evaluation, resuscitation, stabilization, and other treatment of all patients who present to the Emergency Department. The Emergency Department also provides medical direction of out-of-hospital care when requested by paramedics in the City and County of San Francisco or Northern San Mateo County. Emergency Department also provides training and conducts research that will enhance the treatment of patients requiring Emergency Department.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards and requirements set forth in ZSFG Medical Staff Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION OF EMERGENCY DEPARTMENT

The Emergency Department Clinical Service (hereafter referred to as Emergency Department or E.D.) is governed by the Zuckerberg San Francisco General Hospital (ZSFG) Medical Staff and policies and procedures of the University of California San Francisco (UCSF).

1. Chief, Emergency Department

Position Summary:

The Chief of Emergency Department directs and coordinates the Department's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also insures that the Service's functions are integrated with those of other clinical departments and with the Hospital as a whole.

Reporting Relationships:

The Chief of Emergency Department reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department of Emergency Medicine (DEM) Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the

Associate Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee, and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualification:

The Chief of Emergency Department is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Emergency Department include the following:

- Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of ZSFG and DPH;
- In collaboration with the CEO and other ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical service providers by the Department.
- In collaboration with the CEO and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;
- Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and
- Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws and the Rules and Regulations.

2. The following positions are appointed by and report to the Chief, Emergency Department.

a. Medical Director (Vice-Chief) of Emergency Department

The Medical Director of Emergency Department provides the necessary vision and leadership to effectively motivate and direct Emergency Department in developing and achieving goals and objectives that are congruous with the values, mission and strategic plan of Zuckerberg San Francisco General Hospital and the Department of Public Health.

In collaboration with the administrative leadership and other Hospital Leaders, develops and implements policies and procedures that guide and support the provisions of services:

- Identify models of service (staffing/levels of service) to be implemented
- Participates in defining staffing needs and ratios of staffing for clinical operation
- Schedules Faculty for Clinical staffing in the Emergency Department
- Reviews and re-designs physical layout of the Department for optimal delivery of care
- Reviews and evaluates new products for delivery of clinical care
- Participates in interviewing and selecting new faculty for Emergency Department
- Participates in Annual performance review of faculty
- Acts as central liaison between Emergency Department and Clinical Services throughout the hospital.
- Participates in performance improvement projects at monthly ED Executive Committee meetings
- Participates in the design and implementation of Annual Faculty Retreat to review and design new Clinical Service Models and Administrative Systems.
- Meets bi-weekly with Service Chief to review existing Clinical Operations and design new service models
- Generates minutes of the monthly ED Medical Staff meetings
- Co-Chairs the ED Clinical Operations Committee.
- Provides ongoing clinical oversight of the mid-level providers in the ED (nurse practitioners and physician assistants)
- Prepares an annual report of activities to the Chief

b. Assistant Medical Director of Emergency Department

The Assistant Medical Director, in collaboration with the Chief and Vice Chief\Medical Director, of the ZSFG Emergency Department provides clinical administration and oversight of the ZSFG Emergency Department. The Assistant Medical Director, in consultation with the Chief, Vice Chief\Medical Director and related nursing and operational leaders, is responsible for ensuring that services provided are in accord with the institution's mission, vision, values and goals. The Assistant Medical Director supports the Emergency Department Chief and Vice Chief\Medical Director in providing the medical and administrative leadership necessary to deliver patient-centered care as well as assists with the oversight of availability, timeliness and appropriateness of clinical services offered to each Emergency Department patient while working to improve overall departmental performance.

Works closely with ZSFG Chief and Vice Chief\Medical Director in the following:

- Chair special projects as designated by the Emergency Department Chief and Vice Chief\Medical Director and attends hospital or group meetings as required by the project
- Assist in leading initiatives for improving efficiency and improving flow.
- Participate in strategic planning and long-term operations as appropriate
- Assist in identifying staffing needs and support recruitment and retention efforts
- Assist in interviewing potential new staff and working with Chief and Vice Chief\Medical Director in completing the credentialing process
- Ensure that the policies, procedures and clinical activities within Emergency Medicine meet all regulatory requirements including those of California Department of Public Health (CDPH), Center for Medicaid and Medicare Services (CMS), and the Joint Commission (TJC)
- Develop and help implement clinical resource management initiatives and practice guidelines
- Collaborate with directors of other departments to update interdepartmental policies

- Ensure E*Drive is updated with those clinical policies
- Assist in orienting new Physicians and Advanced Practice Providers as needed
- Completion of or agreement to participate in Lean training (e.g. lean Bootcamp and A3 Thinking)
- Attend monthly Emergency Department physician meetings and provide updates to the faculty when requested to by the Chief and Vice Chief\Medical Director
- Attend weekly ED Executive leadership meetings
- Attend weekly DMS (Daily Management System) meetings with Nursing Leadership
- Represent ED Physician leadership at monthly NP meetings
- Participate in hospital committees designed to improve ED care and perform committee responsibilities as assigned
- Participation in Hospital and ED Process Improvements and Quality Improvement efforts
- Serve on the Case Review Committee (CRC)
- Review sentinel events and aggregate data of patients, indicators, and monitors on an as-needed and ongoing basis
- Perform other duties as assigned by the Emergency Department Chief and Vice Chief\Medical Director

~~b. Assistant Medical Director of Emergency Department~~

c. Director of Performance Improvement, Quality Improvement and Patient Safety (PIPS)

The Director of Performance Improvement and Patient Safety (PIPS) is responsible for organizing and implementing the Emergency Department Performance Improvement and Patient Safety Plan by collaborating with other members of Emergency Department and nursing staff. This position reports to the monthly Emergency Department meeting to keep the medical staff informed of PIPS issues. The PIPS director is the representative of Emergency Department to the Hospital Risk Management committee.

The Director(s) of PI\QI are expected to:

- Represent the ED at the monthly risk management committee

- Develop new measures of Quality Improvement for Emergency Care and measure them.
- Develop new processes to improve Quality of Care in the ED
- Collaborate with ED-Nursing Director of PIPS to improve quality of care.
- Monitor and report on performance and quality of care for the following processes
 - Complications
 - Intubations
 - Central venous access
- Monitor and report on
 - Number of Preventable and Non-preventable deaths in the ED
 - The total number of deaths in the ED
- Hold a quarterly PI meeting in collaboration with ED Nursing and Hospital PI.
- Monitor and develop reports on the National Patient Safety Goals (NPSG) as they apply to the ED
 - Develop and implement methods of improving compliance with the NPSG's
- Review episodic cases (U.O.'s or other cases reported to the Chief or Medical Director – for investigation) in collaboration with the Medical Director in which quality of care may be an issue.
- Attend the weekly ED Executive Committee meeting
- Prepare an annual report to the Chief of Service describing the activities of the PIPS for the prior year (due June 30 of each year).
- Attend the ED physician leadership meeting (weekly).

d. Associate Residency Program Director

The Associate Residency Program Director is responsible for the scheduling, orientation, formal teaching, evaluation and coordination of house staff and medical students in the Emergency Department. This position reports monthly to the Emergency Department medical staff meetings and reports directly to the Residency Program Director as well as the Chief, Emergency Department.

e. Director of Pediatric Emergency Medicine.

The Director of Pediatric Emergency Medicine serves as a liaison to Pediatric Services. This position plans and implements protocols and recommends equipment needed for the care of children. This position reports to the Emergency Department medical staff meetings as needed. The director of Pediatric Emergency Medicine prepares an annual report of activities related to Pediatric Emergency Medicine.

e. Base Hospital Medical Director

The Base Hospital Medical Director ensures appropriate training, supervision and credentialing of Base Hospital physicians. This position is jointly responsible with the Nursing Base Coordinator for ensuring compliance with the Base Hospital Quality Assurance Plan and acting as liaison to the Emergency Medical Services Agency. This position reports to the ES medical staff meetings as needed.

f. Disaster Coordinator

The Disaster Coordinator is responsible for coordinating the Emergency Department Disaster Plan with the Hospital Disaster Committee and Emergency Department nursing. The position reports to the Emergency Department medical staff meetings as needed.

g. Medical Student Education Director

The Medical Student Education Director is responsible for the scheduling, orientation, formal teaching, evaluation and coordination of medical student electives, activities and evaluations in the Emergency Department. This position reports monthly to the Emergency Department medical staff meetings.

D. ROLES AND RESPONSIBILITIES

1. Attending Physicians

a. Attending-In-Charge (AIC)

- Provides medical consultation to the base hospital telemetry station.
- Responsible for redistributing available medical staff to ensure optimal patient flow.
- Responsible for discussing diversion countermeasures with the CN and AOD
- Responsible for coordinating E.D. medical staff to respond to disasters and multi casualty incidents (see E.D. Policy, "Disaster Plan".)

b. All Attendings

- Responsible for supervision of medical care delivered in the E.D. by house staff and medical students.
- Ensures adequate documentation on E.D. medical records (see XI.B. below)
- Responsible for transfer of patients out of the E.D. (Refer to XI.F. below and ED Policy, "Transfer of Patients from ED").
- Evaluates and writes notes on all patients seen in the E.D. prior to admission or discharge.
- Supervises sign-out rounds.
- Supervises procedures (see E.D. Policy, "Procedures: Table of Staff Approved to Perform").
- Writes all "do not resuscitate" orders.
- Ensures compliance with universal precautions.
- Sees all patients before patients are allowed to leave against medical advice (see XI.B. below).
- At discharge, ensures that patients have appropriate follow-up and discharge instructions (see XI.B. below).
- Ensures notification of the Medical Examiner of all deaths in the E.D. and ensures that the death registry form is completed.
- Responsible for ensuring appropriate patients receive consultation.
- Communicates with attendings from consultation services where consultants are not available in a timely manner or when

- disagreements over management arise
- Works in a collaborative fashion with nursing:
 - Responds to nursing concerns by either carrying out requests of nursing staff or communicating reasons for not doing so.
 - Notifies charge nurse of problems with nursing care within the E.D.
 - Notifies the charge nurse of problems with equipment or lack of supplies.
 - Ensures compliance with dress code by house staff and students.
 - Enforces the policy of medical staff, house staff and students not eating in the clinical areas.
 - Serves as a role model to house staff and students.
 - Completes Unusual Occurrence reports in appropriate situations.
 - Pages the Chief or Medical Director of the Emergency Department for situations that have potential risk management implications.
 - Identifies appropriate patients for research studies and notifies appropriate research coordinators.

2. All Residents, Interns and Students

- Will review orientation materials prior to their first shift.
- Will discuss with the ED Housestaff Coordinator any requested changes in their scheduled shifts.
- Will comply with necessary Emergency Department administrative requirements including:
 - o Having their picture taken
 - o Providing address and home telephone information
 - o Signing their Training Materials Receipt Form
 - o Returning the rotation evaluation form at the end of their rotation
 - o Returning any meal cards and parking cards at the end of their rotation
- Will call and speak to the attending in charge (AIC) when for any reason they cannot be present and on time for a scheduled shift (628-206-8111) and contact the EM Chief Resident on call (Jeopardy Chief) and Housestaff Coordinator for possible coverage.
- Will not eat in the patient care areas, only in the provider room or ED lounge.
- Will wear appropriate attire while in the patient care areas (see VIII.G. Appropriate Dress, below).
- Will inform the attending when they leave the clinical area for a meal break, or for any extended period of time.

- Will perform the medical functions of a resident or student, under the guidance and supervision of an attending. These include primary patient care and:
 - o An appropriate history and physician examination
 - o Determining the patient's primary care provider
 - o An appropriate treatment plan
 - o Appropriate use of their identification number when ordering laboratory, x-ray, EKG studies, or when ordering or prescribing medications
 - o Follow-up of all diagnostic and therapeutic interventions
- Will document on the medical record all pertinent history, physical findings orders, procedures, reassessments and discharge instructions.
- Will follow appropriate body substance precautions.
- Will call consults as dictated by usual medical practice.
- Will immediately consult with the attending physician on patients who:
 - o Are requesting to leave against medical advice
 - o Are violent
 - o Are unstable
 - o Threaten lawsuits, grievance, etc.
 - o Require admission
- Will treat patients and hospital staff in a professional, courteous manner; at all times showing patients and co-workers respect.
- Will make an effort to learn by participating in, as allowed, ED Conferences and being receptive to teaching at the bedside.

3. Residents (Refer to CHN Website, House Staff Competencies link)

- Will evaluate and manage patients in their assigned clinical areas.
- Senior residents will help manage patient flow and teach medical students and interns as time allows.

4. 4th Year Medical Students (“Acting Interns”)

- Will only evaluate and treat patients in resuscitation rooms as directed by a resident or attending.

45. Nurse Practitioner

- Provides care to patients in the Emergency Department in accordance with policies approved by the Committee on Interdisciplinary Practice.
- Provides appropriate documentation for patients seen.
- Discusses all patients who will be admitted with an attending.

- Contacts the Charge Nurse for absences due to illness.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations as well as with policies established by UCSF.

1. Full-time medical staff are hired after a national search and salary is based on academic, rank and step using the AAMC salary survey as a guideline.
2. Part-time (less than 50%) medical staff may be hired without a national search. Hourly compensation is based on time of day and day of week worked.
3. The applicant must receive a letter of recommendation from the Chief, Emergency Department, ZSFG.
4. The applicant must be eligible for the privileges requested in accordance with the privilege criteria requirements of the Emergency Department, ZSFG.
5. All Emergency Department medical staff applicants must apply for and receive a UCSF faculty appointment within six months of hiring.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

1. Practitioners Performance Profiles

The Practitioner Performance Profiles will include an evaluation of clinical competence based on Performance Improvement and Patient Safety, and Utilization indicators and evaluation by the Chief of the Emergency Department. In the case of the Chief of Service, the Medical Director will perform the evaluation.

Direct observation is not required but may be performed if necessary as part of the peer review process.

2. Staff Status Change

The process for Staff Status Change for members of the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and Rules and Regulations.

3. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and the Ruled and Regulations.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of Affiliated Professionals through Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

D. STAFF CATEGORIES

The Emergency Department staff fall into the same staff categories, which are described in the ZSFG Staff Bylaws, and the Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Emergency Department privileges are developed in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST

The Emergency Department Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Emergency Department privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Emergency Department.

D. TEMPORARY PRIVILEGES

Temporary privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Monitoring (proctoring) requirements for Emergency Department shall be the responsibility of the Chief of the Service and may be delegated to the Medical Director of the Emergency Department.

1. All new Emergency Department medical staff must be proctored within the first *6 months*.
2. Proctoring includes a review of evaluations of the applicant by other clinical service medical staff, house staff, nurses and patients.
3. Proctoring includes a review of clinical indicators such as 72-hour revisit admissions through the Performance Improvement and Patient Safety process.

B. ADDITIONAL PRIVILEGES

Request for additional privileges for the Emergency Department shall be in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Emergency Department shall be in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

V. EDUCATION

Ongoing attending physician education is provided by Case Conferences, Trauma Video Conference, ED Meetings and PIPS activities. The ED encourages and supports faculty to attend the Annual Society of Academic Emergency Medicine meeting as well as the Scientific Assembly of the American College of Emergency Physicians.

VI. EMERGENCY DEPARTMENT HOUSESTAFF TRAINING PROGRAM

(Refer to CHN Website for House staff Competencies link.)

- A. All new housestaff and students undergo orientation as outlined in Section VIII.A. Orientation.
- B. Housestaff and students receive training in the following:
 1. Case conferences held at least once per month
 2. Residency didactic lectures held every Thursday.
 3. Trauma video conference held monthly
 4. Bedside supervision/teaching of all patients seen by housestaff and students.

VII. EMERGENCY DEPARTMENT CONSULTATION CRITERIA

- A. Consultation requested of all services should be requested by residents and attendings. Students and interns should request consults under the supervision and guidance of a resident or attending.

- B. Requests for consultation should be documented clearly on the medical record. This should include the time the consult is requested, the service and the name of the consultant.
- C. If unable to contact a consultant, the Emergency Department attending should be notified. The attending will then call the attending of the consultation service.
- D. Consultations requested of social services should be documented in the same way the consultations are noted for the various medical services.

1. Trauma/Surgery

- All patients meeting Trauma 900/911 criteria
- Trauma patients with spinal or pelvic fractures
- All patients being admitted to ZSFG for traumatic injuries requiring ICU or pediatric admission
 - Patients with cellulitis, lymphangitis or other cutaneous infection that may require surgical debridement.
 - Possible surgical abdomens (i.e., appendicitis, acute cholecystitis, perforated viscus, etc.)
 - Possible compartment syndromes
 - Burns which may require admission
 - Any possible aortic aneurysm, either dissecting or rupturing
 - Caustic ingestions
 - Possible ischemic bowel
 - Painful or not easily reducible hernias

2. Obstetrics/Gynecology

- Any significant concern for ectopic pregnancy
- Significant concern for pelvic inflammatory disease
- Pregnant patients addicted to narcotics
- Endometritis
- Precipitous deliveries in the ED
- All seriously or critically ill pregnant patients
- Severe vaginal bleeding

3. Pediatrics

- Pediatric consultants should see any patient (up to age of 21) in the ED if requested to do so by the ED attending physician.

4. Orthopedic

- Fractures requiring follow up
- Dislocations not reduced by ED providers
- Axial spine fractures
- Septic arthritis

- 5. Neurosurgery**
 - Any patient with neurologic deterioration for whom head CT is being ordered to evaluate intracranial bleeding or hydrocephalous
 - Fractures of the axial spine
 - Suspected acute spinal cord syndrome

- 6. Neurology**
 - Diagnosed or suspected strokes and TIA's
 - New onset seizures and status epilepticus
 - Dementia without previous evaluation
 - Movement disorders of undetermined etiology

- 7. Anesthesiology**
 - Trauma patients requiring intubation according to the agreed upon schedule of airway responsibility.
 - Medical patients with failed airways

- 8. Oral Maxillofacial Service**
 - Facial fractures not covered by the ENT or plastic services
 - Facial lacerations involving cartilage, lip lacerations involving vermilion border, large facial lacerations, complex facial lacerations

- 9. Plastic Surgery**
 - Burns to the face, hands and perineum
 - Hand consults when not covered by Orthopedics

- 10. ENT (Otolaryngology)**
 - Intractable epistaxis
 - Upper airway obstruction
 - Laryngeal or esophageal foreign bodies
 - Suspected epiglottitis

- 11. Ophthalmology**
 - Patients with blowout fractures and entrapment
 - Patients with possible rupture or penetration of the globe.
 - Significant eye injuries including patients with hyphema, lacerations of the eyelids including the margin or the tarsal plate, or the lacrimal drainage system.

- 13. Urology**
 - Patients with urethral obstruction and infection
 - Kidney stones with intractable pain
 - Patients with trauma along the urogenital tract
 - Severe epididymitis\orchitis

- Testicular torsion
- Cellulitis of the scrotum or the perineum

14. Psychiatry

- Patients with suicidal or homicidal ideation
- Patients with new onset psychosis
- Any patient thought to be gravely disabled because of psychiatric reasons.

15. Hand Service

- Patients with significant trauma or infection distal to the elbow covered by either the Orthopedics or Plastic surgery services

VIII. OPERATIONAL ISSUES

D. A. ORIENTATION

1. All medical students will attend a one-hour orientation, which will include a tour of the ED.
2. Interns and Residents will view an on-line orientation material prior to their first shift.
3. Attending staff will receive the Emergency Department Rules and Regulations, view the housestaff on-line website and attend a one-hour meeting with the Chief of Emergency Department or the Medical Director (Vice Chief) as an orientation. Additionally, new attending staff will spend their first shift with a current E.D. attending.
4. Attendings-In-Charge (AIC) will receive a special orientation to the Base Hospital given by the Medical Director of the Base Hospital. They will be required to pass a written test covering the policies and procedures of the Base Hospital.

E. B. SCHEDULING

1. Medical students' schedules are made by the medical education coordinator.
 - Medical students will not average more than 48 hours clinical time per week
 - Medical students will have at least one 24-hour period off per week.
 - Medical students shifts will be no longer than eight hours.
 - Medical students will not be required for clinical duty when student lectures are scheduled.

2. Interns schedules are made by the medical education coordinator.
 - Interns will not average more than 60 hours clinical time per week.
 - Interns will have at least one 24-hour break from clinical time each week.
 - Intern shifts will not be longer than twelve (12) hours. Every attempt will be made to equally distribute night shifts.
3. Resident schedules will be made by the medical education coordinator.
 - These residents will not work more than 60 hour per week.
 - There will be at least one 24-hour time period without clinical work per week.
 - Shifts will not be longer than twelve (12) hours.
4. Attending schedules
 - Schedule requests from part-time faculty must be submitted ~~at~~ two months ahead of time.
 - Part-time faculty must work a minimum of ~~four~~three shifts per month unless prior arrangements are made with the Chief, Emergency Department.
 - Part-time faculty must work at least one night per month.
 - Part-time faculty must average two out of every seven shifts on weekends unless special arrangements are made with the Chief.
 - Faculty may not work more than 12 consecutive hours.
5. Full-time faculty must submit their schedule request at least two months ahead of time. Full-time faculty must note on their schedule request reasons for days off (i.e., personal, reason for work related business).
 - Full-time faculty must request vacation or non-work-related time off (more than 3 consecutive days off in a row) before schedule requests are submitted.
6. Request for changes and schedules are made in the following ways
 - Medical students, interns and residents must notify the medical education coordinator at least 24 hours prior to any scheduled trade.
 - ~~—Attending must notify the Assistant to the Chief prior to a traded shift.~~

~~C. SICK CALLS AND MISSED SHIFTS~~

- ~~1. Medical students and house staff must call the attending physician in the clinical area to which they are assigned when unable to work a scheduled shift.~~

- ~~— The attending in charge will redistribute personnel as necessary.~~
- ~~— Students and house staff may be required to make up missed shifts as determined necessary by the Director of Medical Education.~~

~~2. Attending schedules~~

~~Schedule requests must be submitted by the due date or requests may not be honored.~~

~~Faculty must request off any days they do not wish to work, including unassigned holidays.~~

~~Part-time (per diem) faculty must work a minimum of four shifts per month unless prior arrangements are made with the Chief, Emergency Department.~~

~~Part-time faculty must work 1/3 of their shifts as nights and 1/3 as weekends unless special arrangements are made with the Chief, Emergency Department.~~

~~Faculty may not work more than 12 consecutive hours or have less than 8 hours between shifts.~~

~~Full-time faculty must submit their schedule requests by the due date and note on their schedule request reasons for days off (i.e., personal, reason for work related business).~~

~~Full-time faculty must request approval for 7 or more consecutive days off in a row at least 2 weeks before schedule requests are due. Approval of requested time off will be granted depending on the ability of the department to accommodate the schedule requirements.~~

C. SICK CALLS AND MISSED SHIFTS

1. Medical students and house staff must call the attending physician in the clinical area to which they are assigned when unable to work a scheduled shift.
 - The attending in charge will redistribute personnel as necessary.
 - Students and house staff may be required to make up missed shifts as determined necessary by the Director of Medical Education.

2. Attendings unable to attend a shift should the on-call physician for coverage of the shift.
 - An On-Call system exists to provide coverage in the event that an attending physician is unable to attend a shift.
 - The Chief or Medical Director of Emergency Department should be paged if the on-call physician cannot be reached.

D. SIGN-OUT ROUNDS

Sign-out rounds are held several times each day. At all sign-out rounds, patients should be presented completely and the individual who will assume responsibility for the patient must be assigned at that time. Patients who require admission should be admitted prior to sign-out rounds and patients able to be discharged should be discharged prior to sign-out rounds.

1. Confidentiality must be maintained at all times.
 - The discussion of patients should be quiet and held several feet away from the patients so that confidentiality is maintained.
2. Attendings should sign-out any pending transfers and current diversion status.
3. At the conclusion of each case discussion, a plan for further therapy and diagnostic evaluation must be outlined. The end points for admission or discharge must also be discussed.

E. DIVERSION

1. E.D. diversion is carried out as outlined in the administrative policy “Ambulance Diversion Criteria” (ZSFG Administrative Policy 4.05)
 - Patients, nursing staff and medical staff should be redistributed as the need arises to attempt to avoid total E.D. diversion.
 - If it becomes apparent that the E.D. is unable to provide the standard of care for incoming patients, the charge nurse, attending in charge and AOD should confer regarding the need for total E.D. diversion which must occur before the decision is made to go on diversion.
 - It should be recognized that total E.D. diversion does not divert ambulances with patients for whom the E.D. is a special receiving facility (Level 1 trauma patients, EMSA defined specialty care triage criteria – i.e STAR, STEMI, Burns, Reimplantation, Obstetrics, Acute medical pediatrics, ZSFG campus clinic patients, incarcerated or police custody patients)

F. AVAILABILITY

The Chief, Emergency Department or his designee, is available 24 hours per day, every day for questions, consultation and back up.

- 1.. The Chief or Medical Director (Vice Chief) should be called for any significant risk management issues.
2. The Chief or Medical Director (Vice Chief) can be called to facilitate disputes between the E.D. and a potential admitting service attending or between admitting service attendings regarding the need for admitting a particular patient.

3. The Chief or Medical Director (Vice Chief) should be called when an attending is unable to work a shift in the acute area of the E.D.
4. The Chief or Medical Director (Vice Chief) should be called when there are significant conflicts between medical and nursing staff in the E.D.
5. The Chief or Medical Director (Vice Chief) should be called whenever there is an activation of the hospital's disaster plan.

G. G. APPROPRIATE DRESS

Emergency Department medical staff and members will dress appropriately at all times.

1. The dress of medical staff should evoke a sense of confidence and respect from the patients.
2. Men or women may wear matching top and bottom ZSFG scrub suits.
- ~~3. Men may also wear slacks with a tie and white coat.~~
- ~~4. Women may wear a dress, skirt and blouse, or slacks and white coat.~~
5. The following dress is not acceptable:
 - wearing scrubs from other institutions;
 - blue denim (jeans);
 - tee shirts and sweat shirts
6. Medical staff must wear a name tag that includes the full name and level of training (i.e. medical student, intern, resident, etc.)

IX. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws, Rules and regulations will govern all disciplinary action involving members of the ZSFG Services.

X. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

A. CLINICAL INDICATORS

Clinical indicators include but are not limited to deaths in the E.D., 7 days revisit admissions, deaths, procedural sedation, patients leaving AWOL or AMA, and airway intubation.

B. CLINICAL SERVICE PRATITIONERS PERFORMANCE PROFILES

The Director of PIPS prepares an annual report for the organization and department summarizing the performance of the department based on these clinical indicators.

C. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Emergency Department PIPS Committee consisting of physicians, nurses, and Emergency Department staff is responsible for gathering information, identifying problems, developing and assessing the results if solutions are proposed to solve problems. These reports are made available to the Chief of Emergency Department and the Nursing Director of Emergency Department.

D. MONITORING & EVALUATION OF APPROPRIATENESS OF PROFESSIONAL PERFORMANCE

1. Physicians – Refer to Section IV. - Proctoring and monitoring.
2. House staff are monitored by their supervising attending physicians on each shift. Evaluations are performed at the end of the shift and reported back to individual house staff by the Associate program director.
3. Affiliated Professionals (nurse Practitioners) are evaluated by the attending physicians. Attending physicians provide feedback to the Medical Director and or Chief of the Emergency Department.
4. When applicable, clinical indicators used for attending physicians are used for nurse practitioners.
5. ZSFG Employees other than Affiliated Professionals are monitored and evaluated by their immediate supervisors. Attending physicians provide feedback to appropriate supervisors directly and through the Chief, Emergency Department.

XI. CLINICAL ISSUES

A. EVALUATION OF PATIENTS

1. **TRIAGE:** All patients presented to the Emergency Department will be seen/triaged by an experienced and qualified Triage Nurse. Patients can be seen by a student or intern as a first provider only after a patient has been screened by the Triage Nurse and determined to be stable.
2. Patients seen in the E.D. may be seen initially by students, interns, residents, nurse practitioners or attending. The attending should remain available to hear presentations of new cases and be available to consult on potential admissions or discharge.
3. All patients seen by a resident or medical student must be staffed by an attending before they leave the ED.

B. DOCUMENTATION

1. Before seeing the patient, the intern/resident clicks their initials in the appropriate box in EPIC that notes the time that the evaluation of the patient is initiated.

2. Attending physicians, at the time of admission or discharge, are responsible for ensuring that all appropriate documentation is present on the medical record.
3. The pertinent history is documented. This includes but is not limited to all pertinent positive and negative history:
 - Appropriate timing of the onset of illness or injury.
 - Pertinent past medical history and review of symptoms.
 - Identification of the patient's Primary Care provider (PCP) and or usual source of care.
 - Results of attempt to contact PCP must be documented.
4. Appropriate Physical Exam is documented:
 - The patient's general appearance is noted.
 - Wounds are described in terms of size and location.
 - When appropriate, detailed Neurologic exams are documented including gait (this may require serial examinations as patient's mental status improves).
5. Procedures:
 - All procedures are carefully documented, including prep, anesthetic and extent of procedure in the appropriate procedure template.
 - The results of procedure, including complications, are documented.
6. Orders will be documented:
 - This includes all orders for IV, medications, restraints, oxygen, laboratory test, EKG's, cardiac monitoring x-rays, diet, neurological checks and vital signs.
 - All orders are time stamped in EPIC at the time they are written
 - Before discharge, any verbal orders documented by the nursing staff must be signed by physicians.
7. Patients whose clinical condition changes should have their reassessments documented in the appropriate section on the chart. Examples include:
 - Any discussion with friends or family should be documented here
 - Attendings leaving at the end of a shift should write a note in this section for complicated patients whose disposition has not been decided upon.
8. At the time of discharge the following must be completed:
 - Discharge diagnosis, must be specific and should include all pertinent diagnosis present in the E.D. (i.e. "multiple contusion", "alcoholism",

- “alcohol withdrawal”, etc.)
- Mechanism of injury may be a diagnosis but should never be the only diagnosis
 - Instructions to patients, especially those symptoms necessitating immediate return to the E.D. must be carefully documented.
 - The clinics to which the patient is being referred and the time frame requested for follow-up must be documented.
9. Attending signature with date and time stamp must be completed within the agreed upon time frame from date of service by the Chief of the Emergency Department.
10. An attending note should be completed for all admitted and discharged patients. This must include:
- A brief description of exceptions from and/or additions to the intern/resident note and the most pertinent findings
 - A review of pertinent lab and diagnostic data
 - The attending’s presence for all procedures performed in the E.D.
 - The diagnosis(es)
 - The plan for the patient’s follow-up or admission.
 - The time and date of discharge must be documented
 - Attending signature with date and time stamp must be completed within the agreed upon time frame from date of service by the Chief of the Emergency Department

C. ADMISSIONS

It is the policy of the Emergency Department to admit those patients to the hospital who are likely to benefit from hospitalization or who are likely to deteriorate if discharged from Emergency Department. Patients are also admitted for pain control if deemed necessary.

1. When it is recognized that a patient requires admission to the hospital, the admission disposition should be made in EPIC as soon as this is known. The admitting diagnosis, service, and admitting resident as well as the need for special precautions like isolation should be entered into the admission disposition request.
2. The admitting service should be notified when a patient requires admission to their service. A patient cannot be sent upstairs without approval of the admitting service. Disagreements should be immediately discussed by the attending physician on the admitting service and the emergency department attending physician. Continued disagreements should be referred to the Medical Director or Chief of Emergency

Department.

3. Patients requiring admission who have out of network insurance will be identified by the transfer center. If patients are deemed stable by the attending physician, they can be transferred to an accepting institution. (See XI.E below)
4. All ICU admissions require calling the ICU resident for admission to an ICU bed.
5. The following rules also apply to admissions:
 - Prisoners with chest X-ray consistent with tuberculosis must be admitted unless active tuberculosis can be ruled out
 - An admitting team may only discharge an admitted patient from the E.D. after discussion with the attending physician on the admitting service and requires a note from the inpatient attending physician of record.

D. TRANSFER INTO EMERGENCY DEPARTMENT

Transfer into and out of the Emergency Department is only approved and arranged by attending physician (See ZSFG Administrative Policy 20.07)

1. All non-trauma transfers from other hospitals into the Emergency Department are first screened by the transfer coordinator for eligibility and availability of beds. If patients are deemed eligible and ZSFG beds are available, the transfer coordinator notifies the Emergency Department Attending who will then contact the referring physician. Patients are only accepted if they are then deemed stable for transfer.
 - Patients who are obviously a direct admission should not be accepted to Emergency Department. The referring physician should be referred to the admitting physician of the admitting service.
 - Patients from Laguna Honda Hospital and City Clinics should always be accepted unless there is no bed available for potential admission, the patient is in critical condition (in which case the patient will be transported by paramedics to the nearest appropriate receiving facility), or, ZSFG is on diversion.
2. Patients who meet trauma center criteria from San Francisco hospitals should always be accepted for transfer. These calls need not go through the coordinator.
3. Patients who meet trauma criteria from hospitals outside the jurisdiction of of Zuckerberg San Francisco General Hospital and Trauma Center should be referred to the transfer coordinator-attending physician on the trauma service for acceptance of transfer when the ED is on diversion.

4. Whenever a transfer is accepted, the triage nurse should be notified of the incoming transfer as well as the residents and attending in the area to which the patient will be triaged.

E. TRANSFER OUT OF EMERGENCY DEPARTMENT

Transfer out of the Emergency Department may only be *authorized* by an attending physician in the ED (See ZSFG Administration Policy 20.05)

1. Stable patients who either require a transfer or in whom a transfer is required because of insurance purposes may be transferred with their consent.
2. Unstable patients in whose transfers are required in order to provide appropriate care may be transferred with patient's consent. If the patient is unable to consent these patients may also be transferred.
3. The process for arranging a transfer is as follows:
 - The attending physician asks the charge nurse to have the transfer coordinator verify the patient's eligibility.
 - Upon verification of the patient's eligibility the transfer coordinator notifies the attending physician of the patient's insurance coverage.
 - The attending physician or resident speaks to the appropriate physician to accept transfer.
 - The appropriate physician at the receiving institution should be called to accept the transfer.
 - Once an accepting physician has been identified the ZSFG E.D. attending physician or resident should notify the charge nurse that the transfer has been accepted and document the acceptance on the E.D. medical record
 - The charge nurse should then request the transfer coordinator to prepare necessary transfer documents, copy x-rays and provide transportation (as requested by the attending physician) for transfer.
 - The transfer coordinator shall ensure that the appropriate transfer forms are filled out and provides copies of the medical records, x-rays and EKG's.

F. DISCHARGE AND FOLLOW-UP

1. Patients with Primary Care Providers (PCP's) who can provide necessary follow-up should be referred to these physicians.
2. Out of county patients should be referred to their PCP or the County hospital in which they reside.

3. Every effort should be made to refer San Francisco patients without PCP to primary care clinics in the Department of Public Health. Only those patients requiring specialty care should be referred to specialty clinics.
4. Discharge plans should be discussed with relatives or friends accompanying the patient whenever possible and appropriate.
5. All patients should be instructed in the signs and symptoms which may require their immediate return to the E.D. and these instructions must be documented.
6. Upon discharge, patients are provided with *a copy* of their E.D., prescriptions, instruction sheets, and if necessary, bus tokens or taxi vouchers to ensure their safe transport home.
7. Homeless patients and those patients requiring the services of a social worker should receive a consultation from the social worker prior to discharge.

XII. RISK MANAGEMENT

A. AVAILABILITY

The Risk Manager for the University of California is available 24 hours per day on pager (415-327-9543). The Chief of Emergency Department, or designee, is also available 24 hours per day.

For any questions that may have medical legal implications (see below) the UC Risk Management and Chief, Emergency Department, should be paged.

1. The Unusual Occurrence reporting system does not negate the need to page the UC Risk Manager and Chief, Emergency Department.
2. Requests for information from attorneys or investigators must go through the UC Risk Management.

B. LEAVING AGAINST MEDICAL ADVICE (AMA)

(Refer to ZSFG Administrative Policy 1.10)

1. Patients must be able to understand the consequences of leaving against medical advice before leaving AMA.
2. Patients leaving against medical advice must be interviewed by the attending physician prior to leaving.
3. Patients leaving against medical advice must be informed of the risks of leaving.
4. Patients leaving against medical advice should be given discharge instructions, medications and follow-up as any other patient would receive.

5. Patients leaving against medical advice should be informed as to the conditions which would require immediate return to the E.D.
6. Patients leaving against medical advice should have the above-mentioned discussions documented in their chart.
7. Patients leaving against medical advice should be asked to sign the AMA form. If they refuse *this should be noted and it* should be made a part of the permanent medical record.
8. Patients leaving AMA who are considered “At Risk” before an attending assessment is made should be detained by SFSD until the attending evaluation is completed.

C. RESTRAINTS

(Refer to, “Restraint\Seclusion” ZSFG Administrative Policy 18.09).

1. Patients may be restrained for either safety or behavioral reasons.
 - Patients on 5150’s may be placed in restraints if necessary to avoid elopement.
 - Patients at risk for falling or otherwise hurting themselves may be placed in restraints.
2. Physicians and nurses should review each patient’s status before removing restraints.
3. A restraint order must be placed prior to application

-Orders involving restraint of extremities must specify laterality.

-Restraints for *non-violent, non self-destructive (medical safety)* purposes must be renewed as needed at least **every 24 hours**.

-Restraints for *violent\self-destructive purposes (behavioral safety)* must be renewed as needed at least **every 4 hours** and require face to face assessment by a physician within an hour of initiation and reapplication.

4. If a patient is taken out of restraints prior to the time ordered for restraints to be discontinued; an order to discontinue restraints should be written.

D. CONSENT

(See ZSFG Administrative Policy 3.09)

1. Patients registered into the E.D., if able, sign a consent which permits evaluation and emergency treatment in the E.D.
2. If procedures need to be performed which are not emergent in nature and

the patient is unable to consent, then consent should be obtained from a surrogate decision-maker.

3. Patients unable to consent at registration may have an emergency procedure performed if, “implied consent” applies. The concept of “implied consent” means that a patient with severely impaired ability to understand the consequences of refusing care would, if able to understand the situation, consent to necessary evaluation and treatment.
 - Any necessary treatment should be performed in these cases.
 - The reason for invoking “implied consent” must be carefully documented.

Examples:

- a. A patient with a gun shot wound to the abdomen may not be able to understand the consequence of leaving because of severe anger or fear and may be held because of the high likelihood of death or permanent disability.
 - b. A patient with a scalp laceration due to a fall who is mildly intoxicated and has been observed for several hours may not be permitted to leave, based on the severity of head injury and degree of intoxication.
 - c. A severely demented patient with a paronychia who is somewhat combative may be held until evaluation of the infection has been completed because of severe impairment in ability to understand the consequence of leaving.
4. Blood transfusions in the E.D. always require completion of the Blood Transfusion Consent form.
 5. Consent for surgery or other procedures to be performed outside of the E.D. should be obtained by the admitting service.
- E. DO NOT RESUSCITATE ORDERS AND DEATH IN EMERGENCY DEPARTMENT**
1. Only attending physicians may write do not resuscitate orders in the chart.
 - The order should state reason for the order.
 - Any contact with the family should be noted.
 - The order should specify what procedures may or may not be performed (intubation, defibrillation and use of medications).
 - These orders do not apply to admitted patients outside the E.D.

2. All deaths in the E.D. must be reported to the Medical Examiner's office (see E.D. Policy D, "Death in the ED")
 - Attending physicians do not sign the death certificates
 - The Medical Examiner may choose to take the patient or sign the patient out to a private physician who will then sign the death certificate.
 - The death registry form should be completed by the E.D. attending physician.
 - No devices (tubes, catheters etc.) are to be removed from a deceased patient in the ED.

F. UNIVERSAL PRECAUTIONS

(Refer to E.D Policy E. "Exposures to Blood and Body Fluids")

1. Part of all orientations will include discussion of the use of universal precautions
2. Any exposure to blood or body fluid by medical staff shall report to the Charge Nurse
3. Further treatment and prophylaxis will be determined by the physician in concordance with the needlestick hotline.
4. The attending physician will fill out the report of injury.

G. USE OF INTERPRETERS

1. Medical staff should not rely on anything less than fluency in patient's language to interpret for their patients.
2. CThe use of certified hospital interpreters and the AT&T interpreter line or phone interpreters should always be offered and used with patients and/or their surrogate decision-maker when a language barrier is identified unless an extenuating circumstance is present whenever possible. Exceptions may include when a patient is incapacitated and their surrogate is unavailable or cannot be contacted due to clinical acuity and need for emergent intervention. There may also be times when interpreter services cannot provide timely language interpretation support. However, staff should always do their best to communicate with patients in their preferred language whenever possible.
3. Family members or friends should not be used to interpret for patients. Patients maintain the right to decline the use of certified interpreter services and opt for family or friend after being informed of and offered certified interpretation services, and this declination should be documented in the medical record as a best practice.
4. The use of an interpreter and AT&T line as an interpreter should be noted

in the chart.

XIII. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws, all active members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

Emergency Department shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

As defined in the ZSFG Medical Staff Bylaws, Article VII 7.2.G, a quorum is constituted by at least three (3) voting members of the Active Staff for the purpose of conducting business.

A. EMERGENCY DEPARTMENT STAFF MEETINGS

1. Emergency Department staff meetings are held on the 2nd Tuesday of each month at 2:30 pm

The Emergency Department staff meeting will consist of:

- *Clinical issues*
- *Educational Programs*
- *Medical Research*
- *Administrative topics*
- *Performance Improvement and Patient Safety*
- *Billing and Documentation issues*
- *The Medical Directors report*
- *The PIPS Director report*
- *The Ultrasound Director report*
- *Any ad hoc committee reports*

2. Full-time faculty are required to attend 50% of medical staff meetings.
3. Part-time medical staff are required to read the minutes of the medical staff meetings and are held accountable for all information contained in these minutes.
4. Attendance and participation in the Departments weekly Residency Teaching conferences is determined by the Residency Program Director

in consultation with the Department of Emergency Medicine Steering committee.

XIV. ADOPTION AND AMENDMENT

The Emergency Department Rules and Regulations will be adopted and revised by a majority of all Active members of the Emergency Department annually at a quarterly held Emergency Department meeting.

ATTACHMENT A - EMERGENCY DEPARTMENT PRIVILEGE FORM

Privileges for San Francisco General Hospital

Requested

Applicant: Please initial the privileges you are requesting in the Requested column.
Service Chief: Please initial the privileges you are approving in the Approved column.

ED EMERGENCY MEDICINE 2021

FOR ALL PRIVILEGES: All complication rates, including problem transfusions, deaths, unusual occurrence reports and sentinel events, as well as Department quality indicators, will be monitored semiannually.

12.10 Core Privileges

Responsible for all transfers into and out of the emergency services as well as supervision of all biotelemetry operations. Renders care to adults and children in all areas of emergency services. Provides patient management, including diagnostic and therapeutic treatments, as well as _____ procedures and interventions. Supervises house staff and _____ students.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine.

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 50 cases

12.20 Procedural Sedation

Provides procedural sedation of all forms for patients undergoing procedures in Emergency Services

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.08 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

PROCTORING: Review of 5 cases (completed training within the last 5 years)

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year for the preceding 2

years or,
·Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

12.30 Acute Trauma Care

Comprehensive emergency management of the acutely injured trauma patient, providing initial resuscitation and management of acutely injured trauma patients

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine.

1. Completion of ACGME-approved residency with Board certification/eligibility in Emergency Medicine, Internal Medicine, or Family Practice
2. Availability, clinical performance and continuing medical education consistent with current standards for Emergency Medicine physicians at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgery

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 5 cases

12.31 Limited Privileges for Resuscitative Thoracotomy

Perform antero-lateral resuscitative thoracotomy for trauma, limited to the following circumstances:

*When there is direct communication by phone between the Surgery and ED attendings (or Surgery fellow if the Surgery attending is unavailable).

*The procedure must be performed by a member of the active or courtesy medical staff and not by a trainee.

PREREQUISITES: Current privileges in Actue Trauma Care

PROCTORING: One procedure satisfactorily performed in a thoracotomy cadaver training session within the previous three (3) years or equivalent.

REAPPOINTMENT: One procedure satisfactorily performed in a thoracotomy cadaver training session within the previous three (3) years or equivalent.

12.40 Airway Management

Comprehensive management to control, protect and intubate the airway including medications, adjuncts and cricothyroidotomy.

PREREQUISITES: Currently Board Admissible, Board Certified, or e-Certified by the American Board of Emergency Medicine.

PROCTORING: Review of 6 intubation cases and demonstration of proficiency in the Seldinger technique emergency cricothyroidotomy on a standardized model.

REAPPOINTMENT: Review of 3 intubations cases. Either review of one cricothyroidotomy or demonstration of proficiency in the Seldinger technique emergency cricothyroidotomy on a standardized model.

12.50 Medical Toxicology

Evaluate, diagnose and provide consultative services to adult, adolescent and pediatric patients with clinical pharmacological and toxicological problems in the ambulatory and inpatient settings.

PREREQUISITES: Currently certificate eligible, certified or re-certified in Medical Toxicology

as authorized by a primary board of the American Board of Medical Specialties.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

12.60 Ultrasound

12.61 FAST (Focused Abdominal Sonography in Trauma)

Detection of pericardial or peritoneal fluid

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation of 25 studies. If evidence of 25 documented and reviewed studies from residency or another institution with completion of proctoring is provided, then

the requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

12.62 Pregnancy

Detection of intrauterine pregnancy or peritoneal fluid

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

12.63 Focused Echocardiography

Detection of pericardial effusion, detection of any cardiac activity, and evaluation of global left ventricular systolic function.

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

12.64 Aorta

Detection of abdominal aortic aneurysm

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

12.65 Abdomen Right Upper Quadrant

Detection of gallstones, sonographic Murphy's Sign, pericholecystic fluid and gallbladder wall thickening

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

_____ _____
12.66 Renal

Detection of hydronephrosis and intrarenal calculi

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

_____ _____
12.67 Deep Venous Thrombosis

Detection of compressibility in the common femoral and popliteal veins

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

_____ _____
12.68 Pneumothorax

Detection of pneumothorax

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

_____ _____
12.70 Waived Testing

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years

documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

- A. Fecal Occult Blood Testing (Hemoccult)
- B. Vaginal pH Testing (pH Paper)
- C. Urine Chemistrip Testing
- D. Urine Pregnancy Test (SP Brand Rapid Test)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
12.80 Evoked Potentials

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified By the American Board of Emergency Medicine. At initial request of this privilege, mandatory training and minimum of 12 CME hours by the American Society of Electroencephalographic Technicians (ASET) or the American Academy of Audiology.
PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with evoked potential privileges.
REAPPOINTMENT: Review of 3 cases.

_____ _____
13.00 PEDIATRIC EMERGENCY MEDICINE

_____ _____
13.10 Core Privileges

Responsible for preventive medical services and medical care of patients under the age of 21. Provides patient management, including H&Ps and diagnostic and therapeutic treatments, as well as procedures and interventions, including the areas described below and similar activities.

Supervises house staff and students.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-certified in Pediatric Emergency Medicine by the American Board of Pediatrics or American Board of Emergency Medicine.

PROCTORING: 5 observed cases

REAPPOINTMENT: Current demonstrated competence and documentation of successful treatment of a minimum of 50 patients for the past 24 months based on the result of quality assessment – improvement activities and outcomes.

_____ _____
13.20 Procedural Sedation

Provides procedural sedation of all forms for pediatric patients under the age of 21, undergoing procedures in Emergency Services.

PREREQUISITES: Physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.08 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified or Re-certified in Pediatric Emergency Medicine by the American Board of Pediatrics or American Board of Emergency Medicine. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine, American Board of Pediatrics or Anesthesia or,

- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,

-Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

PROCTORING: Review of 5 cases (completed training within last 5 years).

REAPPOINTMENT: Completion of procedural sedation test as evidenced by a satisfactory score on the examination and has completed at least one of the

following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine, American Board of Pediatrics or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

13.30 Acute Trauma Care

Comprehensive emergency management of the acutely injured pediatric trauma patient up to age 15, providing initial resuscitation and management of acutely injured pediatric trauma patients

PREREQUISITES: Currently Board Admissible, Board Certified or Re-certified in Pediatric Emergency Medicine by the American Board of Pediatrics or American Board of Emergency Medicine. Availability, clinical performance and continuing medical education consistent with current standards for Pediatric Emergency Medicine physicians at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgery

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 5 cases

13.40 Airway Management

Comprehensive management to control, protect and intubate the airway including medications, adjuncts and cricothyroidotomy in pediatric patients under the age of 21

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Emergency Medicine.

PROCTORING AND REAPPOINTMENT: Physician will be assessed for proficiency by an expert in pediatric emergency airways. Demonstration of proficiency will occur by intubation of a standardized model or a patient and performance of the Seldinger technique for emergency cricothyroidotomy on a standardized model. This assessment should occur twice over the span of two years. Expert is defined as an individual who meets any of the following:

*Serves as an instructor at a difficult airway course, including simulation labs conducted by the Department of Emergency Medicine

*Serves on an advisory committee for a national body (ACEP, AAP, etc.) on topics related to emergency airways.

*Requirements for one supervised intubation can be met by successful completion of one intubation on a pediatric patient.

13.60 Ultrasound

Perform ultrasound in pediatric patients under the age of 21 as follows:

13.61 FAST (Focused Abdominal Sonography in Trauma)

Detection of pericardial or peritoneal fluid

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation of 25 studies. If evidence of 25 documented and reviewed studies from residency or another institution with completion of proctoring is provided, then the requirement is documentation and review of 3 studies at SFGH
PEER REVIEW: Documentation and review of 3 studies

13.62 Pregnancy

Detection of intrauterine pregnancy or peritoneal fluid
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH
PEER REVIEW: Documentation and review of 3 studies

13.63 Focused Echocardiography

Detection of pericardial effusion, detection of any cardiac activity, and evaluation of global left ventricular systolic function.
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH
PEER REVIEW: Documentation and review of 3 studies

13.64 Aorta

Detection of abdominal aortic aneurysm
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH
PEER REVIEW: Documentation and review of 3 studies

13.65 Abdomen Right Upper Quadrant

Detection of gallstones, sonographic Murphy's Sign, pericholecystic fluid and gallbladder wall thickening
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH
PEER REVIEW: Documentation and review of 3 studies

13.66 Renal

Detection of hydronephrosis and intrarenal calculi
PREREQUISITES: Currently board admissible, certified or recertified by

the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

_____ _____
13.67 Deep Venous Thrombosis

Detection of compressibility in the common femoral and popliteal veins
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

_____ _____
13.68 Pneumothorax

Detection of pneumothorax

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution, then requirement is documentation and review of 3 studies at SFGH

PEER REVIEW: Documentation and review of 3 studies

_____ _____
13.70 Waived Testing (Under the age of 21)

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care in pediatric patients under the age of 21. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

- _____ _____
_____ _____
_____ _____
_____ _____
- A. Fecal Occult Blood Testing (Hemoccult)
 - B. Vaginal pH Testing (pH Paper)
 - C. Urine Chemistrip Testing
 - D. Urine Pregnancy Test (SP Brand Rapid Test)

_____ _____ **13.80 CTSI (Clinical and Translational Science Institute) - Clinical Research**

Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

Prerequisites: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants.

Proctoring: All OPPE metrics acceptable

Reappointment: All OPPE metrics acceptable

CTSI Medical Director

Date

Applicant signature: _____ Date: _____

Department Chief signature: _____ Date: _____

ATTACHMENT B - EMERGENCY DEPARTMENT POLICIES

Please refer to policies maintained in Clinical Service Office

**ATTACHMENT C - EMERGENCY DEPARTMENT STUDENT/INTERN
ORIENTATION MANUAL**

Please refer to policies maintained in Clinical Service Office

ATTACHMENT D - EMERGENCY DEPARTMENT HOUSE STAFF MANUAL

Please refer to policies maintained in Clinical Service Office



Department of Public Health

London Breed
Mayor

Gabriel Ortiz, MD, PhD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	<i>ZSFG Clinical Service Rules and Regulations</i>
Clinical Service :	<i>Pediatrics</i>
Date of last approval:	
Summary of R&R updates:	
Update #1:	C. Organization, 4. Directors of Education: Updated responsibilities to include oversight of both undergraduate and graduate medical education aspects
Update #2:	Appendix A: Organization Chart Updated names of those who hold positions. Structure of Organization Chart and Position Titles have not changed.

**PEDIATRIC
RULES AND REGULATIONS**

20212023

PEDIATRIC RULES AND REGULATIONS
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I. DEPARTMENT OF PEDIATRICS

A. SCOPE OF SERVICE

The Department of Pediatrics at the Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) includes comprehensive primary care services as well as the evaluation, diagnosis, management, and treatment of the illnesses, injuries, and diseases that affect neonates, children, adolescents, and young adults, using appropriate staff, space, equipment, and supplies.

The Pediatric Rules and Regulations define the standards and procedures for members of the department. Standards of clinical practice will be consistent with the standards established by the American Academy of Pediatrics and other pediatric organizations. The Pediatric Rules and Regulations supplement the standards and procedures set forth in the ZSFG Medical Staff Bylaws and Rules and Regulations. If there is a conflict between the Pediatric Rules and Regulations and the ZSFG Medical Staff Bylaws, the Medical Staff Bylaws will prevail unless there are circumstances where the Pediatric department adopts a more stringent standard.

The Department of Pediatrics at the ZSFG will review and revise all policies and procedures every three years or more frequently, if needed.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of the ZSFG is a privilege which shall be extended to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in the ZSFG Medical Staff Bylaws.

C. ORGANIZATION (Appendix A)

The officers of the Department of Pediatrics at the ZSFG are the Chief of Pediatrics, the Vice Chief of Pediatrics, the Acting Chief of Pediatrics, the Director(s) of Education, the Medical Director of the Children's Health Center, the Medical Director of the Infant Care Center, the Medical Director of the Pediatric Inpatient Unit, and the Medical Director of the Nocturnist Service.

1. Chief of Pediatrics

- a. Appointment and review of the Chief of Pediatrics will occur by the process specified in the Medical Staff Bylaws.
- b. Responsibilities (Appendix B)
 - i. Provide overall direction of the clinical, educational, and scholarly activities for the department; and
 - ii. Review and recommend all new appointments, requests for privileges, and reappointments; and
 - iii. Appoint the remaining officers of the department; and
 - iv. Oversee the financial affairs of the department; and
 - v. Attend the Medical Executive Committee, the Dean's meeting, the Chiefs of Service meeting, and other meetings, as called from time to time by the Executive Administrator or the Chief of Staff; and
 - vi. Assure that the quality of patient care provided in Pediatrics is monitored and evaluated; and
 - vii. Implement any needed disciplinary action, as set forth in the Pediatric Rules and Regulations or the Bylaws and Rules and Regulations of the Medical Staff.

2. Vice Chief of Pediatrics

- a. Appointment of the Vice Chief of Pediatrics is the prerogative of the Chief of Pediatrics.
- b. The term of appointment is open and subject to annual performance review by the Chief of Pediatrics.
- c. Responsibilities (Appendix B):
 - a. The Vice Chief provides oversight of quality and compliance issues for the department; and
 - b. The Vice Chief assists the Chief with other issues, as requested.

3. Acting Chief of Pediatrics

- a. Appointment of the Acting Chief of Pediatrics is the prerogative of the Chief of Pediatrics.
- b. Responsibilities (Appendix B):
 - c. The Acting Chief of Pediatrics serves as the Chief of Pediatrics in the absence of the Chief.

4. Director(s) of Education

- a. Appointment of the Director(s) of Education is the prerogative of the Chief of Pediatrics.
- b. The term of appointment is open and subject to annual performance review by the Chief of Pediatrics.
- c. Responsibilities (Appendix B)
 - i. Provide leadership in undergraduate and graduate medical educational issues for the department by supporting and enhancing the educational mission; and
 - ii. Oversight of ZSFG Pediatric Clerkship and Sub-Internship Rotations; and
 - iii. Serve as the ZSFG Pediatric Residency Site Director, including supervision of ZSFG chief residents; and
 - iv. Serve as the liaison for all trainees who rotate in Pediatrics at ZSFG; and
 - v. Coordinate ZSFG Grand Rounds scheduling; and
 - vi. Oversight of ZSFG Faculty Development Activities
 - ~~ii. Serve as the ZSFG Clerkship Director in Pediatrics; and~~
 - ~~iii. Serve as Director of the ZSFG Longitudinal Rotation in Pediatrics; and~~
 - ~~iv. Serve as the liaison for all trainees who rotate in Pediatrics at ZSFG; and~~
 - ~~v. Assist in planning and coordinating intern orientation.~~

5. **Medical director, Children’s Health Center (CHC)**
 - a. Appointment of the Medical Director of the CHC is the prerogative of the Chief of Pediatrics.
 - b. The term of appointment is open and subject to annual performance review by the Chief of Pediatrics.
 - c. Responsibilities (Appendix B)
 - i. Provide leadership and oversight of the CHC; and
 - ii. Provide overall direction for clinical and quality improvement activities in the CHC; and
 - iii. Collaborate with the Chief and other departmental leaders; and
 - iv. Develop and maintain budgets, reports, protocols, policies, procedures and guidelines, as necessary, in collaboration with the Nurse Manager, Departmental Manager and Chief of Pediatrics; and
 - v. Actively participate in the Performance Improvement and Patient Safety Program relating to the CHC; and
 - vi. Interface with Ambulatory Care and Primary Care Leadership in the DPH San Francisco Health Network (SFHN) and ZSFG and actively participate in appropriate DPH programs.

6. **Medical Director, Infant Care Center (ICC)**
 - a. Appointment of the Medical Director of the ICC is the prerogative of the Chief of Pediatrics.
 - b. The term of appointment is open and subject to annual performance review by the Chief of Pediatrics.
 - c. Responsibilities (Appendix B)
 - i. Provide leadership and oversight of the ICC; and
 - ii. Provide overall direction of clinical and quality improvement activities in the ICC; and
 - iii. Collaborate with the Chief and other departmental leaders; and
 - iv. Develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary; and
 - v. Actively participate in the Performance Improvement and Patient Safety Program relating to the ICC; and
 - vi. Prepare budgets and other reports, in collaboration with the Nurse Manager, Assistant Director of Nursing for Maternal/Child Health, Departmental Manager, and/or Chief of Pediatrics.

7. **Medical Director, Pediatric Inpatient Unit**
 - a. Appointment of the Medical Director of the Pediatric Inpatient Unit is the prerogative of the Chief of Pediatrics.
 - b. The term of appointment is open and subject to annual performance review by the Chief of Pediatrics.
 - c. Responsibilities (Appendix B)
 - i. Provide leadership and oversight of the Pediatric Inpatient Unit; and
 - ii. Provide overall direction of clinical and quality activities on the Pediatric Inpatient Unit; and
 - iii. Collaborate with the Chief of Pediatrics and other departmental leaders; and
 - iv. Develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary; and
 - v. Actively participate in the Performance Improvement and Patient Safety activities relating to the Pediatric Inpatient Unit; and
 - vi. Prepare budgets and other reports, in collaboration with the Nursing manager, Departmental Manager, and/or Chief of Pediatrics.

8. Director of the Nocturnist Service

- a. Appointment of the Director of the Nocturnist Service is the prerogative of the Chief of Pediatrics.
- b. The term of appointment is open and subject to annual performance review by the Chief of Pediatrics.
- c. Responsibilities (Appendix B)
 - i. Provide leadership and oversight of the Nocturnist Service; and
 - ii. Provide overall direction of clinical and quality activities on the Nocturnist Service and ensure adequate staffing; and
 - iii. Collaborate with the Chief of Pediatrics and other departmental leaders; and
 - iv. Develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary; and
 - v. Actively participate in the Performance Improvement and Patient Safety activities relating to the Pediatric Service; and
 - vi. Prepare budgets and other reports, in collaboration with the Nursing manager, Departmental Manager, and/or Chief of Pediatrics.

II. CREDENTIALING

The Department of Pediatrics at the ZSFG follows the existing Rules and Regulations of the ZSFG Medical Staff of the ZSFG. In addition, the Pediatric Department has agreed upon the following rules and regulations for its members:

- A. Faculty meetings: Each month, the Pediatric Faculty meeting reviews Credentials and Pediatric Performance Improvement and Patient Safety (PIPS) issues. All active medical staff members are required to attend at least 50% of the faculty meetings during each year to maintain their medical staff appointments. Courtesy and affiliated professional staff members are also invited to the monthly faculty meeting, along with the ZSFG Associate Administrator for Maternal and Child Health and the Pediatric Departmental Administrator. If deemed necessary by any member of the department, Morbidity and Mortality reports are discussed at the faculty meeting.
- B. Morbidity and Mortality conferences: Pediatric Morbidity and Mortality conferences are held each month. All deaths, as well as problems and adverse outcomes, will be discussed at these conferences and a Pediatric Morbidity and Mortality file will be maintained on all cases reviewed during these conferences. Attendance rosters for the Morbidity and Mortality conferences will be maintained by the Pediatric administrative office and all active medical staff members are expected to attend at least 50% of Pediatric Morbidity and Mortality conferences each year in order to maintain their medical staff appointment.
- C. Committee participation: All active medical staff members serve on ZSFG committees and they are expected to attend at least 50% of committee meetings each year as a requirement of their reappointment, per ZSFG Medical Staff Rules and Regulations. In addition, all active medical staff members are required to attend the Annual Medical Staff meeting every two years.
- D. Certification: All active pediatric staff members are expected to maintain certification in cardiopulmonary resuscitation (Neonatal Advanced Life Support or Pediatric Advanced Life Support, depending on specialty privileges) if required for their medical staff appointment. Courtesy pediatric staff members are also expected to maintain certification in cardiopulmonary

resuscitation (Neonatal Advanced Life Support or Pediatric Advanced Life Support, depending on specialty privileges), if required for their medical staff privileges.

1. Licensure: Current medical licensure is required for all active medical staff members and appropriate professional licensure is required for all affiliated professionals.
 2. DEA certification: DEA certification is required for all active and courtesy Pediatric staff, unless waived by the Chief of Pediatrics. PNP Furnishing Certification is required for all affiliated professionals who furnish medications as part of their duties.
 3. Subspecialty certification: Specialty board certification or eligibility for certification (or other verification of the completion of the board certification process) is required for all active and courtesy medical staff members who note their specialty certification and/or request specialized privileges.
- E. Proctoring: All medical staff members will be proctored by the Chief of Pediatrics or her/his designee during the first year of their appointment. The proctoring evaluation will be completed in the first three months of the first year of appointment. The Chief of Pediatrics, or her/his designee, will re-evaluate all medical and affiliated professional staff members at the time of their reappointment.
- F. Liability insurance coverage: All members of the ZSFG medical staff who have UCSF faculty appointments in the UCSF Department of Pediatrics, with or without salary, are covered under the University of California's self-insured professional liability program for activities which are performed within the course and scope of their faculty appointments, including clinical, teaching, research and administrative activities. These activities are under the direction of the Chief of Pediatrics. The University's coverage extends to activities performed at University-owned and affiliated hospitals such as the ZSFG. It does not extend to any faculty member's activities performed at facilities not owned by or affiliated with the University unless there is a professional services agreement between UCSF and the facility for that faculty member's services.
- Consistent with section 2.2-4 of the ZSFG Medical Staff Bylaws, "individuals who are not members of the faculty of the University or not employed by the City and County of San Francisco, shall maintain professional liability insurance in an amount not less than \$1 million each occurrence, \$3 million aggregate and, if applicable, with an insurance carrier acceptable to the Executive Administrator."
- G. Removal of privileges: Any faculty appointment may be rescinded by the Chief of Pediatrics, in consultation with the Pediatric Credentials Committee, which is composed of the active staff members in Pediatrics.
- H. New appointments: The process of application for membership to the Medical Staff of the ZSFG through the Pediatric Department follows the process specified in the ZSFG Bylaws.
- I. Reappointments: The process of reappointment to the Medical Staff of the ZSFG through the Pediatric Department follows the process specified in the ZSFG Bylaws, Rules and Regulations.
1. Practitioners' Performance Profiles: To maintain appointment in the ZSFG Pediatric department, staff members must supply evidence of clinical activity and/or teaching activity at the ZSFG during the previous two years.

2. **Modification of Privileges:** The reasons for changes or modifications in clinical privileges must be submitted, in writing, to the Chief of Pediatrics and must be approved by the time of reappointment.
 3. **Staff Status Change:** The process for Staff Status Change for members of the Pediatric department is in accordance with the ZSFG Bylaws, Rules and Regulations and accompanying manuals.
- J. **Affiliated Professionals:** The process of appointment and reappointment to the Affiliated Professional staff of ZSFG through the Pediatric Department follows the process specified in the ZSFG Bylaws, Rules and Regulations as well as the Pediatric Rules and Regulations.
- K. **Staff categories:** Pediatric departmental staff fall into the same staff categories which are described in Article III of the ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

III. DELINEATION OF PRIVILEGES

- A. **Development of Privilege Criteria:** Pediatric departmental privileges are developed in accordance with the ZSFG Medical Staff Bylaws.
- B. **Annual Review of Clinical Privileges Request Form:** Every year, the Pediatric department Privilege Request Form shall be reviewed by the Chief of Pediatrics.
- C. **Clinical privileges (Appendix C):** Pediatric privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws. All requests for clinical privileges will be evaluated and approved by the Chief of Pediatrics.
- D. **Temporary privileges:** Temporary Privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

IV. PROCTORING AND MONITORING

- A. **REQUIREMENTS:** Proctoring and monitoring requirements for the Pediatric Department shall be the responsibility of the Chief of Pediatrics or her/his designee. A minimum of 3 patient cases per appointment period will be reviewed for active members. In the case of new privileges, a minimum of 5 cases will be reviewed. For courtesy members, the review will consist of cases on which they consulted, as outlined above, with a maximum of five.
- B. **ADDITIONAL PRIVILEGES:** Requests for additional privileges for the Pediatric Department shall be in accordance with ZSFG Bylaws, Rules and Regulations.
- C. **REMOVAL OF PRIVILEGES:** Requests for removal of privileges for the Pediatric Department shall be in accordance with ZSFG Bylaws, Rules and Regulations.

V. EDUCATION

Pediatric departmental members are encouraged to attend UCSF courses or other conferences to obtain continuing medical education (CME) credits.

VI. CONSULTATION CRITERIA

The Pediatric on-call physician, the pediatric inpatient attending or the attending neonatologist is notified for all pediatric admissions and for all emergency department visits or Children's Health Center visits which lead to hospitalization or transport to other facilities.

The Pediatric on-call physician, the pediatric inpatient attending or the attending neonatologist is available for in-person or phone consultation regarding any pediatric patient at any time.

VII. DISCIPLINARY ACTION

The ZSFG Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the Pediatric Department at the ZSFG.

VIII. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Pediatric Department at the ZSFG participates in all of the hospital's performance improvement and patient safety activities.

IX. MEETING REQUIREMENTS

- A. Attendance: In accordance with the ZSFG Medical Staff Bylaws, all active staff members are expected to participate in the governance and quality evaluation process of the Medical Staff by attending at least 50% of all assigned committee meetings, Pediatric faculty meetings, Pediatric morbidity and mortality conferences, and annual medical staff meetings.
- B. The Pediatric Department shall hold a faculty meeting as frequently as necessary, but at least quarterly, to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.
- C. Quorum: As defined in the ZSFG Medical Staff Bylaws, a quorum for the purpose of conducting business is constituted by at least three (3) voting members of the active staff.

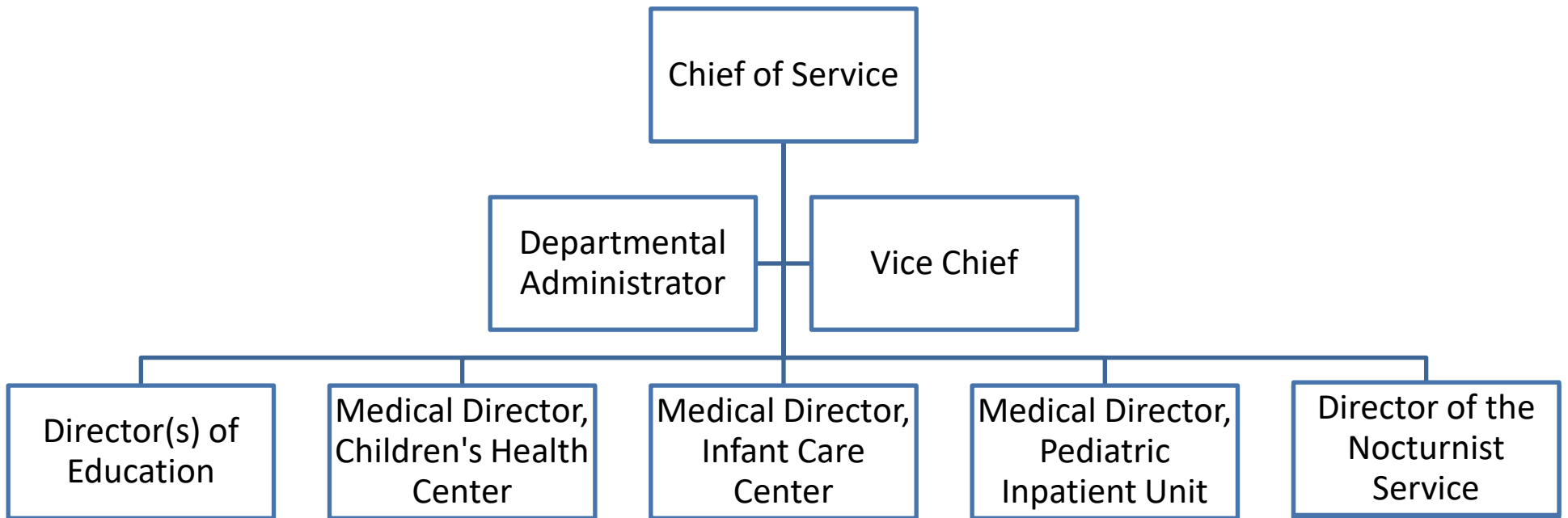
X. ADOPTION AND ADMENDMENT

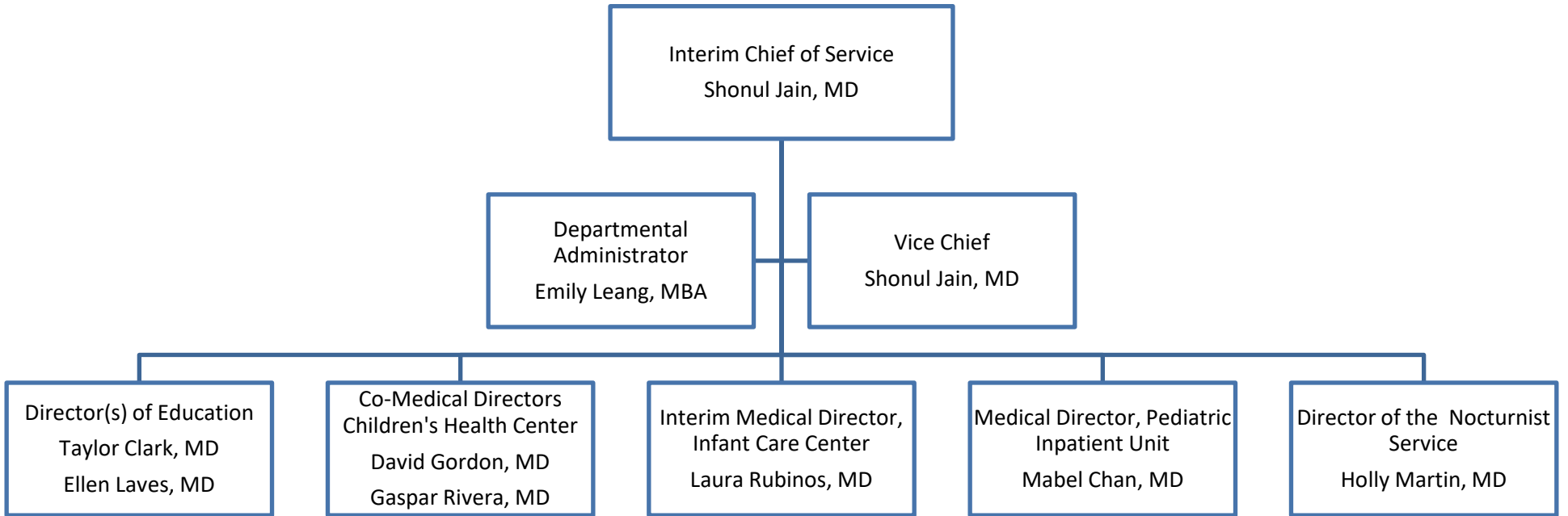
Every two years, the Pediatric departmental rules and regulations will be reviewed, revised, and adopted by a majority vote of all active members of the Pediatric department at a faculty meeting.

Appendix A

Organizational structure

Pediatric Department at the ZSFG





APPENDIX B
OFFICERS OF THE DEPARTMENT OF PEDIATRICS
JOB DESCRIPTIONS

Chief of Pediatrics

The Chief of Pediatrics directs and coordinates the department's clinical, educational, and scholarly functions, in keeping with the values, mission, and strategic plan of the Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief of Pediatrics also ensures that the department's functions are integrated with the functions of other clinical departments and with the Hospital as a whole.

Reporting relationships:

The Chief of Pediatrics reports directly to the Vice Dean and the Chair of the Department of Pediatrics at the University of California, San Francisco (UCSF). The Chief of Pediatrics is reviewed at least every four years by an *ad hoc* committee appointed by the Chief of Staff at ZSFG. Reappointment of the Chief of Pediatrics occurs upon recommendation by the Chief of Staff, in consultation with the Vice Dean, the Chair of the Department of Pediatrics at UCSF, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief of Pediatrics maintains working relationships with these persons and groups and with other clinical departments.

Position qualifications:

The Chief of Pediatrics is Board certified, has a faculty appointment at UCSF, and is a member of the active medical staff at ZSFG.

Major responsibilities:

To provide the necessary vision and leadership to effectively motivate and direct the Department of Pediatrics at the ZSFG in order to achieve the goals and objectives that are consistent with the values, mission, and strategic plan of the ZSFG and the DPH;

To collaborate with the Executive Administrator and other ZSFG leaders, develop and implement policies and procedures which support the provision of clinical services by reviewing and approving the Service's scope of service statement, review and approve the Service policies and procedures, identify new clinical services that need to be implemented, and support clinical services provided by the Department;

To collaborate with the Executive Administrator and other ZSFG leaders, participate in the operational processes that affect the Department by participating in the budgeting process, recommend the number of qualified and competent staff to provide care, evaluate space and equipment needs, select outside sources for needed services, and supervise the selection, orientation, in-service education, and continuing education of all departmental staff;

To serve as a leader for the Department's performance improvement and patient safety programs by setting performance improvement priorities, determine the qualifications and competencies of

departmental personnel who are or are not licensed independent practitioners, and maintain appropriate quality control programs;

To perform all other duties and functions specified in the ZSFG Medical Staff Bylaws.

Vice Chief of Pediatrics

The Vice Chief of Pediatrics provides leadership and oversight for Pediatric quality and compliance issues and assists the Chief of Pediatrics with other issues, as requested.

Reporting relationships:

The Vice Chief of Pediatrics reports to the Chief of Pediatrics.

Position qualifications:

The Vice Chief of Pediatrics is Board certified, has a faculty appointment at UCSF, and is a member of the active medical staff at the ZSFG.

Major responsibilities:

To provide leadership and oversight for quality and compliance for the Pediatric Department.

To assist the Chief of Pediatrics with clinical, educational, financial, personnel, or other issues, as requested.

Director(s) of Education

Reporting relationships:

The Director(s) of Education reports to the Chief of Pediatrics.

Position Qualifications:

The Director(s) of Education is a member of the active medical staff at the ZSFG.

Major responsibilities:

To provide leadership and oversight for education activities for the Department of Pediatrics, including pediatric undergraduate medical education (UME) and pediatric graduate medical education (GME).

The Director of Pediatric Undergraduate Medical Education has the following responsibilities:

- 1) Oversight of the ZSFG Pediatric Clerkship; and
- 2) Oversight of the ZSFG Sub-Internship Rotations; and

- 3) Serve on the SOM Pediatrics Grading Committee; and
- 4) Create faculty development opportunities related to medical education; and
- 5) Collaborate with the Director of Pediatric Graduate Medical Education; and
- 6) Coordinate assignments and responsibilities for all undergraduate medical education learners within ZSFG Pediatrics to ensure appropriate use of resources; and
- 7) Prepare an annual report of Pediatric UME activities for the Pediatric service and other audiences.

The Director of Pediatric Graduate Medical Education has the following responsibilities:

- 1) Collaborate with the ZSFG-based Pediatric chief residents, Residency Program leadership team, Pediatric Medical Directors, Chief of Service, Administrative leaders, and Director of Pediatric Undergraduate Medical Education on all ZSFG graduate medical education issues; and
- 2) Serve on the ZSFG GME committee; and
- 3) Coordinate ZSFG Grand Rounds scheduling with the ZSFG-based Chief Residents and administrative team; and
- 4) Support the onboarding of ZSFG cardiology fellows; and
- 5) Prepare an annual report of Pediatric GME activities for the Pediatric service and other audiences.

Medical Director Children's Health Center (CHC, Outpatient clinic)

Reporting relationships: The Medical Director of the Children's Health Center reports to the Chief of Pediatrics.

Position qualifications: The Medical Director of the Children's Health Center is Board certified and is a member of the active medical staff at the ZSFG.

Major Responsibilities:

To provide medical leadership and oversight of the Children's Health Center, assure that quality medical care is provided to all patients in the Center, and maintain appropriate standards of care.

To organize and regularly lead meetings with providers who work in the Children's Health Center, to mentor faculty and affiliated staff who work in the Children's Health Center, to work collaboratively with the Nurse Manager on all clinical, financial and administrative issues relating to the Children's Health Center, , and to participate in activities related to the ZSFG hospital priorities, DPH SFHN initiatives, , performance improvement, and quality improvement.

To organize staffing of the Children's Health Center in primary, urgent, and specialty care areas with pediatricians who evaluate and supervise ongoing care and coordinate annual staffing and personnel budget with the Chief of Pediatrics and Department Manager.

To develop policies and guidelines for medical evaluation and management of common pediatric conditions in primary, urgent, and specialty care.

To develop and implement performance improvement, patient safety and quality improvement plans for the unit, generate reports for morbidity and mortality conferences, oversee and submit appropriate data

and information for hospital PIPS and other committees, for appropriate health insurers such as San Francisco Health Plan, for the San Francisco Department of Health, the California Department of Health, and other organizations and agencies.

To identify and advocate for the programmatic, administrative, personnel, and physical needs of the Children's Health Center.

To maintain statistics for Children's Health Center activities, ascertain patient satisfaction, and monitor quality of care.

To oversee all educational and training activities in the Children's Health Center for clinicians and trainees, collaborate with ancillary services (e.g., lab, nutrition, behavioral health, social services), coordinate clinical activities with nursing and hospital administration, and work collaboratively with the nurse manager to maintain policies and procedures for the Children's Health Center.

To coordinate with the directors of other departments and other Pediatric units at the ZSFG and maintain a strong liaison and alignment with DPH leaders in the San Francisco Health Network. To actively participate in the both the DPH San Francisco Health Network primary care and ZSFG ambulatory specialty care infrastructure, including relevant meetings, initiatives, and priorities.

Medical Director, Infant Care Center

Reporting relationships:

The Medical Director of the Infant Care Center reports to the Chief of Pediatrics.

Position qualifications:

The Medical Director of the Infant Care Center is Board certified and is a member of the active medical staff at the ZSFG.

Major responsibilities:

To provide medical leadership and oversight of the Infant Care Center, assure that quality medical care is provided to all infants in the unit, and maintain appropriate standards of care.

To organize and regularly lead meetings with providers who work in the Infant Care Center, to mentor faculty who work in the Infant Care Center, to meet regularly with the Department Manager and Nurse Manager to review financial issues, and to participate in activities related to the hospital rebuild, performance improvement, quality improvement, and LEAN training.

To organize 24-hour coverage of the unit with neonatologists who evaluate all unstable infants and attend high-risk deliveries and resuscitations.

To develop policies and guidelines for medical management of common neonatal conditions and ensure appropriate post-discharge follow-up of all high risk infants.

To develop and implement performance improvement, patient safety and quality improvement plans for the Infant Care Center; to generate reports for morbidity and mortality conferences, for CCS, for CPQCC, for the San Francisco Department of Health, and the California Department of Health; to maintain a neonatal data base, including birth weight, weight-specific survival, transports, neonatal deaths, diagnoses, and complications.

To identify and advocate for the programmatic and equipment needs of the Infant Care Center.

To develop and maintain an education program for neonatal staff, oversee monthly morbidity and mortality conferences to be held jointly with Obstetrics, and provide in-service education programs.

To coordinate with the directors of other departments and other Pediatric units at the ZSFG, maintain a strong liaison with the obstetrical perinatologists and nurse midwives to develop joint protocols and problem solving, and conduct nursery liaison management meetings on a monthly basis or more frequently, if needed.

To coordinate the relationship with the regional intensive care nursery at UCSF and maintain transport and outreach education agreements.

Medical Director, Pediatric Inpatient Unit

Reporting relationships:

The Medical Director of the Pediatric Inpatient Unit reports to the Chief of Pediatrics.

Position qualifications:

The Medical Director of the Pediatric Inpatient Unit is Board certified and is a member of the active medical staff at the ZSFG.

Major responsibilities:

To provide medical leadership and oversight of the Pediatric Inpatient Unit, assure that quality medical care is provided to all patients on the unit, and maintain appropriate standards of care.

To organize and regularly lead meetings with providers who work in the Pediatric Inpatient Unit, to mentor faculty who work in the Infant Care Center, to meet regularly with the Department Manager and Nurse Manager to review financial issues, and to participate in activities related to the hospital rebuild, performance improvement, quality improvement, and LEAN training.

To organize daily supervision of the unit with pediatricians who evaluate all unstable pediatric patients and provide ongoing care to hospitalized patients.

To develop policies and guidelines for medical management of common pediatric conditions.

To develop and implement performance improvement, patient safety and quality improvement plans for the unit, generate reports for morbidity and mortality conferences, for CCS, for the San Francisco Department of Health, the California Department of Health, and other organizations and agencies.

To identify and advocate for the programmatic and equipment needs of the pediatric inpatient unit.

To develop and maintain an education program for nursing staff.

To coordinate with the directors of other departments and other Pediatric units at the ZSFG and maintain a strong liaison with public health nursing and other nursing leaders.

To develop and maintain transport agreements.

The Medical Director of the Pediatric Inpatient Unit has decision-making authority over the attending physicians who work on the unit. The attending physician on the inpatient pediatric service is responsible for providing clinical care to hospitalized pediatric patients on the inpatient and intensive care units.

Director, Nocturnist Service

Reporting relationships:

The Director of the Nocturnist Service reports to the Chief of Pediatrics.

Position qualifications:

The Director of the Nocturnist Service is Board certified and is a member of the active medical staff at the ZSFG.

Major responsibilities:

To provide medical leadership and oversight of the Nocturnist Service, assure that quality medical care is provided to all patients, and maintain appropriate standards of care.

To organize and regularly lead meetings with providers who work on the Nocturnist Service, to mentor faculty who work on the service, to meet regularly with the Department Manager and Nurse Manager to review financial issues, and to participate in hospital-based activities such as performance improvement and quality improvement.

To organize nightly staffing of the service with pediatricians who evaluate pediatric patients throughout the hospital including ICU and the Emergency Department.

To develop policies and guidelines relevant to the Nocturnist Service.

To develop and implement performance improvement, patient safety and quality improvement plans for the service, generate reports for morbidity and mortality conferences, for CCS, for the San Francisco Department of Health, the California Department of Health, and other organizations and agencies.

To identify and advocate for the programmatic and equipment needs of the service.

To develop and maintain an education program for nursing staff and faculty.

To coordinate with the directors of other departments and other Pediatric units at the ZSFG.

The Director of the Nocturnist Service has decision-making authority over the pediatricians who work on the service. The attending nocturnist is responsible for providing clinical care to hospitalized pediatric patients on all the inpatient and intensive care units and providing support to the Emergency Department.

Privileges for Zuckerberg San Francisco General Hospital & Trauma Center

Name:

Pediatrics

PEDIATRICS 2021

FOR ALL PRIVILEGES: All complication rates, including transfusions, deaths, unusual occurrence reports, patient complaints, and sentinel events, as well as Department quality indicators, will be monitored semiannually.

Requested Approved

32.10 CORE PRIVILEGES

Admit, work-up and provide treatment or consultative services to pediatric patients in the ambulatory and inpatient setting; including lumbar punctures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.11 PEDIATRIC HOSPITALIST PRIVILEGE

Admit, work-up and provide treatment or consultative services to pediatric patients in the ED and all inpatient settings. Privileges include diagnostic and therapeutic treatment interventions, and procedures, including lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics. Current PALS certification by the American Heart Association.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.20 SPECIAL PEDIATRIC PRIVILEGES

32.21 CENTRAL LINE PLACEMENT

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or Pediatric Critical Care Medicine.

PROCTORING: Review of 3 cases.

REAPPOINTMENT: Review of 2 cases.

32.21.1 PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) LINE PLACEMENT

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or a member of Service prior to 10/17/00. Documentation of additional training/experience

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

32.22 LASER SURGERY

Removal of congenital and acquired lesions (tattoos, hemangiomas, pigmented lesions)

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics. Appropriate training, completion of the laser safety module prepared by the ZSFG Laser Safety Committee and baseline eye examination within the previous 1 year.

PROCTORING: 2 observed procedures

REAPPOINTMENT: 2 cases in the previous two years

32.23 CIRCUMCISION

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics.

Documentation of additional training/experience

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

Privileges for Zuckerberg San Francisco General Hospital & Trauma Center

Name:

Pediatrics

32.24 PROCEDURAL SEDATION

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics and has completed at least one of the following:

- 1) Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- 2) Management of 10 pediatric airways via BVM or ETT per year in the preceding 2 years or,
- 3) Current BLS, NRP, or PALS certification (age appropriate) by the American Heart Association

PROCTORING: Review of 5 cases (completed training within the last 5 years)

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:

- 1) Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- 2) Management of 10 pediatric airways via BVM or ETT per year for the preceding 2 years or,
- 3) Current BLS, NPR, or PALS certification (age appropriate) by the American Heart Association

32.25 INSERTION OF INTRAUTERINE DEVICE (IUD)

PREREQUISITES: Currently board admissible, board certified or re-certified by the American Board of Pediatrics, American Board of Pediatrics in Adolescent Medicine, or special dispensation from the chief of service for equivalent training. Documentation of appropriate additional training.

PROCTORING: 2 observed procedures.

REAPPOINTMENT: 2 cases in the previous 2 years.

32.26 CARE OF NEWBORNS

Management of well and sick neonatal patients, in conjunction with the Attending Neonatologist. Includes attendance at high-risk deliveries, neonatal resuscitation and stabilization, diagnostic and therapeutic treatment, interventions, and procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics. Current NRP certification by the American Heart Association.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

Privileges for Zuckerberg San Francisco General Hospital & Trauma Center

Name:

Pediatrics

32.40 PEDIATRIC SUBSPECIALTY PRIVILEGES

Patient management, including diagnostic and therapeutic treatment, procedures, and interventions.

32.41 ADOLESCENT MEDICINE

Provide comprehensive primary preventive care, including family planning, evaluation, assessment, and management of chronic diseases common to adolescents and young adults.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Adolescent Medicine or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases. REAPPOINTMENT: Review of 3 cases.

32.42 ALLERGY AND IMMUNOLOGY

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with allergy or immunologic diseases, in the ambulatory and inpatient settings.. Core privileges include allergy skin testing and interpretation.

PREREQUISITES: Currently Board Admissible, Board Certified, Re-Certified by the American Board of Pediatrics or a subspecialty board of Pediatrics and the American Board of Allergy and Immunology or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.43 PEDIATRIC CARDIOLOGY

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with cardiovascular disease; and electrocardiography interpretation including signal averaged ECG, in the ambulatory and inpatient settings.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Pediatric Cardiology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.44 CHILD ABUSE

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with suspected child abuse, in the ambulatory and inpatient settings.. Core privileges include forensic physical and/or sexual abuse exams using colposcopy, or other photo documentation of injuries.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Child Abuse, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

Privileges for Zuckerberg San Francisco General Hospital & Trauma Center

Name:

Pediatrics

32.45 PEDIATRIC DERMATOLOGY

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with dermatologic diseases, in the ambulatory and inpatient settings.. Core privileges include skin biopsy and interpretation of results.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology in Pediatric Dermatology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.46 GENETICS

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with genetic diseases, in the ambulatory and inpatient settings..

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics and the American Board of Medical Genetics, or special dispensation from the chief of service for equivalent training or a member of the Service prior to 10/17/00.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.47 PEDIATRIC GASTROENTEROLOGY

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with gastroenterology diseases, in the ambulatory and inpatient settings..

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Pediatric Gastroenterology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.48 PEDIATRIC INFECTIOUS DISEASE

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with infectious diseases, in the ambulatory and inpatient settings..

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Pediatric Infectious Disease, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.49 NEONATOLOGY/PERINATAL

Management of critically ill newborns including diagnostic and therapeutic treatment, procedures and interventions, umbilical arterial and umbilical venous line placement, neonatal intensive care, neonatal resuscitation, ventilator management, including conventional and high-frequency ventilators, inhaled Nitric Oxide (NO), endotracheal intubation, lumbar puncture, tube thoracostomy for pneumothorax, thoracentesis, paracentesis, pericardial tube placement for pneumopericardium, surfactant administration, parenteral nutrition, bladder tap, exchange transfusion

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Neonatology.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

Privileges for Zuckerberg San Francisco General Hospital & Trauma Center

Name:

Pediatrics

32.50 PEDIATRIC NEUROLOGY

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients in the ambulatory and inpatient settings with neurology diseases.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology with special qualifications in Child Neurology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.60 ADDICTION MEDICINE

Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and currently board admissible, certified, or recertified by the American Board of Pediatrics. Approval of the Director of the Addiction Medicine Service required for all applicants.

PROCTORING: Review of 5 cases. If not board certified in addiction medicine, additional review of 3 cases of adult or pregnant patients. Review to be performed by Addiction Medicine Service Director or designee.

REAPPOINTMENT: Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

Addiction Medicine/Designee

Date

32.70 LIMITED PRIVILEGES

32.71 EXAM ONLY

The physician shall perform exams on patients for teaching purposes for residents or medical students. The physician will have no involvement in the clinical care of patients.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics.

PROCTORING: Observation of 2 teaching sessions.

REAPPOINTMENT: Observation of 2 teaching sessions.

Privileges for Zuckerberg San Francisco General Hospital & Trauma Center

Name:

Pediatrics

32.90 CTSI (Clinical and Translational Science Institute) - Clinical Research

Admit and follow pediatric patients for the purposes of clinical investigation in the inpatient or ambulatory CTSI Clinical Research Center settings.

Prerequisites: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants.

Proctoring: All OPPE metrics acceptable

Reappointment: All OPPE metrics acceptable

CTSI Medical Director

Date

Zuckerberg San Francisco General Hospital & Trauma Center

Name:

Pediatrics

I hereby request clinical privileges as indicated above.

Applicant

date

FOR DEPARTMENTAL USE:

_____ Proctors have been assigned for the newly granted privileges.

_____ Medications requiring DEA certification may be prescribed by this provider.

_____ CPR certification is required.

APPROVED BY:

Division Chief

date

Service Chief

date

Submit



Committee on Interdisciplinary Practice
Standardized Procedures Summary of Changes from **July 2023**

Standardized Procedure Name:	CPC Standardized Procedure
Department(s):	Community Primary Care (SP)
Date of last approval:	Sept 2015
Summary of SP updates:	<ul style="list-style-type: none"> • Both contraceptive implant protocols of this SP were updated to align with those in the OBGYN SP. • CIDP endorsed these revisions after recommendation received from Credentials to standardize these protocols across services. • Seeking vote to approve the changes to Protocol 8 and 9 of this SP (the entire SP not up for vote today).
Update #1:	Removed BLS maintenance standard (this is managed by HR)
Update #2:	<p>Protocol 8: Contraceptive Implant Insertion</p> <ul style="list-style-type: none"> i. All references to “removal” removed from this protocol re: in a separate protocol ii. “insertion is performed under local anesthetic using aseptic technique” language directly from the OBGYN SP iii. “time out performed per hospital policy” language directly from the OBGYN SP iv. “NP, CNM, PA” changed to “affiliated staff” v. “LCR” changed to “EMR” (note: this SP has not been revised since 2015) vi. Proctoring: changed to 3 insertions for new provider and 2 insertions for experienced; Proctor must be qualified provider; chart review all observed cases – directly from the OBGYN SP vii. Reappointment: 6 insertions every 2 years and 1 chart review every 2 years – directly from the OBGYN SP
Update #3:	<p>Protocol #9: Contraceptive Implant Removal</p> <ul style="list-style-type: none"> i. Deleted “and remains effective for 3 years” – brands vary

Standardized Procedure Name:	FCM Standardized Procedure
Department(s):	Family Community Medicine (SP)
Date of last approval:	May 2020
Summary of SP updates:	<ul style="list-style-type: none"> • Both contraceptive implant protocols of this SP were updated to align with those in the OBGYN SP. • CIDP endorsed these revisions after recommendation received from Credentials to standardize these protocols across services. • Seeking vote to approve the changes to Protocol 14 and 15 of this SP (the entire SP not up for vote today).
Update #1:	<p>Protocol 14 Insertion of contraceptive implant</p> <ul style="list-style-type: none"> i. Proctoring: changed direct observation from 2 to 3 for new provider and from 1 to 2 for experienced provider
Update #2:	<p>Protocol 15 Contraceptive Implant Removal</p> <ul style="list-style-type: none"> i. Proctoring: changed from 6 to 3 for new provider ii. Reappointment: changed from 8 to 6 and 1 chart review every 2 years

Standardized Procedure Name:	Medicine Standardized Procedure
Department(s):	Department of Medicine
Date of last approval:	Jan 2017
Summary of SP updates:	<ul style="list-style-type: none"> • Both contraceptive implant protocols of this SP were updated to align with those in the OBGYN SP. • CIDP endorsed these revisions after recommendation received from Credentials to standardize these protocols across services. • Seeking vote to approve the changes to Protocol 26 and 27 of this SP (the entire SP not up for vote today).
Update #1:	<p>Protocol 26: Contraceptive Implant Insertion</p> <ul style="list-style-type: none"> i. Proctoring: changed direct observation from 2 to 3 for new provider and from 1 to 2 for experienced provider
Update #2:	<p>Protocol 27: Contraceptive Implant Removal</p> <ul style="list-style-type: none"> i. Proctoring: changed from 6 to 3 for new provider ii. Added “Proctor must be a qualified provider” – language directly



Department of Public Health

Gabriel Ortiz, MD, PhD
Chief of Staff

London Breed

	from the Office of the Mayor SP
	iii. Reappointment: from 8 to 6 removals every 2 years and 1 chart review every 2 years



Community Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER /PHYSICIAN
ASSISTANT

These standardized procedures are for the following Primary Care Clinics:

Castro Mission Health Center
Chinatown Public Health Center
Community Health Programs for Youth
Curry Senior Center
Maxine Hall Health Center
Medical Respite and Sobering Center
Ocean Park Health Center
Potrero Hill Health Center
Silver Avenue Health Center
Southeast Health Center
Special Programs for Youth
Tom Waddell Urban Health

PREAMBLE

Title: Community Primary Care

- I. Policy Statement
 - A. It is the policy of the Community Health Network and 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 individual clinical sites within the

Community Primary Care Clinical Service 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 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.

A Certified Nursing Midwife (CNM) is a registered nurse who has had additional training in midwifery and who has met the requirements of Section 1460 of the Nurse Practice Act. The Scope of Practice of the CNM includes the care of women during the antepartal, intrapartal, postpartal, interconceptional periods, provides family planning, conducts deliveries and cares for the newborn and infant.

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 six 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 Delegation of Services Agreement (documents supervising agreement between supervising physician and PA).

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

III. Circumstances Under Which NP/CNM/PA May Perform Function

A. Setting

1. Location of practice is the various clinical sites within the Community Primary Care Service.
2. Role in each setting may include primary and urgent care in all settings.

B. Supervision

1. Overall Accountability:
The NP/CNM/PA is responsible and accountable to: the clinic Medical Director, Chief of Service, supervising physician and other supervisors as applicable.
2. A consulting attending physician, will be available to the NP/CNM/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. Acute, severe respiratory distress
 - h. An adverse response to respiratory treatment or a lack of Therapeutic response.

IV. Scope of Practice

1. Health Care Management: Primary Care
2. Health Care Management: Acute and Urgent Care
3. Health Care Management: Prenatal Care
4. Furnishing Medications and Drug Orders
5. Procedure: Arthrocentesis and Intraarticular Injections
6. Procedure: Endometrial Biopsy
7. Procedure: Incision and Drainage of Skin Abscesses
8. Procedure: Insertion of

Contraceptive Implant

9. Procedure: Removal of Contraceptive Implant
10. Procedure: Insertion of Intrauterine Device
11. Procedure: Surface Trauma and Wound Care
12. Procedure: Splinting
13. Procedure: Waived Testing
14. Procedure: Tattoo Removal

V. Requirements for the Nurse Practitioner /Certified Nurse Midwife/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. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each practice site for each PA.

B. Specialty Training

1. Specialty requirements: FNP, CNM, ANP, PNP.

Note:

Pediatric Nurse Practitioners may treat all patients up to age 21 years.

Adult Nurse Practitioners may treat all patients from age 13 and above.

Family Nurse Practitioners and Physician Assistants can treat patients of all ages.

2. At least two (2) years of Clinical Experience in specialty area desired.
- C. Evaluation of NP/CNM/PA Competence in performance of standardized procedures.
1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and/or other supervisors, as applicable will assess the NP/CNM/A's ability to practice.
 - a. Clinical Practice
 - Length of proctoring period will be 3 months and will include 5 chart reviews and 1 case of direct observation.
 - The evaluator will be the Medical Director, Chief of Service or physician designee.
 2. Bi-Annual Reappointment: Medical Director, and/or designated physician and/or supervisor must evaluate the NP/CNM/PA's appropriate clinical competency for the setting by review of 5 charts and direct observation as determined by the evaluator.
 3. 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 and/or supervisor at appropriate intervals until acceptable skill level is achieved.
 4. Ongoing:
 - 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 (e) (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.

VI. 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 its 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: Health Care Management – Primary Care

A. DEFINITION

This protocol covers the procedure for age-appropriate health care management in primary care, clinics within the Community Primary Care Clinical Service including health centers, health center satellite locations, and the Ambulatory Care Call Center. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses.

B. DATA BASE

1. Subjective Data

- a. Screening: 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.
- b. Ongoing/Continuity: review of symptoms and history relevant to the disease process or presenting complaint.
- c. Pain history to include onset, location, and intensity.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- 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 SFGH 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. Age appropriate screening tests, and /or diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- c. Immunization update.
- d. Referral to specialty clinics and supportive services, as needed.

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. Initiation or change of medication other than those in the formulary/ies.
 - f. Problem requiring hospital admission or potential hospital admission.

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

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

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). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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: 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 at health sites within the Community Primary Care Clinical Service including health centers, health center satellite locations, and the Ambulatory Care Call Center.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

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 SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes and a statement of the current status of the disease.

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.

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. Uncommon, unfamiliar, unstable, and complex patient conditions
- e. Upon request of patient, NP, PA, or physician
- f. Initiation or change of medication other than those in the formularies.
- g. Any Problem requiring hospital admission or potential hospital admission.

3. Education

Patient education should include treatment modalities.
Discharge information and instructions.

4. Follow-up

As appropriate regarding patient health status and diagnosis.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)
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 # 3: Health Care Management – Prenatal Care

A. DEFINITION

This protocol covers the procedure for the routine prenatal care of essentially healthy women. This includes the provision of comprehensive education and primary care during the prenatal and postpartum period and the promotion of a healthy pregnancy and optimal outcome in all appropriate sites within the Community Primary Care clinical service.

B. DATA BASE

1. Subjective Data
 - a. Complete appropriate history.
 - b. Symptoms relevant to the prenatal health process.
2. Objective Data
 - a. Initial prenatal visit includes a complete physical examination with sizing of uterus and fetal heart tones if at least 10 weeks.
 - b. Routine follow-up visits, the physical exam to include:
 1. Blood pressure
 2. Weight and weight gained or lost since last visit.
 3. Urinalysis at initial visit and then at every visit \geq 26 weeks gestation or prn based on risk factors.
 4. Fetal heart tones
 5. Abdominal exam for fundal height (starting at 20 wks gestation) and presentation (starting at 36 weeks).
 6. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 7. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.
 - c. Pelvic examination when indicated by history.

C. DIAGNOSIS

Assessment and diagnosis of pregnancy status, risk factors, or disease process consistent with the subjective and objective findings.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.

1. Routine prenatal labs, including but not limited to: blood type and screen, Rubella titer, CBC, hemoglobinopathy evaluation, HBsAG, RPR, HIV antibody, pap smear (if indicated), clean catch urine culture, chlamydia, gonorrhea and GBS culture.
 2. First and Second Trimester integrated genetics screening, if desired by patient
 3. Glucose Load Test (GLT) at 24 to 28 weeks Gestational Age. Do 1 hr. GLT at 1st visit if at high-risk for Diabetes (as per SFGH GDM Screening Protocol). Do a 3 hr GTT if 1 hr GLT elevated.
 4. If patient is RH Negative repeat antibody screen and order Rhogam at 28 weeks.
 5. Order and review all imaging studies as appropriate.
 - b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.
 1. Furnishing of prenatal vitamins.
 - c. Immunization update.
 - d. Referral to specialty clinics and supportive services as needed (e.g. nutritionist, social work, health education WIC).
2. Patient conditions requiring consultation as per Preamble section III b 2.
 - 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. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.
 3. Education
 - a. Normal process and progression of pregnancy.
 - b. Psychosocial issues pertinent to pregnancy, age of client and home situation.
 - c. Signs and symptoms of complications
 - d. Fetal kick counts.
 - e. Stages of labor.
 - f. Pain management during labor and delivery.
 - g. Infant nutrition: breast or formula feeding.
 - h. Postpartum family planning.

4. Follow-up (Intervals determined by risk factors)
 - a. Every 4-8 weeks until 28 weeks gestational age.
 - b. Every 2 to 4 weeks from 28 to 38 weeks gestational age.
 - c. Every week after 38 weeks gestational age.

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 of five (5%) sample of medical records of patients treated by the physician assistant within 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.

F. Management of HIV-Infected Pregnant Women at The Bay Area Perinatal Aids Center (BAYPAC)

1. Obstetric and HIV care of BAYPAC patients by the BAYPAC nurse practitioner will be co-managed by the BAYPAC attending., Reproductive Infectious Disease fellow and/or other OB attending.
2. Obstetric care will be transferred to the OB attending (with continued NP management of HIV care co-managed by the OB attending) for the following conditions:
 - a. Renal insufficiency or failure.
 - b. Heart disease, Class II or greater.
 - c. Hyperthyroidism.
 - d. Rh isoimmunization.
 - e. Uncontrolled seizure disorder.
 - f. Neoplasia.
 - g. High order multiple gestations (>2 fetuses).
 - h. Twin gestation other than dichorionic, diamniotic, concordant growth.
 - i. Acute hepatitis.
 - j. Psychiatric conditions with psychosis.
 - k. Isoimmune thrombocytopenia.
 - l. Severe anemia (hemoglobin <7, not responding to iron and nutrition therapy).
 - m. Uterine or cervical malformation or incompetence.
 - n. Significant chronic illness (i.e., lupus, RA, Crohns).
 - o. Preterm pre-eclampsia.
 - p. Severe pre-eclampsia.

3. Record Keeping
 - a. Patient visit, consent forms, and other procedure specific documents will be recorded in HERO and LCR as appropriate.

Protocol #4: 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 Delegation of Service document. Nurse practitioners and midwives 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, determine what formulary/ies will be listed for the protocol. The formulary/ies to be used are 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 SFGH 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. When ordering respiratory treatments, a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device and frequency of treatments. Patient response will be monitored and documented.
- 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 LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
 - i. location of practice
 - ii. diagnosis, illness, or condition for which medication is ordered
 - iii. 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:
 - 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 physician 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. Unexplained historical, physical or laboratory findings.
 - d. Upon request of patient, NP, PA, or physician.
 - e. Failure to improve pain and symptom management.
 - f. Acute, severe respiratory distress
 - g. An adverse response to respiratory treatment or lack of therapeutic response.
 - h. Patients on maintenance buprenorphine
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\LCR\MAR 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.

Procedure #5: Arthrocentesis and Intraarticular Injections

A. DEFINITION

This protocol covers arthrocentesis of the knee and elbow. The procedure is insertion of a needle into the joint space to aspirate fluid for analysis and/or inject medicine.

1. This procedure can be completed at any health site within the Community Primary Care Clinical Service.
2. Performance of procedure:
 - a. Indications
 - Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of the joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of this will distinguish among hemarthrosis, effusion, fracture and septic arthritis.
 - b. Precautions
 - Patients with a coagulopathy
 - c. Contraindications
 - Severe dermatitis or soft tissue infection overlying the joint.

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, allergies.
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, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.
 - d. All Point of Care Testing (POCT) will be performed according to SFGH 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. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, clinic, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. All patients requiring this procedure.

3. Education

Patients will be informed that pain relief may occur immediately due to the early onset of certain drug preparations, but the longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

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 and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisite, Proctoring and Reappointment Competency

Prerequisite

1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
2. Training will include:
 - a. Indications for procedure and treatment.
 - b. Risks and benefits of procedure and medication.
 - c. Related anatomy and physiology.
 - d. Consent process consistent with hospital policy.
 - e. Time out policy and procedure.
 - f. Wound infection and wound healing mechanisms.
 - g. Use of required equipment.
 - h. Steps in performing procedures.
 - i. Ability to interpret results and formulate follow-up plans
 - j. Ability to recognize complications

Proctoring Period

1. New provider to procedure, a minimum of 2 successful observed demonstrations.
2. Experienced provider to procedure, a minimum of 1 successful observed demonstration.
3. Explanation needed for any exceptions to minimum requirements.
4. Chart review will be done on all observed procedures.
5. Documentation of completion of training must be sent to the Medical Staff office.

Reappointment Competency Documentation

1. The evaluator will be an Attending Physician
2. Perform a minimum of 1 procedure every two years.
3. One chart review every two years.

Procedure # 6: Endometrial Biopsy

A. DEFINITION

Evaluation of the endometrium by obtaining tissue for pathological diagnosis.

1. Indications:

Women considered at increased risk for endometrial cancer (including but not limited to: abnormal uterine bleeding, endometrial cells on Pap, unopposed estrogen therapy, tamoxifen therapy) will be evaluated by endometrial biopsy as well as others requiring evaluation of endometrial tissue (infertility, infection) will be evaluated by endometrial biopsy.

2. Precautions:

Consult an MD before performing biopsies on women with extreme retroversion or anteversion of the uterus. Also, consult when the procedure requires manual dilatation of the cervix.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

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 SFGHMC 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 before procedure is performed,
- b. Diagnostic tests for purposes of disease identification.
- c. Screening tests performed as part of age-appropriate health maintenance.
- d. Biopsy tissue is sent to pathology.

- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. 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. Initiation or adjustment of medication other than those in the formularies.
 - f. 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 and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, counter sign and date a minimum of five percent (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, problems, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. SUMMARY OF PREREQUISTES, PROCTORING AND REAPPOINTMENT COMPETENCY

<p>Prerequisites:</p> <ol style="list-style-type: none"> 1. At least 6 months experience in women's health care. 2. Provider will observe a qualified provider do procedure 2 times
<p>Proctoring Period:</p> <ol style="list-style-type: none"> 1. New provider to procedure, a minimum of 2 successful observed demonstrations 2. Experienced provider to procedure, a minimum of 1 successful observed demonstrations 3. Explanation needed for any exceptions to minimum requirements 4. Two chart reviews.

Reappointment Competency Documentation:

1. The evaluator will be an attending physician.
2. Perform a minimum of 1 procedure every 2 years.
3. 1 chart review every 2 year.

Procedure #7: Incision and drainage of skin abscesses

A. DEFINITION

Incision and Drainage (I&D) of abscesses involves making an incision in the skin to draw pus from the abscess. This protocol excludes abscesses on the face, neck, perirectal and genitalia.

1. Location to be performed: For the purposes of this protocol, the procedure may be completed at all of the health care sites within the Community Primary Care Clinical Service.
2. Performance of procedure:
 - i. Indications:
 - Abscess amenable by size and location to I&D with local anesthesia
 - Known allergies/adverse reactions to material used for incision and drainage, immuneo compromised
 - ii. Precautions:
 - Large abscesses that require extensive incising or debridement
 - iii. Contraindications:
 - Deep abscesses that may require more extensive anesthesia
 - Abscesses that invade the palmar or plantar spaces
 - Suspected pseudo aneurysm must be ruled out by further diagnostic evaluation
 - iv. Exclusions:
 - Abscesses on the face, neck, perirectal area, and genitalia

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, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - c. All Point of Care Testing (POCT) will be performed according to SFGHMC 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 before procedure is performed and obtained according to hospital policy.
 - b. Explain procedure to the patient
 - c. Time out performed per hospital policy.
 - d. Diagnostic tests for purposes of disease identification.
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. 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. Initiation or adjustment of medication other than those in the formularies.
 - f. 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 and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Documentation

Prerequisite

1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
2. Procedure performed following standard medical technique according to departmental standards.
3. One year experience in wound care.
4. Training will include:
 - a. Indications for procedure and treatment
 - b. Risks and benefits of procedure and medications

- c. Related anatomy and physiology
- d. Consent process consistent with hospital policy
- e. Wound infection and healing mechanisms
- f. Use of required equipment
- g. Steps in performing procedure
- h. Ability to interpret results and formulate follow up plans
- i. Ability to recognize complications

Proctoring Period

1. New provider to procedure will have a minimum of 2 successful observed demonstrations.
2. Experienced provider to procedure will have a minimum of 1 successful observed demonstration.
3. Explanation will be needed for exceptions to the minimum requirements.
4. Documentation of training or experience will be sent to the Medical Staff Office.

Reappointment Competency Documentation

1. The evaluator will be an Attending Physician
2. Perform a minimum of 1 procedure every 2 years.
3. 1 chart review every 2 years.

Procedure #8: Procedure: Insertion of Contraceptive Implant

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm via a preloaded inserter. Insertion is performed under local anesthetic using aseptic technique.

1. Location to be performed: This procedure can be completed at all Community Primary Care clinical sites.

2. Performance of procedure:

Indications:

a. A woman desires long acting, reversible contraception.

b. Precautions:

i. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.

ii. May have drug interactions with anti-HIV medications and some herbal products.

iii. See drug precautions/interactions in implant prescribing information.

c. Contraindications:

i. Known or suspected pregnancy

ii. Current or past history of thrombotic disease

iii. Hepatic tumors, active liver disease

iv. Known, suspected or history of breast cancer

v. Undiagnosed abnormal genital bleeding

vi. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective data

a. History and review of symptoms relevant to implant insertion, including sexual history to rule out preexisting pregnancy.

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

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, including a negative pregnancy test.

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify if patient is eligible for implant insertion/~~removal~~.

D. PLAN

1. Therapeutic treatment plan

a. Patient consent obtained before procedure is performed.

a-b. Time out performed per hospital policy.

b-c. Timing of insertion: see prescribing information.

c-d. Implant inserted/~~removed~~ as described in prescribing information.

d-e. Initiation or adjustment of medication per furnishing/drug orders protocol.

e-f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring attending consultation

a. Difficult insertions/removals.

b. Acute decompensation of patient situation.

c. Upon request of patient, ~~NP, CNM, PA affiliated staff~~, or physician

3. Education

Discharge information and instructions for care of site, expectant side effects, precautions and urgent/emergent symptoms.

4. Follow-up

As appropriate for implant insertion procedure.~~removal~~.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and ~~LCR-EMR~~ as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of prerequisites, proctoring, and reappointment competency

Prerequisites: 1. Completion of a company sponsored training program
Proctoring period: 1. For a new provider to procedure, Performance of a minimum of 2 <u>3</u> successful observed demonstrations of insertions <u>for a new provider and 2 insertions for a provider who has prior experience with independent insertion.</u>

~~2. For an experienced provider to pro a minimum of 1 successful observed demonstration of an implant insertion.~~

2. Proctor must be a qualified provider

2.3. Chart review of all observed cases.

Reappointment competency documentation:

1. 1. Performance of 4 6 insertions every 2 years and

1.2. 1 chart review of an insertion every two years.

Protocol #9: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm ~~and remains effective for 3 years~~. Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within the OB/GYN service.
2. Performance of procedure:
 - a. Indications
Woman desires removal of implant or implant is expired.
 - b. Precautions: See prescribing information.
 - c. Contraindications: See prescribing information.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - c. All Point of Care Testing (POCT) will be performed according to SFGH 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 before procedure is performed and obtained according to hospital policy.
 - b. Diagnostic tests for purposes of disease identification.
 - c. Timing of removal: See prescribing information
 - d. Removal: as described in prescribing information
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

- f. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring consultation as per Preamble, section IIIb2.
 - a. Acute decompensation of patient situation.
 - b. Difficult Implant removal.
 - c. Upon request of patient, affiliated staff or physician
 - d. If patient desires removal and rod is not readily palpable.
 3. Education
Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.
 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 and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Completion of a company sponsored training class
Proctoring period: a. Performance of a minimum of 3 removals for a new provider and 2 removals for a provider who has prior experience with independent removal. b. Proctor must be a qualified provider. c. Chart review of all observed cases
Reappointment Competency Documentation: a. Performance of 4 removals every 2 years.

b. 1 chart review needed every two years.

Procedure #10: Procedure: Insertion of Intrauterine Device

A. DEFINITION

Intrauterine devices offer a highly effective, safe, long-term contraception.

1. Indications: Patient desires intrauterine device.
2. Precautions:
 - a. Abnormalities of the uterus resulting in distortion of the uterine cavity
 - b. Postpartum endometritis or postabortal endometritis in the past 3 months
3. Contraindications:
 - a. Pregnancy or suspicion of pregnancy
 - b. Acute pelvic inflammatory disease or current behavior suggestion of a high risk for pelvic inflammatory disease
 - c. Known or suspected uterine or cervical malignancy
 - d. Genital bleeding of unknown etiology
 - e. Mucopurulent cervicitis
 - f. Wilson's disease (for Paraguard IUD (TM))
 - g. Allergy to any component of Paraguard IUD™
 - h. A previously placed IUD that has not been removed

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
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 SFGHMC 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 before procedure is performed,
 - b. Timeout performed per hospital policy
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - e. 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/CNM/PA, or physician
 - e. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.

3. Education
 - a. Discharge information and instructions.

4. Follow-up
 - a. As appropriate for procedure performed.

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). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5) per cent 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.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

1. Prior experience or training required for this procedure.
2. 6 months experience in women's health care.
3. Review of departmental policies and procedures.

Proctoring:

1. Direct observation of 2 successful insertions by a qualified provider.
2. Documentation of training course completion.

Reappointment Competency Documentation:

1. Performance of one procedure every 2 years.
2. One chart review every 2 years.

Procedure # 11: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the Community Primary Care Clinical Service that are beyond simple cuts and abrasions. These wounds may require local anesthesia and suturing.

1. Location to be performed: this procedure can be completed any all health sites within the Community Primary Care Clinical Service.
2. Performance of procedure/minor surgery:
 - a. Indications: This protocol covers patients presenting to the Community Primary Care Service for assessment and treatment of lacerations, avulsions, bites and stings, burns and abscesses.
 - b. Precautions
 - Immunocompromised patients.
 - c. Contraindications:
 - Wound infection
 - Wound that has remained open for longer than six (6) hours.
 - Lacerations to the hand greater than 6 hours old.
 - Vascular compromise or cases when direct pressure does not stop bleeding.
 - Wounds requiring large areas of debridement or excision prior to closure.
 - Wounds with bone fragments involved.
 - Wounds with tendon, ligament, vessel or nerve involvement.
 - Head lacerations where galea disruption is greater than 2 cm.
 - Facial lacerations with cosmetic considerations (i.e., eyelids and vermillion borders).
 - Lacerations penetrating into joints.
 - Patients requiring conscious sedation.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.

- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, tetanus prophylaxis history, current medications, allergies.

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. Appropriate motor, sensory and vascular exam of the involved area according to the departmental resources (i.e. specialty guidelines).
- d. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- e. All Point of Care Testing (POCT) will be performed according to SFGHMC 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. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. 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. Upon request of patient, nurse practitioner, physician assistant, or physician
- d. Initiation or change of medication other than those in the formulary(ies)
- e. 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 and LCR as appropriate.

For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five percent (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 patients.

F. SUMMARY OF PREREQUISITES, PROCTORING AND REAPPOINTMENT COMPETENCY

<p>Prerequisite</p> <ol style="list-style-type: none"> 1. New provider will attend a wound care/suturing course or lab at AN outside facility or through SFGH. 2. Training will Include: <ol style="list-style-type: none"> a. Indications for procedure and treatment b. Risks and benefits of procedure c. Related anatomy and physiology d. Consent process consistent with hospital policy e. Time out process consistent with hospital policy f. Wound infection and wound healing mechanisms g. Use of required equipment h. Steps in performing procedure i. Ability to recognize complications.
<p>Proctoring Period</p> <ol style="list-style-type: none"> 1. New provider to procedure, a minimum of 2 successful observed demonstrations. 2. Experienced provider to procedure, a minimum of 1 successful observed demonstration. 3. Explanation needed for any exceptions to minimum requirements. 4. Documentation of completion of training must be sent to the medical staff office
<p>Reappointment Competency</p> <ol style="list-style-type: none"> 1. Evaluator will be the Medical Director, Physician-in-Charge or other attending physician.

2. Must perform wound care/suturing a minimum of 1 time every two years.
3. One chart review every two years.

Procedure #12: Splinting

A. DEFINITION

Splinting involves the immobilization of joints and/or limbs or appendages to stabilize and protect fractures, and/or to provide comfort for patients with fractures, sprains, or other musculoskeletal injuries.

1. Location to be performed: This procedure may be completed at all health care sites within the Community Primary Care Clinical Service.
2. Performance of procedure:
 - a. Indications: fractures, sprains, tendon injuries, other musculoskeletal injuries and conditions for which splinting may be part of the standard of care for treatment
 - b. Precautions: known allergies/adverse reactions to materials used for splinting
 - c. Contraindications: open fractures, otherwise complicated fractures or other musculoskeletal conditions, coagulation disorder

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, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - c. All Point of Care Testing (POCT) will be performed according to SFGH POCTMC 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. Explain procedure to the patient.
 - d. Diagnostic tests for purposes of disease identification.

- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician, specialty clinics, and supportive services, as needed.
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 in the formulary (ies)
 - f. 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 and LCR as appropriate.

For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites

1. Procedure performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
2. Training will include:
 - a. Indications for procedure and treatment
 - b. Risk and benefits of procedure
 - c. Related anatomy and physiology
 - d. Obtain Consent consistent with hospital policy
 - e. Perform a time Out consistent with hospital policy.
 - f. Use of required equipment

- g. Steps in performing procedure
- h. Ability to interpret results and formulate follow up plans.
- i. Ability to recognize complications.

Proctoring Period

1. New provider to procedure, a minimum of 2 successful observed demonstrations.
2. Experienced providers to procedure, a minimum of 1 successful observed demonstration.
3. Explanation needed for any exceptions to minimum requirements.
4. Documentation of completion of training must be sent to the Medical Staff Office.

Reappointment Competency Documentation

1. The Medical Director, Physician-in-Charge or other attending physician shall be the evaluator.
2. Perform 1 procedure every two years.
3. 1 Chart review every two years.

Procedure #13: Waived Testing

A. DEFINITION

Waived testing relates to common laboratory tests that do not involve an instrument and are typically performed by providers at the bedside or point of care.

- 1) Location where waived testing is to be performed: any in- or outpatient location providing emergency or primary care
- 2) The following non-instrument based waived tests are currently performed at SFGH:
 - a. Fecal Occult Blood Testing (Hemocult ®)
Indication: Assist with detection or verification of occult blood in stool.
 - b. Vaginal pH Testing (pH Paper)
Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.
 - c. SP® Brand Urine Pregnancy
Indication: Assist with the diagnosis of pregnancy.
 - d. Chemstrip® Urine Dipstick
Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

- 1) Subjective Data
Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed
- 2) Objective Data
Each waived test is performed in accordance with approved SFGH policies and procedures specific for each test as well as site-specific protocols and instructions for:
 - a. Indications for testing
 - b. Documentation of test results in the medical record or LCR
 - c. Actions to be taken (follow-up or confirmatory testing, Attending consultation, referrals) based on defined test results.
 - d. Documentation or logging of tests performed

C. DIAGNOSIS

Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.

D. PLAN

1. Testing

- a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
- b. Use gloves and other personal protective equipment, as appropriate.
- c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.

Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.

- a. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?

2. Test Results requiring Attending Consultation

Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

3. Education

- a. Inform patient of test results and need of additional tests, as necessary

4. Follow-up

- a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

Test and control results will be recorded in the medical record as per site-specific protocols (may be in paper charts or entered in electronic data bases).

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,

Proctoring:

Successful completion of Halogen quizzes for each of the waived tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module.

Reappointment Competency Documentation:

Renewal required every two years with documentation of successful completion of the required Halogen quizzes. Provider must have passed each required module with a score of 80%.

Any additional comments: N/A

Procedure #14: Tattoo Removal

A. DEFINITION

The removal of a tattoo (or multiple tattoos) from a patient's skin using the medlite CB laser. The treatment is always conducted in conjunction and consultation with a laser technician from PRI, the company which rents the laser to the City and County of San Francisco. Treatment is scheduled every six to eight weeks, until such time as the desired cosmetic outcome is achieved or complications arise requiring the cessation, suspension, or modification of therapy.

1. Location to be performed: San Francisco General Hospital and Trauma Center and affiliated SFDPH ambulatory settings.
2. Performance of procedure:
 - a. Indications:
 1. The presence of one or more tattoos on the patient's skin, with a primary focus on gang-related tattoos or tattoos which convey gang-affiliation, especially in areas not usually covered by clothing (face, neck, hands, forearm's etc.)
 - b. Precautions:
 1. A health screening questionnaire is completed by all program participants prior to acceptance into the program.
 2. Providers check in with patients prior to each treatment session.
 3. Extensive post-treatment counseling regarding after-care is conducted following each treatment session, along with any supplies needed to properly care for the treatment site.
 - c. Contraindications:
 1. Immunodeficiency
 2. Pregnancy
 3. Acute intoxication
 4. Open wounds at or near treatment site
 5. Acute infection at or near treatment site.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to tattoo removal
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data
 - a. Physical exam appropriate to tattoo removal.
 - b. The tattoo removal is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

C. DIAGNOSIS

Assessment of subjective and objective data to identify eligibility for tattoo removal.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed.
 - b. Time out performed.
 - c. Diagnostic tests for purposes of disease identification.
 - 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.
4. Follow-up
Six to eight weeks following treatment or as needed to address any concerns or complications.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

- a. Observation of twenty five tattoo removal clinic sessions.
Completion of the laser safety module prepared by the SFGH Laser Safety Committee and baseline eye examination within the previous 1 year.

Proctoring Period:

- a. 10 cases by a provider with active privilege for tattoo removal or who has met proctoring and reappointment competency requirements as outlined in the SP.

Reappointment Competency Documentation:

- a. Completion of 5 procedures every 2 years.
- b. Completion of 5 chart reviews every 2 years.



**Zuckerberg San Francisco San Francisco General Hospital
Committee on Interdisciplinary Practice**

**STANDARDIZED PROCEDURES
NURSE PRACTITIONER / PHYSICIAN ASSISTANT
Family and Community Medicine**

PREAMBLE

Title: FAMILY COMMUNITY MEDICINE

I. Policy Statement

- A. It is the policy of the Community Health Network and 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, Physician Assistants, Certified Nurse Midwives, 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 all appropriate sites with the FCM department.

II. Functions to Be Performed

The following standardized procedures are formulated as process protocols to explain the overlapping functions performed by the NP/PA in their practice. Each practice area will vary in the functions that will be performed, such as primary care in a clinical setting or inpatient care on 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 (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 the Physician Assistant Practice Agreement.

The NP/PA conducts 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 all appropriate sites within the FCM department.
2. Role in each setting may include primary care, urgent care services in all settings and inpatient care in the Skilled Nursing Facility and inpatient units.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to: the Physician-in-Charge or the Medical Director at each site, and the Chief of Service of Family and Community Medicine, or other designated physician.
2. A consulting physician, who may include attending physicians or chief residents, 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 specific 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, 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 condition.
- h. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.
- i. An adverse response to respiratory treatment, or a lack of therapeutic response.

IV. Scope of Practice

Protocol #1: Acute/Urgent Care

Protocol #2: Primary Care

Protocol #3: Prenatal Care

Protocol #4: Discharge of Inpatients

Protocol #5: Furnishing Medications/Drug Orders

Protocol #6: Procedure: Surface Trauma and Wound

Protocol #7: Procedure: Splinting

Protocol #8: Procedure: Incision and Drainage of Abscess

Protocol #9: Procedure: Arthrocentesis and Intraarticular Injections

Protocol #10: Procedure: Nail Debridement

Protocol #11: Procedure: Nail Removal/Matrisectomy

Protocol #12: Procedure: Insertion of Intrauterine Device

Protocol #13: Procedure: Endometrial Biopsy

Protocol #14: Procedure: Contraceptive Implant Insertion

Protocol #15: Procedure: Contraceptive Implant Removal

Protocol #16: Procedure: Skin Biopsy

Protocol #17: Procedure: Trigger Point Injection

Protocol #18: Procedure: Waived Testing

Protocol #19: Procedure: Paracentesis

Protocol #20: Procedure: Lumbar Puncture

Protocol #21: Procedure: Ordering Blood Transfusions

Protocol #22: Procedure: Thoracentesis

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

1. Active California Registered Nurse, Nurse Practitioner, or Physician Assistant license.
2. Successful completion of a program which conforms to 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. Maintenance of certification of American Heart Association Basic Life Support for Healthcare Providers (BLS-HCP)
5. Possession of a National Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates on file in the Medical Staff Office.
7. Furnishing Number and DEA Number.
8. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center Physician Assistant Practice Agreement.

B. Specialty Training

1. Adult or Family Medicine
2. At least two (2) years of clinical experience in specialty area desired.

C. 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 will assess the NP/PA's ability to practice.

a. Clinical Practice

- Length of proctoring period will be three months, which can be shortened or lengthened on a case by case basis, to complete five (5) chart reviews.
- The evaluator will be the Physician-in-Charge, Medical Director, or other designated clinician.
- The method of evaluation in clinical practice will be five (5) chart reviews and direct observations, with at least one case representing each core protocol (health care management acute/urgent care, health care maintenance: primary care, health care maintenance: prenatal care, discharge of inpatients, and furnishing medications/drug orders if applicable). Additional proctoring requirements are specified in the remaining protocols.

2. Biennial Reappointment:

Physician-in-Charge, Medical Director or designated clinician will evaluate the NP/PA's competence through five (5) chart reviews, with at least one case representing each core protocol (health care management acute/urgent care, health care maintenance:

primary care, health care maintenance: prenatal care, discharge of inpatients, and furnishing medications/drug orders if applicable). Additional requirements are specified in the remaining protocols.

3. Follow-up:
Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Physician-in-Charge, Medical Director or clinician designee at appropriate intervals until acceptable skill level is achieved.

VI. 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 procedure will be reviewed every three years by the NP/PA and the Physician-in-Charge or 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, and problems involving workers' compensation claims. This Protocol will be performed in the all appropriate sites within the FCM department.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

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, and 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.

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. 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

Patient education including treatment modalities.
Discharge information and instructions.

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.

Protocol #2: Health Care Management – Primary Care/Inpatient Units

A. DEFINITION

This protocol covers the procedure for age-appropriate health care management in primary care, and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses. This protocol will be performed at all appropriate sites within the FCM department.

B. DATA BASE

1. Subjective Data

- a. Screening: 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.
- b. Ongoing/Continuity: review of symptoms and history relevant to the disease process or presenting complaint.
- c. Pain history to include onset, location, and intensity.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- 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 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. Age appropriate screening tests, and /or diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- c. Immunization update.
- d. Referral to specialty clinics and supportive services, as needed.

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. Initiation or change of medication other than those listed in or approved by the formulary/ies.
- Problem requiring hospital admission or potential hospital admission.

3. Education

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

4. Follow-up

As indicated and appropriate to patient health status and diagnosis.

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).

Protocol #3: Health Care Management; Prenatal Care

A. DEFINITION

This protocol covers the procedure for the routine prenatal care of essentially healthy women. This includes the provision of comprehensive education and primary care during the prenatal and postpartum period and the promotion of a healthy pregnancy and optimal outcome. This protocol will be performed at all appropriate sites within the FCM department.

B. DATA BASE

1. Subjective Data
 - a. Complete appropriate history.
 - b. Symptoms relevant to the prenatal health process.
2. Objective Data
 - a. Initial prenatal visit includes a complete physical examination with sizing of uterus at presentation and fetal heart tones if at least 10 weeks.
 - b. Routine follow-up visits, the physical exam to include:
 1. Blood pressure
 2. Weight and weight gained or lost since last visit.
 3. Urinalysis as indicated
 4. Fetal heart tones
 5. Abdominal exam for fundal height (starting at 20 weeks gestation) and presentation (starting at 34 weeks).
 6. Presence of edema generalized or dependent.
 7. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 8. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.
 - c. Pelvic examination when indicated by history.

C. DIAGNOSIS

Assessment and diagnosis of pregnancy status, risk factors, or disease process consistent with the subjective and objective findings.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Age appropriate screening tests, and /or diagnostic tests for purposes of disease identification.
 1. Routine prenatal labs, including but not limited to: blood type and screen, Rubella titer, CBC, HBsAg, RPR, HIV antibody, pap smear, clean catch urine culture, chlamydia, and gonorrhea, GDM screening and GBS culture. If indicated VZV titer and TB screening.

2. First and Second Trimester integrated genetics screening, if desired by patient
 3. Glucose Load Test (GLT) at 24 to 28 weeks gestational age. Do 1 hr. GLT at 1st visit if at high-risk for Diabetes (as per ZSFG GDM Screening Protocol). Do a 3 hr GTT if 1 hr GLT elevated.
 4. If patient is Rh negative repeat antibody screen and order RhoGAM at 28 weeks or earlier if vaginal bleeding.
 5. Order and review all imaging studies as appropriate.
 - b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.
 1. Furnishing of prenatal vitamins.
 - c. Immunization update.
 - d. Referral to specialty clinics and supportive services as needed (e.g. nutritionist, social work, health education, WIC).
2. Patient conditions requiring physician consultation:
- a. Maternal Conditions
 1. Pelvic mass noted by a physical exam or ultrasound. A corpus luteum cyst of 3.0 cm or less noted on ultrasound is a normal finding in the first trimester and does not need referral.
 2. Uterine malformations or lesions that would preclude a vaginal delivery (e.g., a myoma in the lower uterine segment that obstructs the endocervical canal). Certain uterine malformations are associated with miscarriage and preterm delivery. For these patients, consultation should be obtained after the first visit. Patients with large fibroids in the lower uterine segment should be seen at 32-34 weeks to discuss delivery plans.
 3. Selected maternal infections with potential fetal sequelae (i.e.: toxoplasmosis, cytomegalovirus, rubella, parvovirus, syphilis, severe primary herpes, HIV).
 4. Recurrent pyelonephritis (more than one episode during pregnancy) or recurrent urinary tract infections (more than three during pregnancy despite antibiotic prophylaxis).
 5. Nephrolithiasis
 6. Persistent proteinuria (+1 or greater on a clean catch) in the absence of a urinary tract infection. A 24-hour urine for protein, serum creatinine and an urinalysis with microscopy should be obtained prior to consultation.
 7. Persistent severe anemia with hematocrit less than 28% despite iron therapy.
 8. History of thromboembolic disease regardless of etiology.
 9. Hypothyroidism and hyperthyroidism

10. Preconceptional counseling (type I or Type II diabetics or any maternal disease that could be exacerbated by pregnancy, e.g., SLE,)
 11. Seizure disorder which is well controlled on medications.
 12. Blood pressure greater than 130/80 or if significant change from baseline in systolic or diastolic blood pressure.
- b. Fetal Conditions
1. Suspected IUGR with ultrasound EFW less than or equal to the 10th percentile. Start antenatal testing the same day of diagnosis (if gestational age is greater than 26 weeks). A marked drop off in growth or poor interval growth on interval ultrasound should also be referred for consultation, even if percentile is still above the 10th percentile.
 2. Fetal macrosomia with EFW greater than 95th percentile on ultrasound.
 3. Oligohydramnios (AFI less than or equal to 5) client needs to be seen for OB consultation the same day (usually at the Birth Center).
 4. Polyhydramnios noted on ultrasound (AFI greater than or equal to 24).
 5. Any fetal structural abnormality detected by ultrasound. A level 2 ultrasound should be obtained if not already done.
 6. Presence of antibodies to C, c, D, Kell, E, e or Duffy. Please call the OB attending or the lab medicine resident at ZSFG for rarer or unusual antibodies that you may have questions about.
- c. Obstetrical History
1. Recurrent pregnancy loss (history of three or more spontaneous abortions (SABs) if under age 35, two or more SABs if over age 35). Ideally, refer for preconceptional counseling or after initial visit if already pregnant.
 2. History of preterm birth, refer to High Risk OB.
 3. History of cesarean section. Refer to High Risk OB if undocumented or classical scar, or if two or more prior cesarean sections.
- d. Refer to HROB referral guidelines for further conditions requiring consultation from an OB or transfer of care.
3. Education
- a. Normal process and progression of pregnancy.
 - b. Psychosocial issues pertinent to pregnancy, age of client and home situation.
 - c. Signs and symptoms of complications
 - d. Fetal kick counts.
 - e. Stages of labor.

- f. Pain management during labor and delivery.
- g. Infant nutrition: breast or formula feeding.
- h. Postpartum family planning.
- i. Antenatal testing when indicated.

- 4. Follow-up (Intervals determined by risk factors)
 - a. Every 4 weeks until 28 weeks gestational age.
 - b. Every 2 weeks from 28 to 36 weeks gestational age.
 - c. Every week after 36 weeks gestational age.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

Protocol #4: Discharge of Inpatients

A. DEFINITION

This protocol covers the discharge of inpatients from ZSFG. Directive to discharge patient will be from the attending physician in charge.

B. DATA BASE

1. Subjective Data

- a. Review: health 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 of subjective and objective data and medical diagnoses, ensure that appropriate treatments have been completed, identify clinical problems that still require follow-up and that 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.

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.

3. Education

- a. Review inpatient course and what will be needed for 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.

PROTOCOL #5: 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.

Nurse practitioners may order Schedule II-V controlled substances when in possession of a DEA number. Schedule II-III controlled substances may be ordered for, but not limited to, the following conditions: patients presenting with acute and chronic pain and patients presenting with ADHD or other mental health-related disorders requiring the use of controlled substance II medications. 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.

These formularies include ZSFG/ Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal (including Contract Drug List and formularies of managed care Medi-Cal plans), AIDS Drug Assistance Program, Anthem Blue Cross, Blue Shield, California Care, Pacific Care, Health Net, Healthy Families, United Healthcare, and Medicare Part D formularies.

This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

1. DATA BASE

1. Subjective Data

- a. 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.

2. 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. When ordering respiratory treatments a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device, and frequency of treatments. Patient response will be monitored and documented.
- c. Nurse Practitioners/PA may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the electronic health record (EHR). 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, quantity, amount 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., NP furnishing no. and DEA no. if applicable

2. Patient conditions requiring 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 or approved by the formulary (ies)
 - f. Problem requiring hospital admission or potential hospital admission
 - g. Uncommon, unfamiliar, unstable, and complex patient conditions
 - h. When requesting specialty consultation
 - 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.
 - j. Acute, severe respiratory distress
 - k. An adverse response to respiratory treatment, or lack of therapeutic response.
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 information from patient visits will be recorded in the medical record/ MAR as appropriate.

Protocol # 6: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the Family Community Medicine care sites.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications: This protocol covers patients presenting to FCM for assessment and treatment of lacerations, abrasions, avulsions, bites and stings, burns and abscesses.
 - b. Precautions
 - Immunocompromised patients.
 - c. Contraindications:
 - Wound infection
 - Noninfected wound caused by clean object that has remained open for longer than eighteen (18) hours (or twenty-four [24] hours for head wounds).
 - Vascular compromise or cases when direct pressure does not stop bleeding.
 - Wounds requiring large areas of debridement or excision prior to closure.
 - Wounds with bone fragments involved.
 - Wounds with tendon, ligament, vessel or nerve involvement.
 - Head lacerations where galea disruption is greater than 2 cm.
 - Facial lacerations with cosmetic considerations (i.e., eyelids and vermillion borders).
 - Lacerations penetrating into joints.
 - Patients requiring conscious sedation.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, tetanus prophylaxis history, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.

- b. Appropriate motor, sensory and vascular exam of the involved area 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 Admin 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. The procedure is performed following standard medical technique.
- d. Diagnostic tests for purposes of disease identification.
- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. 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. Upon request of patient, nurse practitioner, physician assistant, or physician
- d. Initiation or change of medication other than those listed in or approved by the formulary(ies)
- e. 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

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

1. New practitioner will attend a wound care/suturing course or lab (at outside facility or through ZSFG).
2. Training will Include:
 - a. Indications for procedure and treatment
 - b. Risks and benefits of procedure
 - c. Related anatomy and physiology
 - d. Consent process consistent with hospital policy
 - e. Time out process consistent with hospital policy
 - f. Wound infection and wound healing mechanisms
 - g. Use of required equipment
 - h. Steps in performing procedure
 - i. Ability to recognize complications.

Proctoring Period

1. New practitioner to procedure, a minimum of 2 successful observed demonstrations. Chart review of all observed cases.
2. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstration. Chart review of all observed cases.
3. Explanation needed for any exceptions to minimum requirements.
4. Documentation of completion of training: orientation checklist, wound care lab letter, documentation of chart reviews.

Reappointment Competency Documentation

1. Evaluator will be the Medical Director, Physician-in-Charge or designated physician.
2. Ongoing competency evaluation:
 - a. Must perform wound care/suturing a minimum of 1 times every 2 years.
 - b. One charts review needed to monitor competency every 2 years.

PROTOCOL #7: Procedure: Splinting

A. DEFINITION

Splinting involves the immobilization of joints and/or limbs or appendages to stabilize and protect fractures, and/or to provide comfort for patients with fractures, sprains, or other musculoskeletal injuries.

1. Location to be performed: At all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications: fractures, sprains, tendon injuries, other musculoskeletal injuries and conditions for which splinting may be part of the standard of care for treatment
 - b. Precautions: known allergies/adverse reactions to materials used for splinting
 - c. Contraindications: open fractures, otherwise complicated fractures or other musculoskeletal conditions, coagulation disorder

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, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 Administration 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. Explain procedure to the patient.
 - d. Diagnostic tests for purposes of disease identification.

- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician, specialty clinics, and supportive services, as needed.
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
 3. Education
Discharge information and instructions.
 4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

1. Procedure performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
2. Training will include:
 - a. Indications for procedure and treatment
 - b. Risk and benefits of procedure
 - c. Related anatomy and physiology
 - d. Obtain Consent consistent with hospital policy
 - e. Perform a Time Out consistent with hospital policy.
 - e. Use of required equipment
 - f. Steps in performing procedure
 - g. Ability to interpret results and formulate follow up plans.
 - h. Ability to recognize complications.

Proctoring Period

1. New practitioners to procedure, a minimum of 2 successful observed demonstrations. Chart review of observed cases.

2. Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstration. Chart review of observed cases
3. Explanation needed for any exceptions to minimum requirements.
4. Documentation of completion of training must be sent to the Medical Staff Office.

Reappointment Competency Documentation

1. The Medical Director, Physician-in-Charge, attending physician or other designated physician shall be the evaluator.
2. Ongoing competency evaluation
 - a. Practitioner shall complete 1 procedure every 2 years.
 - b. 1 Chart review of procedure must be completed every 2 years.

PROTOCOL # 8: Procedure: Incision and Drainage (I&D) of Abscess

A. DEFINITION

Incision and Drainage (I&D) of an abscess involves making an incision in the skin in order to drain pus from an abscess. This protocol excludes abscesses on the face, neck, perirectal area and genitalia.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications: abscess amenable by size and location to I&D with local anesthesia
 - b. Precautions: known allergies/adverse reactions to materials used for incision and drainage, immunocompromised patients
 - c. Contraindications: location near major blood vessels, nerves, or other significant anatomical structures that involve palmar or plantar spaces; location or large size of abscess necessitating I&D performed in an operating room under general anesthesia, and/or by specialist; coagulation disorder.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Obtain Patient consent consistent with hospital policy before procedure is performed.
 - b. Explain procedure to the patient.
 - c. Time Out performed per hospital policy.

- d. Diagnostic tests for purposes of disease identification.
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. 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. Upon request of patient, nurse practitioner, physician assistant, or physician
 - d. Initiation or change of medication other than those listed in or approved by the formulary(ies)
 - e. 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

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisite, Proctoring and Reappointment Competency Documentation

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

1. Procedure performed following standard medical technique according to departmental standards.
2. One year experience in wound care.
3. Training will include:
 - a. Indications for procedure and treatment
 - b. Risks and benefits of procedure and medications
 - c. Related anatomy and physiology
 - d. Consent process consistent with hospital policy
 - e. Wound infection and healing mechanisms
 - f. Use of required equipment
 - g. Steps in performing procedure
 - h. Ability to interpret results and formulate follow up plans
 - i. Ability to recognize complications

Proctoring

1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations.
2. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration.
3. Explanation will be needed for exceptions to the minimum requirements.
4. Documentation of training or experience will be sent to the Medical Staff Office.

Reappointment Competency Documentation

1. Medical Director, Physician-in-Charge, attending physician or designated physician shall be the proctor.
2. Ongoing competency evaluation
 - a. Completion of 1 procedure every 2 years.
 - b. 1 chart review every 2 years.

PROTOCOL # 9: Procedure: Arthrocentesis and Intra-articular Injections

A. DEFINITION

This protocol covers arthrocentesis of the knee and elbow (and injection of corticosteroids and/or xylocaine preparations for pain relief). This procedure is insertion of a needle into the joint space (the tendon sheath, bursa or carpal canal) to aspirate fluid for analysis and/or inject medicine.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications:

Acute and chronic inflammatory musculoskeletal diseases/disorders such as osteoarthritis, tenosynovitis, bursitis, and entrapment neuropathies.

Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of this will distinguish among hemarthrosis, effusion, fracture and septic arthritis.

- b. Precautions:

Patients with a coagulopathy
 - c. Contraindications:

Severe dermatitis or soft tissue infection overlying the joint or acute trauma.

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, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated.
 - c. All Point of Care Testing (POCT) will be performed according to ZSFG Admin 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 prior to start of procedure.
- b. Time out performed per hospital policy.
- c. The procedure is performed following standard medical technique.
- d. Diagnostic tests for purpose of disease identification.
- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. Referral to orthopedic physician, specialty clinic and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. All patients requiring this procedure.

3. Education

Patients will be informed that pain relief may occur immediately due to the early onset of certain drug preparations, but that longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
2. Training will include;
 - a. Indications for procedure and treatment.
 - b. Risks and benefits of procedure and medication.
 - c. Related anatomy and physiology.
 - d. Consent process consistent with hospital policy.

- e. Time out policy and procedure
- f. Wound infection and wound healing mechanisms.
- g. Use of required equipment.
- h. Steps in performing procedures.
- i. Ability to interpret results and formulate follow-up plans.
- j. Ability to recognize complication.

Proctoring Period:

1. New practitioners to procedure will have a minimum of 2 successful observed demonstrations of each procedure/injection site.
2. Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration for each procedure/injection site.
3. Explanation of any exception to the above requirements will be sent as an attachment to the Proctoring Report.
4. Chart review will be done on all observed procedures.
5. Documentation of competency and proctoring will be sent to the Medical Staff Office at completion of the proctoring period.

Reappointment competency Documentation:

1. Performance of 2 procedures every 2 years.
2. 2 chart reviews every 2 years.

PROTOCOL # 10: Procedure: Nail Debridement

A. DEFINITION

Nail debridement is the removal of elongated overgrown nail material.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications: Elongated nail material, overgrowth, thick nail, painful fungal nails.
 - b. Precautions: Vascular status, caution to amount of nail removed.
 - c. Contraindications: none.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 Admin 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. Trim nails with use of sterile instrumentation.
 - b. Diagnostic tests for purposes of disease identification.
 - c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - 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. Upon request of patient, nurse practitioner, physician assistant, or physician
- d. Problem requiring hospital admission or potential hospital admission
- e. Uncommon, unfamiliar, unstable, and complex patient conditions

3. Education

Discharge information and instructions. Instructions will include signs and symptoms of infection and follow-up if infection occurs.

4. Follow-up

Will be determined based on individual needs for interval palliative survey.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Training, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

1. Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience. If has experience will still require direct observation.
2. Training will include;
 - a. Indications for procedure and treatment.
 - b. Risks and benefits of procedure and medication.
 - c. Related anatomy and physiology.
 - d. Consent process
 - e. Wound infection and wound healing mechanisms assessment
 - f. Use of required equipment.
 - g. Steps in performing procedures.
 - h. Ability to interpret results and formulate follow-up plans.
 - i. Documentation and CPT and ICD-10 coding
 - j. Ability to recognize complication.

Proctoring:

1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations.
2. Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration.
3. Chart review of all observed cases.

Reappointment Competency:

1. Performance of 1 procedure and 1 chart review every 2 years.
2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

PROTOCOL # 11: Procedure: Nail Removal/Matrisectomy

A. DEFINITION

Nail removal or Matrisectomy is the complete or partial removal of the nail bed and nail plate.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications: Chronic or acute nail infection (including fungal) or ingrown nails.
 - b. Precautions: Severe infections that would indicate major surgical intervention and vascular status.
 - c. Contraindications: Poor blood flow and other diagnoses not ruled out.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. The procedure is performed following standard medical technique
 - 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 Admin 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 before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

- e. 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. Upon request of patient, nurse practitioner, physician assistant, or physician
 - d. Problem requiring hospital admission or potential hospital admission
 3. Education

Patient will be informed of post matrixectomy care. Will be instructed in signs and symptoms of infection and follow up if infection occurs.
 4. Follow-up

High risk patients will be followed at intervals for nail care. Post matrixectomy patients will be followed as needed to evaluate healing.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record.

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Training, Proctoring and Reappointment Competency

- Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
1. Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience. If has experience will still require direct observation.
 2. Training will include NP/PA being able to demonstrate knowledge of the following:
 - a. Indications for procedure and treatment.
 - b. Risks and benefits of procedure and medication.
 - c. Related anatomy and physiology.
 - d. Consent process
 - e. Wound infection and wound healing mechanisms assessment
 - f. Use of required equipment.
 - g. Steps in performing procedures.
 - h. Ability to interpret results and formulate follow-up plans.
 - i. Documentation and CPT and ICD-10 coding

j. Ability to recognize complication.

Proctoring:

1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations.
2. Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration.
3. Chart review of all observed cases.

Reappointment Competency:

1. Performance of 1 procedure and 1 chart review every 2 years.
2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

Protocol #12: Procedure: Intrauterine Device Insertion

A. DEFINITION

Intrauterine devices offer highly effective, safe, long-term contraception.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications
 - i. Patient desires intrauterine device (IUD)
 - b. Precautions
See specific IUD prescribing information
 - c. Contraindications
 - i. Pregnancy or suspicion of pregnancy
 - ii. Known or suspected PID or cervical infection
 - iii. Post-partum endometritis or post-abortal endometritis.
 - iv. Known or suspected uterine or cervical malignancy
 - v. Genital bleeding of unknown etiology
 - vi. Wilson's disease (for copper IUD)
 - vii. Allergy to any component of IUD

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, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 Admin 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 before procedure is performed and obtained according to hospital policy.

- b. Time out performed per hospital policy.
- c. The procedure is performed following standard medical technique.
- d. Diagnostic tests for purposes of disease identification.
- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. 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. Initiation or adjustment of medication other than those in or approved by the formularies.
- f. 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. All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Requirements to be completed prior to initiation of proctoring and provision of direct patient care:</p> <ul style="list-style-type: none"> a. Prior experience or training required for this procedure. b. 6 months experience in women's health care. c. Review of departmental policies and procedures.
<p>Proctoring:</p> <ul style="list-style-type: none"> a. Direct observation of a minimum of 2 for a new provider and 2 procedures for a provider who has prior experience with independent IUD insertion. b. Documentation of training course completion.
<p>Reappointment Competency:</p> <ul style="list-style-type: none"> a. Performance of 1 insertion every 2 years. b. One chart review of an insertion every 2 years.

Protocol #13: Procedure: Endometrial Biopsy

A. DEFINITION

Evaluation of the endometrium by obtaining tissue for pathological diagnosis.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications
Women considered at risk for endometrial cancer (including but not limited to: abnormal uterine bleeding, endometrial cells on Pap smear, unopposed estrogen therapy, tamoxifen therapy) and others needing evaluation of endometrial tissue (infertility, infection) will be evaluated by endometrial biopsy.
 - b. Precautions
Consult a physician before performing biopsies on women with extreme retroversion or anteversion of the uterus. Also consult when procedure requires manual dilation of the cervix.
 - c. Contraindications
None

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 Admin 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 before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.

- c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- d. Diagnostic tests for purposes of disease identification.
- e. Biopsy tissue is sent to pathology.
- f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- g. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. As noted in precautions for procedure.
- b. Acute decompensation of patient situation.
- c. Unexplained historical, physical or laboratory findings
- d. Uncommon, unfamiliar, unstable, and complex patient conditions
- e. Upon request of patient, NP, PA, or physician
- f. Initiation or adjustment of medication other than those listed in or approved by the formularies.
- g. 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

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

- a. At least 6 months experience in women's health care.
- b. Provider will observe a qualified provider do procedure 2 times

Proctoring Period:

- a. New practitioner to procedure, a minimum of 3 successful observed demonstrations
- b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 2 successful observed demonstrations
- c. Chart review of all observed cases.

Reappointment Competency Documentation:

- a. Performance of 1 procedure every 2 years.
- b. 1 chart review every 2 years.

Protocol #14: Procedure: Contraceptive Implant Insertion

A. DEFINITION

The transdermal contraceptive implant is placed under the skin of the upper arm ~~via a preloaded inserter and remains effective for three years.~~ Insertion is performed under local anesthetic using aseptic technique.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications
 - i. Women desires long acting, reversible contraceptive.
 - b. Precautions
 - i. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.
 - ii. May have drug interactions with anti-HIV medications and some herbal products.
 - iii. See drug precautions/interactions in contraceptive implant prescribing information.
 - c. Contraindications
 - i. Known or suspected pregnancy
 - ii. Current or past history of thrombotic disease
 - iii. Hepatic tumors, active liver disease
 - iv. Known, suspected or history of breast cancer
 - v. Undiagnosed abnormal genital bleeding
 - vi. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to presenting complaint or procedure/surgery to be performed, including sexual history to rule out preexisting pregnancy.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, including over-the-counter and herbal remedies, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam, including a negative pregnancy test.
 - c. All Point of Care Testing (POCT) will be performed according to ZSFG Admin 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 before procedure is performed and obtained according to hospital policy.
- b. Timing of insertion: see prescribing information.
- c. Implant insertion as described in prescribing information.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Difficult insertions.
- b. Acute decompensation of patient situation.
- c. Upon request of NP, PA or physician

3. Education

Discharge information and instructions for care of site, expected side effects, precautions and urgent/emergent symptoms.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring, and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

- a. Completion of a company sponsored training program

Proctoring:

- a. Direct observation of 23 insertions by a qualified provider for providers new to this procedure.
- b. Direct observation by a qualified provider of 42 insertion for an experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years).
- c. Chart review of all observed cases.

Reappointment Competency Documentation:

- a. A minimum of 6 insertions every 2 years.
- b. 1 chart review needed every 2 years.

Protocol #15: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm and remains effective for five (5) years. Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications
Woman desires removal of implant or implant is expired.
 - b. Precautions: See prescribing information.
 - c. Contraindications: See prescribing information.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 Admin 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 before procedure is performed and obtained according to hospital policy.
 - b. Diagnostic tests for purposes of disease identification.
 - c. Timing of removal: See prescribing information
 - d. Removal: as described in prescribing information
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
 - a. Acute decompensation of patient situation.
 - b. Difficult Implant removal.
 - c. Upon request of patient, affiliated staff or physician
 - d. If patient desires removal and rod is not readily palpable.
3. Education
Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.
4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Requirements to be completed prior to initiation of proctoring and provision of direct patient care:</p> <ol style="list-style-type: none"> a. Completion of a company sponsored training class
<p>Proctoring Period:</p> <ol style="list-style-type: none"> a. Performance of a minimum of <u>63</u> removals for a new provider and 2 removals for a provider who has prior experience with independent removal. b. Proctor must be a qualified provider. c. Chart review of all observed cases.
<p>Reappointment Competency Documentation:</p> <ol style="list-style-type: none"> a. Performance of <u>86</u> removals every 2 years. b. <u>2-1</u> chart review needed every two years.

Protocol # 16: Procedure: Skin Biopsy

A. DEFINITION

Removal of a small portion of abnormal skin to be treated in a laboratory. There are three types of skin biopsy:

- Shave biopsy: the outer part of the suspect area is removed.
- Punch biopsy: a small cylinder of skin is removed using a punch tool.
- Excision biopsy: the entire area of abnormal growth is removed.

1. Location to be performed: all sites within the FCM department.
2. Performance of procedure:
 - i. Indications
 - a. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.
 - ii. Precautions
 - a. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
 - b. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
 - c. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.
 - iii. Contraindications: None

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 Admin 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 before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
 - d. Diagnostic tests for purposes of disease identification.
 - e. Biopsy tissue is sent to pathology *as appropriate*.
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician 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. Initiation or adjustment of medication other than those listed in or approved by the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.

3. Education
Pre-procedure and post procedure education as appropriate and relevant in verbal or written format.

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

- a. 2 direct observations of a qualified provider doing each procedure
- b. Review of aseptic technique
- c. Review of departmental policy and procedure

Proctoring Period

- a. New practitioner to procedure, a minimum of 2 successful observed demonstrations of each procedure

- b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations of each procedure
- c. Chart review of all observed cases.

Reappointment Competency

- a. Evaluator will be the Medical Director or other qualified provider
- b. Competency
 - 1. Perform 1 of each procedure every 2 years.
 - 2. 1 chart review of each procedure every 2 years.

PROTOCOL #17: Procedure: Trigger Point Injection

A. DEFINITION:

A trigger point injection is the insertion of a needle into a trigger point, with or without injection of solution (e.g. saline, steroids, and anesthetics) into the region of the trigger point.

1. Indications:

- When a trigger point (a focal area of soft tissue hyperirritability refers pain with palpation or elicits a twitch response) or a taut area of skeletal muscle, is felt to be contributing to pain

2. Precautions/contradictions:

- Allergy to injectable medication
- Close proximity to vital organs (e.g. potential risk of pneumothorax)

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, injury event history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- 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 Admin POCT policy and procedure #16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes such as myofascial pain with trigger points.

D. PLAN

1. Therapeutic Treatment Plan

- a. Explain the procedure to the patient.
- b. Patient consent obtained before procedure is performed.
- c. Time Out performed per hospital policy.
- d. The procedure is performed following standard medical technique according to the departmental guidelines.
- e. Diagnostic tests for purposes of disease identification.
- f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- g. 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. Upon request of patient, NP/PA, or physician
 - d. Problem requiring hospital admission or potential hospital admission.

3. Education

Patient will be informed that pain relief may occur immediately if anesthetics or steroids are injected. Baseline pain may recur upon clearance (“wearing out”) of the medications from the area of injection. Patient will be instructed in signs and symptoms of infection or allergy and procedures to follow if they occur.

4. Follow-up

Patients will be seen in follow up within 4-6 weeks.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Prerequisite, Proctoring and Reappointment Competency

<p>Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Training by 3 direct observations of a qualified provider performing trigger point injections will occur.</p> <p>Standardized Training will include NP/PA being able to demonstrate knowledge of the following for all noted injection sites:</p> <ol style="list-style-type: none"> 1. Indications for procedure and treatment 2. Risks and benefits of procedure and medication 3. Related anatomy and physiology 4. Consent process 5. Wound infection and wound healing mechanisms 6. Use of required equipment 7. Steps in performing procedures 8. Ability to interpret results and formulate follow-up plans 9. Documentation and CPT and ICD-10 coding 10. Ability to recognize complication
<p>Proctoring:</p> <ol style="list-style-type: none"> a. New practitioners to procedure will have a minimum of 2 successful observed demonstrations of each injection site. b. Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance

<p>assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstrations of each injection site.</p> <ul style="list-style-type: none">c. Chart review of all observed cases.
<p>Reappointment Competency</p> <ul style="list-style-type: none">a. Performance of 2 injections every 2 years.b. 2 chart reviews every 2 years.

Procedure #18: Waived Testing

A. DEFINITION

Waived testing relates to common laboratory tests that do not involve an instrument and are typically performed by providers at the bedside or point of care.

1. Location where waived testing is to be performed: All appropriate sites within the FCM department.
2. The following non-instrument based waived tests are currently performed at ZSFG:
 - a. Fecal Occult Blood Testing (Hemoccult ®)
Indication: Assist with detection or verification of occult blood in stool.
 - b. Vaginal pH Testing (pH Paper)
Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.
 - c. SP® Brand Urine Pregnancy
Indication: Assist with the diagnosis of pregnancy.
 - d. Chemstrip® Urine Dipstick
Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

1. Subjective Data
 - a. Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed
2. Objective Data
 - a. Each waived test is performed in accordance with approved ZSFG policies and procedures specific for each test as well as site-specific protocols and instructions for:
 - i. Indications for testing
 - ii. Documentation of test results in the electronic health record

- iii. Actions to be taken (follow-up or confirmatory testing, Attending consultation, referrals) based on defined test results.
- iv. Documentation or logging of tests performed

C. DIAGNOSIS

Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.

D. PLAN

1. Testing

- a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
- b. Use gloves and other personal protective equipment, as appropriate.
- c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.
- d. Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.
- e. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?

2. Test Results requiring Attending Consultation

- a. Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

3. Education

- a. Inform patient of test results and need of additional tests, as necessary

4. Follow-up

- a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

Test and control results will be recorded in the medical record as per site-specific protocols (may be in paper charts or entered in electronic data bases).

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics.
Proctoring: Successful completion of online learning modules for each of the waived tests the practitioner is performing at ZSFG, i.e., achievement of passing scores of at least 80% on each module.
Reappointment Competency Documentation: Renewal required every two years with documentation of successful completion of the required online learning modules. Provider must have passed each required module with a score of 80%.
Any additional comments: N/A

Protocol #19: Procedure: Abdominal Paracentesis

- A. Definition - Abdominal paracentesis is a procedure that entails inserting a trocar and cannula through the abdominal wall under local anesthetic for aspiration of peritoneal fluid (ascites). The term ascites denotes the accumulation of fluid in the peritoneal cavity.
1. Locations to be performed: All appropriate sites within the FCM department.
 2. Performance of Procedure: (When possible any paracentesis should be performed bedside with ultrasound guidance or have fluid localized by radiology and transport patient on same bed used for marking. Procedure may be performed without ultrasound or radiologic guidance.)
 - i. Indications:
 - a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhosis related, for example).
 - b. Pt with ascites, fever, abdominal pain (to evaluate for spontaneous bacterial peritonitis).
 - c. Symptomatic treatment of tense ascites.
 - ii. Precautions;
 - a. Intra-abdominal adhesions or suspicion for loculated fluid.
 - b. Pregnancy
 - c. Necessity for ultrasound guided paracentesis if any conditions listed above are present.
 - d. Peritoneal dialysis
 - iii. Contraindications:
 - a. Fibrinolysis or DIC.
 - b. Cellulitis at puncture site
 - c. Acute abdomen requiring surgical intervention.

B. Data Base

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
2. Objective Data
 - a. Physical exam appropriate to presenting symptoms.

- b. Laboratory (including platelet count, PT/PTT), Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes.

3. Plan

1. Therapeutic Treatment Plan.
 - a. Informed consent obtained prior to procedure and according to hospital policy.
 - b. Time out performed according to hospital policy.
 - c. Diagnostic tests for purpose of identifying disease etiology. Sent for cytology as relevant.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders Protocol.
 - e. Referral to specialty clinic, supportive services for provider as needed.
2. Patient conditions requiring attending consultation
 - a. All patients with any condition listed in precaution section.
 - b. Acute decompensation of patient.
 - c. Upon the request of the patient, PA, NP or physician.
3. Education
 - a. Appropriate and relevant patient and family education in written and/or verbal format.
 - b. Contact information for follow up should needle puncture site result in leaking ascitic fluid.
4. Follow-up
 - a. As indicated and appropriate for procedure performed.

E. Record Keeping

Patient visit, consent forms, and other documents will be included in the medical record, and other patient data bases, as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Requirements to be completed prior to initiation of proctoring and provision of direct patient care:</p>

- | |
|---|
| <ol style="list-style-type: none"> 1. Training by a privileged provider or documentation of previous training. |
|---|

<p>Proctoring:</p>

- | |
|---|
| <ol style="list-style-type: none"> 1. Providers new to procedure must complete a minimum of 4 observed successful procedures and 4 chart reviews prior to completion of proctoring period. One of the procedures may be performed on a simulated model |
|---|

2. Experienced providers must complete a minimum of 2 successful procedures prior to completion of proctoring period. Designation of experienced practitioner requires documentation of:
 - a. Previous proctoring and
 - b. Ongoing performance assessment within the past two years.

Reappointment Evaluation:

1. To maintain ongoing competency a minimum of 4 procedures every 2 years must be met. One of the procedures may be performed on a simulated model. If requirements not met, provider will be proctored through 1 successful procedure.
2. Four chart reviews every two years.
3. Evaluation must be done by Medical Director or designated physician.

Protocol #20: Procedure: Lumbar Puncture

A. DEFINITION

A diagnostic procedure used to identify infectious, inflammatory, and neoplastic processes of the central nervous system. Lumbar puncture is also used to

administer diagnostic as well as therapeutic agents. Lumbar puncture can also be done to determine the intracranial pressure.

1. Location to be performed: All appropriate sites within the FCM department.
2. Performance of Lumbar Puncture
 - a. Indications
 1. To obtain Cerebral Spinal Fluid (CSF) for diagnosis of infectious, inflammatory or neoplastic diseases
 2. To determine the presence of subarachnoid hemorrhage
 3. To diagnose and treat increased intracranial pressure for selective patients
 - b. Precautions
 1. Platelets < 100,000
 2. Patients on anticoagulants or who have bleeding tendencies (F.F., Von Willebrand's, Hemophilia, Liver disease)
 3. Patient taking ASA/NSAIDS/Cox II Inhibitors
 - c. Contraindications
 1. Increased intracranial pressure secondary to mass or mass effect
 2. INR greater than 1.4
 3. Therapeutic anticoagulation or blood dyscrasias
 4. Soft tissue infection at the entry site / spinal osteomyelitis
 5. Known spinal cord arteriovenous malformations
 6. Posterior fossa lesion
 7. Patient refusal

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure to be performed including but not limited to presence of headache or meningitis symptoms, motor/sensory deficits, and new/persistent CSF leak.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin containing-products, anticoagulants, anti-platelet agents, and non-

steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination, assessment of papilledema, and integrity of the lumbar skin site.
- b. The procedure is performed following standard medical technique according to The Handbook of Neurosurgery by Mark Greenberg, Section 23.7.3. Lumbar Puncture.
- c. Laboratory evaluation to include CBC with platelets, PT, PTT, and
- d. INR. Brain imaging evaluation to rule out a mass lesion, a posterior fossa lesion, or subarachnoid hemorrhage, as indicated by history and physical exam.
- e. 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. Differential diagnoses would include but not limited to meningitis, encephalitis, sarcoidosis, subarachnoid hemorrhage, meningeal carcinomatosis, increased intracranial pressure, and decreased intracranial pressure.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent, consistent with hospital policy, obtained before procedure is performed.
- b. Timeout conducted consistent with hospital policy.
- c. Diagnostic tests on the CSF for purposes of disease identification may include protein level, glucose level, gram stain, culture and sensitivity, blood cell count and differential, and measurement of CSF pressure. Additional diagnostic tests may include: cytologic testing, staining for AFB, cryptococcal antigen, serologic testing for syphilis, Lyme disease, viral titers, immunoglobulin profiles, and oligoclonal banding.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. All patients requiring this procedure will receive Attending Consultation

3. Education

- a. Discharge information and instructions pertaining to lumbar puncture.

4. Follow-up

As appropriate for procedure performed.

- a. Assess for signs and symptoms of insertion site infection
- b. Assess for signs of CSF leak
- c. Assess for complaints of headache in the upright position

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Completion of standardized procedure training on site
Proctoring Period <ul style="list-style-type: none">a. Minimum of 3 successful observed demonstrationsb. Minimum of 3 chart reviews
Reappointment Competency <ul style="list-style-type: none">a. Evaluation will be performed by Supervising Physician and/or his or her designeeb. Ongoing competency evaluation.<ul style="list-style-type: none">1. Completion of three procedures every 2 years.2. Three chart reviews needed every 2 years.

Protocol #21: Procedure: ORDERING TRANSFUSIONS

A. DEFINITION

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

NOTE: Transfusion orders generally consist of at least two parts: the blood component order directed to Blood Bank staff, e.g. "Type and cross 2 units of RBC", and the order to administer the ordered components usually intended for nursing staff, e.g. "transfuse 2 RBC units at the patient's next outpatient visit on (date)". These orders may be written at the same time or sequentially.

1. Location to be performed: Inpatient, outpatient setting.
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
Absolute: none
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 evaluation.
 - 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
3. Education
Discharge information and instructions, post-transfusion orders for outpatients.
4. Follow-up
As appropriate for patients condition and reason transfusions were given.

E. RECORD KEEPING

Patient visit, consent forms, and other transfusion-specific documents including completed transfusion report form will be included in the medical record and other patient data bases, as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
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<ul style="list-style-type: none"> a. Successful completion of the 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.
<p>Proctoring Period:</p> <ul style="list-style-type: none"> a. Read and Sign the ZSFG Administrative Policy and Procedure 2.03 “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. Review of 1 (some say “countersigned”) transfusion order and review of documentation in the patient medical record.
<p>Reappointment Competency Documentation:</p> <ul style="list-style-type: none"> 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 and review of 1 medical record every 2 years. c. Review of any report from the Transfusion Committee. d. Evaluator will be the medical director or other designated physician.

Medical Director or Division Chief Approval or Service Chief Approval

***Teresa Villela, MD
ZSFG Chief of Service***

***Lisa Pasquel, MD
Osteopedics
Author: Joanne Zou, NP
CIDP Approval Date: 7/01/2020
Credentials Approval Date: 8/03/2020
MEC Approval Date: 8/20/2020
Gov. Body Approval Date: 8/25/2020***

Protocol #22: Procedure: Thoracentesis

- A. DEFINITION: Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid. This procedure can be done in the Inpatient hospital units.
1. Performance of procedure
 - Indications
 - a. For the purposes of this protocol, thoracentesis may be used to determine the cause of a pleural effusion or
 - b. To relieve the symptoms of non-acute respiratory distress
 - Precautions
 - a. INR >2.0
 - b. Platelets <30,000
 - Contraindications
 - a. Infection in the tissues near the puncture site.
 - b. Acute respiratory compromise
 - c. Significant pulmonary parenchymal disease
- B. DATA BASE
1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
 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 SFGH 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 before procedure is performed and obtained according to hospital policy.
- b. Time out performed per hospital policy.
- c. Diagnostic tests for purposes of disease identification.
- d. Initiation or adjustment of medication per Furnishing Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
All patients needing procedure

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Requirements to be completed prior to initiation of proctoring and provision of direct patient care:</p> <ul style="list-style-type: none"> a. Onsite training by a qualified provider.
<p>Proctoring Period</p> <ul style="list-style-type: none"> a. New provider to procedure, a minimum of 3 successful observed demonstrations and 3 chart reviews b. Experienced provider to procedure, a minimum of 2 successful observed demonstrations. Designation of experienced practitioner requires documentation of: <ul style="list-style-type: none"> 1) previous proctoring and

- 2) ongoing performance assessment within the past two years.
- c. Proctoring for 1 of the procedures may be performed on a simulated model.

Reappointment Competency

- a. The evaluator will be an Attending Physician or another clinician that has unrestricted privileges to perform thoracentesis
- b. Ongoing competency evaluation.
 - 1. Perform a minimum of 3 procedures every 2 years.
 - 2. Three chart reviews every 2 years.
- c. Proctoring for 1 of the procedures may be performed on a simulated model.

2020 FAMILY COMMUNITY MEDICINE STANDARDIZED PROCEDURE

Medical Director or Division Chief Approval or Service Chief Approval:
Teresa Villela, MD
ZSFG Family Community Medicine Chief of Service
Author: Jennifer Kanenaga, NP

CIDP Approval Date: 7/01/2020
Credentials Approval Date: 8/03/2020
MEC Approval Date: 8/20/2020
Gov. Body Approval Date: 8/25/2020



San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice
STANDARDIZED PROCEDURE – NURSE PRACTITIONER /
PHYSICIAN ASSISTANT

2017

PREAMBLE

Title: Department of Medicine

I. Policy Statement

- A. It is the policy of 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 Title 16, 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 1M Clinic room 1M 13, Cardiology 5G1, Cardiac Catheterization Lab, Unit 5B Nurse Lounge, GI Fellows Conference Room, Hematology/Oncology Administration Office, GI Conference Room 3D22, Occupational Health Clinic, HERO Medical record system 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 primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting and in performance of procedures.

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 six 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 Delegation of Services Agreement (documents supervising agreement between supervising physician and PA).

The NP/PA conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel patients on preventative health care, perform invasive procedures and furnish medications/issue drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

1. Location of practice is: Inpatient Units, GCRC, Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Infusion Center, 3 D Gastroenterology Clinic, Occupational Health Service, Positive Health Clinic, Hematology/Oncology Clinic, 1M and 5F Cardiology Clinics, Ward 17 Renal Dialysis Service and the Emergency Department.
- 2). Role may include primary care, urgent care, furnishing medications, performing procedures and coordinating admissions and discharges. Role may also include admissions, transfers and discharges. Role may also include clinical research studies.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to: site Medical Director, Chief of Service, designated physician and other supervisors as applicable.
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. Acute, severe respiratory distress.
 - h. An adverse response to respiratory treatment, or a lack of therapeutic response.
 - i. Problem requiring invasive or surgical procedure.
 - j. Need for transfusion.
 - k. Review of electrocardiograms, if no prior interpretation or change from previous recording.
 - l. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.
 - m. Upon oncology providers seeing a newly diagnosed oncology patient in outpatient clinic.
 - n. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
 - o. Conditions severe enough to warrant partial or total disability work status prescription.
 - p. Any problem requiring transfer of care to the Emergency Department.
- 4, For cardiology and GI providers only: NP/PA management of medical emergencies, including cardio-pulmonary arrest, shock and life-threatening bleeding shall include initial evaluation and stabilization of the patient through the utilization of Advanced Cardiac Life Support (ACLS), alerting the supervising physician and activation of the Code Blue Team by dialing X61122.

IV. Scope of Practice

- Protocol #1: Core: Acute/Urgent Care
- Protocol #2: Core: Primary Care
- Protocol #3: Discharge of Inpatient
- Protocol #4: Furnishing Medications/Drug Orders
- Protocol #5: Routine Occupational Health Screening
- Protocol #6: Evaluation and treatment of Occupational Illness/Injury and Exposure to Physical Chemical and Biological Hazards
- Protocol #7: eReferral Review
- Protocol #8: Procedure: Abdominal Paracentesis
- Protocol #9: Procedure: Arthrocentesis and Intraarticular Injections
- Protocol #10: Procedure: Bone Marrow Aspiration and Biopsy

- Protocol #11: Procedure: Colonoscopy
- Protocol #12: Procedure: Esophagogastroduodenoscopy (EGD)
- Protocol #13: Procedure: Esophageal Manometry and Prolonged Ambulatory pH Monitoring
- Protocol #14: Procedure: Exercise Tread Mill Test
- Protocol #15: Procedure: High Resolution Anoscopy
- Protocol #16: Procedure: Incision and Drainage Skin Abscesses with Administration of Local Anesthesia
- Protocol #17: Procedure: Intraventricular Chemotherapy Administration via Ommaya Reservoir
- Protocol #18: Procedure: Lumbar Puncture
- Protocol #19: Procedure: Lumbar Puncture with the Administration of Intrathecal Chemotherapy
- Protocol #20: Procedure: Moderate Sedation
- Protocol #21: Procedure: Ordering Blood Transfusions
- Protocol #22: Procedure: Ordering Chemotherapy
- Protocol #23: Procedure: Skin Biopsies
- Protocol #24: Procedure: Thoracentesis
- Protocol #25: Procedure: Waived Testing
- Protocol #26: Procedure: Contraceptive Implant Insertion
- Protocol #27: Procedure: Contraceptive Implant Removal

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. Nurse Practitioners hired prior to the current Board requirement will be “grandfathered” in when up for reappointment.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider. Please note other certification may be required for specific procedures and ACLS may be required for procedures performed by cardiology and GI providers.
5. Possession of a National Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each

practice site for each PA.

B. Specialty Training

1. Specialty requirements: NP Specialization in Acute Medicine, Family Medicine, Adult Medicine, Geriatric Medicine or Physician Assistant.
2. Two (2) years experience as a nurse practitioner/physician assistant in an adult medical clinic or an inpatient acute med/surg, critical care or Emergency Department setting or previous experience in Oncology within the last three (3) years preferred.
3. Clinical research and human subjects training (Research Unit only).
- 4.. All staff working in Occupational Health will receive training from an OHS Physician in:
 - a. California and CCSF Workers Compensation procedures.
 - b. Management of body fluid exposures.
5. Board certification or eligibility for board certification by the National Board for Certification of Hospice and Palliative Nurses (NBCHPN), as a Hospice & Palliative APN (HPAPN) (Palliative Care NP only).

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 and/or designated physician and other supervisors, as applicable will assess the NP/PA's ability to practice.
 - a. Clinical Practice
 - Length of proctoring period will be 3 months; review of cases and medical record reviews will be as listed in each protocol or procedure.
 - The evaluator will be Medical Director, Chief of Service and/or designated physician or privileged provider as applicable.
 - The method of evaluation in clinical practice will be five (5) chart reviews and direct observations, with at least one case representing each core protocol (combined core functions discharge of inpatients, and furnishing medications/drug orders). Additional proctoring requirements are specified in the remaining protocols.
2. Biennial Reappointment: Medical Director, and/or designated physician must evaluate the NP/PA's clinical competence through five (5) chart reviews, with at least one case representing each

core protocol (combined core functions discharge of inpatients, and furnishing medications/drug orders).and additional proctoring requirements as described in each procedure.

3. Follow-up: areas requiring increased proficiency as determined by the initial or biennial evaluation will be re-evaluated by the Medical Director, and/or designated physician, at appropriate intervals. If staff have not achieved competency within two years of initial appointment, provider may no longer operate under these standardized procedures.

4. 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.

5. 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 (e) (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, Nurse Midwives, Registered Nurses, 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 its 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: Core Functions – Primary Care/Inpatient Units

A. DEFINITION

This protocol covers the procedure for health care management in primary care, specialty clinics, inpatient units and emergency department. Scope of care includes health care maintenance and promotion and management of common acute, subacute, and chronic illnesses within the Medicine Service.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
- c. Review of systems: present status of current symptoms (present, stable or absent).
- d. Pain history to include onset, location and intensity.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- 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 SFGHMC 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, or controlled, uncontrolled). Refine diagnoses as information becomes available and adjust treatment plans accordingly.

D. PLAN

1. Treatment

- a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol. Initiation or adjustment of medications as covered in Research Protocols.

- c. Immunization update.
 - d. Referral to specialty clinics and supportive services, as needed.
 - e. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS (only relevant for GI and cardiology providers).
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. Uncommon, unfamiliar, unstable, and complex patient conditions
 - e. Upon request of patient, NP, PA, or physician
 - f. Initiation or change of medication other than those in the formulary/ies.
 - g. Problem requiring hospital admission or potential hospital admission.
 - h. Patients on Chemotherapy, referrals for radiation therapy.
 - i. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.
 3. Education
 - a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
 - b. Anticipatory guidance and safety education that is age and risk factor appropriate.
 - c. Discharge information and instructions.
 4. Follow-up

As indicated and appropriate to patient health status and diagnosis.
- 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 electronic medical record (EMR) will be used to obtain and record patient information as required and appropriate. For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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: Core Functions – Primary Care

A. DEFINITION

This protocol covers the procedure for health care management in primary care, specialty clinics, inpatient units and emergency department. Scope of care includes health care maintenance and promotion and management of common acute, subacute, and chronic illnesses within the Medicine Service.

B. DATA BASE

3. Subjective Data

- e. History and review of symptoms relevant to the presenting complaint and/or disease process.
- f. Past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
- g. Review of systems: present status of current symptoms (present, stable or absent).
- h. Pain history to include onset, location and intensity.

4. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- 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 SFGHMC 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, or controlled, uncontrolled). Refine diagnoses as information becomes available and adjust treatment plans accordingly.

D. PLAN

3. Treatment

- f. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
- g. Initiation or adjustment of medication per Furnishing/Drug Orders protocol. Initiation or adjustment of medications as covered in Research Protocols.
- h. Immunization update.
- i. Referral to specialty clinics and supportive services, as needed.

j. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS (only relevant for GI and cardiology providers).

4. 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. Uncommon, unfamiliar, unstable, and complex patient conditions
- e. Upon request of patient, NP, PA, or physician
- f. Initiation or change of medication other than those in the formulary/ies.
- g. Problem requiring hospital admission or potential hospital admission.
- h. Patients on Chemotherapy, referrals for radiation therapy.
- i. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.

3. Education

- d. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
- e. Anticipatory guidance and safety education that is age and risk factor appropriate.
- f. Discharge information and instructions.

4. Follow-up

As indicated and appropriate to patient health status and diagnosis.

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 electronic medical record (EMR) will be used to obtain and record patient information as required and appropriate. For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 #3: Discharge of Inpatients

A. DEFINITION

This protocol covers the discharge of inpatients from San Francisco General Hospital and Trauma Center. Direction to discharge patient will come from the attending physician.

B. DATA BASE

1. Subjective Data

- a. Review: health 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 of subjective and objective data and medical diagnoses, ensure that appropriate treatments have been completed, identify clinical problems that still require follow-up and that 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 and communication with primary care, specialty clinics, skilled nursing facility providers, and support 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. Initiation or change of medication other than those in the formulary.

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 including a reconciled medication list and a discharge summary. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

Protocol #4: 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. If the PA has completed the education module, the certification must be attached to the PA’s Delegation of Service Agreement.

Nurse practitioners may order Schedule II - V controlled substances when in possession of a DEA license. Schedule II - III controlled substances may be ordered for, but not limited to, the following conditions: patients presenting with acute and chronic pain and patients presenting with ADHD or other mental health-related disorders requiring the use of controlled substance II 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 formular/ies to be use are: 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 (including Contract Drug List and formularies of managed care Medi-Cal plans), Healthy San Francisco, Medicare Part D plans, AIDS Drug Assistance Program, Blue Cross, Blue Shield, California Care, Pacific Care, Health Net, Healthy Families, United Healthcare, and Medicare Part D formularies. 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 SFGH 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. When ordering respiratory treatments a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device, and frequency of treatments. Patient response will be monitored and documented.
 - 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 LCR/eCW, 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, quantity, amount 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 and date of birth
 - 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. 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 or approved by the formulary (ies)
- f. Problem requiring hospital admission or potential hospital admission
- g. Uncommon, unfamiliar, unstable, and complex patient conditions
- h. When requesting specialty consultation
- 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.
- j. Acute, severe respiratory distress
- k. An adverse response to respiratory treatment, or lack of therapeutic response.
- l. 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\LCR\MAR as appropriate. When a physician assistant writes a drug order for a controlled substance, the supervising physician must sign and date the chart containing such a drug order within seven (7) days.

Protocol #5: Routine Occupational Health Screening

A. DEFINITION

This protocol covers the procedures for screening history, physical examination, diagnostic evaluation of and appropriate preventive interventions for adult employees of the City and County of San Francisco (CCSF) and other affiliated clients within the Occupational Health Service. Relevant activities include:

1. Employment pre-placement, promotion and fitness-for-duty evaluations
 - a. Includes specific medical certifications such as California DMV Class A/B License, medical clearance for respirator use
2. Specific medical surveillance programs for occupational hazards (physical, chemical and biological)
 - a. Includes pertinent preventive interventions such as immunizations and N95 respirator fit-testing, including UCSF campus employees.

B. DATA BASE

1. Subjective Data
 - a. Screening: age- and examination/job-appropriate history that can include but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
 - b. Ongoing/Continuity: review of symptoms and history relevant to the patient's age, health history, examination type and job class
 - c. Pain history obtained to include onset, location, and intensity
2. Objective Data
 - a. Job description and other relevant qualification requirements/guidelines
 - b. Physical examination consistent with health history and examination type
 - c. Laboratory and imaging evaluation, as indicated, relevant to history and examination type
 - d. Previous medical records and clinical consultation reports, as needed
 - e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

1. Assessment of data from the subjective and objective findings identifying risk factors, disease/injury/disability and medical qualification for work

duties

D. PLAN

1. Action/Intervention
 - a. Age- and examination- appropriate screening/diagnostic testing or referral to primary health care system for consultation (as needed to complete occupational assessment)
 - b. Age- and examination/job-appropriate preventive interventions, including but not limited to:
 - 1) Education as described below
 - 2) Immunizations
2. Patient conditions requiring Physician consultation
 - a. Acute decompensation of patient situation, including hostile or threatening patient behavior
 - b. Any problem requiring transfer of care to an Emergency Department or specialist Physician
 - c. Unexplained historical, physical, or laboratory findings
 - d. Upon request of patient, NP, PA or Physician.
 - e. Conditions severe enough to warrant partial or total disability work status prescription
5. Education
 - a. Regarding occupational hazards and personal protection/safety measures
 - b. Regarding relevant health issues
 - c. Regarding relevant administrative/regulatory procedures
4. Follow-up
 - a. As indicated to complete assessment and disposition

E. RECORD KEEPING

All information relevant to patient evaluation/care will be recorded in the patient's OHS medical record, which is maintained in the OHS clinic.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites <ol style="list-style-type: none">a. Onsite training of procedures by a qualified provider.b. Review of departmental policy and procedure
Proctoring Period <ol style="list-style-type: none">a. 5 chart reviews and 1 direct observation of both protocol #5 and #6
Reappointment Competency <ol style="list-style-type: none">a. 5 chart reviews to cover both Occupational Health protocols #5 and #6

PROTOCOL #6: Evaluation and Treatment of Occupational Illness/Injury and Exposure to Physical, Chemical and Biological Hazards

A. DEFINITION

This protocol covers the procedures for screening history, physical examination, diagnostic evaluation and treatment of adult employees of the City and County of San Francisco (CCSF) and other affiliated clients who present to the Occupational Health Service with specific occupational health complaints or concerns. Relevant activities include:

1. Diagnosis and treatment of occupational injury or illness
2. Assessment and appropriate intervention following potentially significant occupational exposure to hazards (e.g. tuberculosis, human body fluids, chemical agents etc.).

B. DATA BASE

1. Subjective Data
 - a. Initial visit: Age- and incident-appropriate history that can include but is not limited to: history of current problem and detailed mechanism of injury or exposure, current symptoms, past medical history including relevant hospitalizations/injuries/immunizations, past surgical history, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
 - b. Subsequent visits: Interval history to include current symptoms, response to treatment, impact of injury/illness on function
 - c. Pain history obtained to include onset, location, and intensity
2. Objective Data
 - a. Focused physical examination
 - b. Focused diagnostic testing
 - c. Review of relevant past medical records, exposure data
 - d. Job description or other knowledge of essential job duties
 - e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

1. Assessment of data from the subjective and objective findings identifying diagnosis of illness/ injury or exposure risk factors.
2. Assessment of need for prescribed work restrictions or total disability

D. PLAN

1. Treatment
 - a. Pharmaceutical agents (see Furnishing Medications/Drug Orders Protocol)
 1. As needed to cure or relieve injury/illness symptoms or conditions
 2. As needed prophylaxis following exposure to hazards
 - b. Referrals as clinically indicated
 1. To primary care clinician (for non-occupational conditions)
 2. To Emergency Department
 3. To Physician specialist
 4. To mental health clinician
 5. To nurse case manager or claims adjuster (for issues of disability benefit management)
 - c. Prescription of appropriate work and other activity restrictions
 - d. Education as described below
2. Patient conditions requiring Physician consultation
 - a. Acute decompensation of patient situation, including hostile or threatening patient behavior
 - b. Any problem requiring transfer of care to an Emergency Department or specialist clinician
 - c. Unexplained historical, physical, or laboratory findings
 - d. Problem that is not resolved after reasonable trial of therapies
 - e. Unexplained historical, physical, or laboratory findings
 - f. Upon request of patient, NP, PA or Physician.
 - g. Initiation or change of medication other than those in the formulary (ies).
 - h. Conditions severe enough to warrant partial or total disability work status prescription
3. Education
 - a. Regarding injury/illness diagnosis, treatment options, prognosis, activity restrictions/disability, follow-up plan
 - b. Regarding risk of exposure to specific hazard, prevention/prophylaxis options, follow-up plan
 - c. Regarding workers' compensation and other disability benefit programs
4. Follow-up
 - a. As indicated to complete assessment and disposition

E. RECORD KEEPING

1. All information relevant to patient evaluation/care will be recorded in the patient's OHS medical record, which is maintained in the OHS clinic.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites a. Onsite training of procedures by a qualified provider.
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b. Review of departmental policy and procedure
Proctoring Period a. 5 chart reviews and 1 direct observation of both protocol #5 and #6 b.
Reappointment Competency a. 5 chart reviews to cover both Occupational Health protocol #5 and #6

Protocol #7: Procedure: Abdominal Paracentesis

- A. Definition - Abdominal paracentesis is a procedure that entails inserting a trocar and cannula through the abdominal wall under local anesthetic for aspiration of peritoneal fluid (ascites). The term ascites denotes the accumulation of fluid in the peritoneal cavity.
1. Locations to be performed: Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Outpatient Infusion Center, 3D GI Clinic, , and Inpatient units.
 2. Performance of Procedure: (When possible any paracentesis should be performed bedside with ultrasound guidance or have fluid localized by radiology and transport patient on same bed used for marking. Procedure may be performed without ultrasound or radiologic guidance.)
 - i. Indications:
 - a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhosis related, for example).
 - b. Pt with ascites, fever, abdominal pain (to evaluate for spontaneous bacterial peritonitis).
 - c. Symptomatic treatment of tense ascites.
 - ii. Precautions;
 - a. Patients with INR greater than 2.0 should receive FFP prior to procedure Patients with platelets less than 20 should receive platelet infusion prior to procedure
 - b. Intra-abdominal adhesions or suspicion for loculated fluid.
 - c. Pregnancy
 - d. Necessity for ultrasound guided paracentesis if any conditions listed above are present.
 - e. Peritoneal dialysis
 - iii. Contraindications:
 - a. Fibrinolysis or DIC.
 - b. Cellulitis at puncture site
 - c. Acute abdomen requiring surgical intervention.
- B. Data Base
1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
 2. Objective Data
 - a. Physical exam appropriate to presenting symptoms.
 - b. Laboratory (including platelet count, PT/PTT), Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and

exam.

C. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes.

D. Plan

1. Therapeutic Treatment Plan.

- a. Informed consent obtained prior to procedure and according to hospital policy.
- b. Time out performed according to hospital policy.
- c. Diagnostic tests for purpose of identifying disease etiology. Sent for cytology as relevant.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders Protocol.
- e. Referral to specialty clinic, supportive services for provider as needed.

2. Patient conditions requiring attending consultation

- a. All patients with any condition listed in precaution section.
- b. Acute decompensation of patient.
- c. Upon the request of the patient, PA, NP or physician.

3. Education

- a. Appropriate and relevant patient and family education in written and/or verbal format.
- b. Contact information for follow up should needle puncture site result in leaking ascitic fluid.

4. Follow-up

- a. As indicated and appropriate for procedure performed.

E. Record Keeping

Patient visit, consent forms, and other documents will be included in the medical record, and other patient data bases, as appropriate. 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.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

- 1. Training by a privileged provider or documentation of previous training.

Proctoring:

- 1. Providers new to procedure must complete a minimum of 4 observed successful procedures and 4 chart reviews prior to completion of proctoring period. One of the procedures may be performed on a simulated model

2. Experienced providers must complete a minimum of 2 successful procedures prior to completion of proctoring period.

Designation of experienced practitioner requires documentation of

- 1) Previous proctoring and 2) ongoing performance assessment within the past two years.

Reappointment Evaluation:

1. To maintain ongoing competency a minimum of 4 procedures every 2 years must be met. One of the procedures may be performed on a simulated model. If requirements not met, provider will be proctored through 1 successful procedure.
2. Four chart reviews every two years.
3. Evaluation must be done by Medical Director or designated physician.

Protocol #8: Procedure: Arthrocentesis & Intraarticular Injections

A. DEFINITION

This protocol covers arthrocentesis and injection of corticosteroids and/or lidocaine preparations for pain relief. The procedure is insertion of a needle into the joint space to aspirate fluid for analysis and/or inject medicine.

1. Location to be performed: Inpatient Units, Adult Medical Clinic and Medical Specialty Clinics on Ward 92 and the Emergency Department.
2. Performance of procedure:
 - a. Indications
 - Acute and chronic inflammatory musculoskeletal diseases/ disorders such as osteoarthritis, tenosynovitis, bursitis, and entrapment neuropathies.
 - Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of the joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of fluid will help distinguish among hemarthrosis, effusion, fracture, and septic arthritis.
 - b. Precautions
 - Patients with a coagulopathy.
 - c. Contraindications
 - Severe dermatitis or soft tissue infection overlying the joint
 - Acute trauma to the area.

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, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. The procedure is performed following standard medical technique.
 - c. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.
 - d. All Point of Care Testing (POCT) will be performed according to SFGH 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, prior to start of procedure.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - e. Referral to orthopedic physician, specialty clinic, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
 - a. All patients requiring this procedure.

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 electronic medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisite:</p> <ol style="list-style-type: none"> a. The NP/PA will observe a qualified provider 1 time if experienced and if new, 2 times. b. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
<p>Proctoring Period</p> <p>A minimum of 2 successful observed demonstrations and 2 chart reviews.</p>
<p>Reappointment Competency:</p> <p>An attending physician or designated qualified provider will be the evaluator.</p> <p>Provider must:</p> <ol style="list-style-type: none"> 1. Perform a minimum of 4 procedures every 2 years 2. 2 chart reviews needed every 2 years.

Protocol #9: Procedure: Bone Marrow Aspiration and Biopsy

- A. Definition – Bone marrow may be removed by aspiration or needle biopsy under local anesthesia and both are often used concurrently to obtain the best possible marrow specimens.
1. Procedure may be performed in the 4C Infusion center and Inpatient Units.
 2. Performance of procedure:
 - a. Indications:
 - To diagnose cytopenias, hematological malignancies, granulomas, and aplastic, hypoplastic, and pernicious anemias.
 - To diagnose primary and metastatic tumors.
 - To determine the cause of infection.
 - To aid in the staging of disease, such as Hodgkin’s disease.
 - To evaluate the effectiveness of chemotherapy and help monitor myelosuppression.
 - b. Relative contraindications include infection at the site of biopsy, thrombocytopenia less than 30K or uncorrected coagulopathy.

B. Data Base

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
2. Objective Data
 - a. Physical exam appropriate to presenting symptoms.
 - b. Laboratory including CBC and coags, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

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, and uncontrolled).

D. Plan

1. Therapeutic Treatment Plan.
 - a. Obtain informed consent prior to procedure and according to hospital policy.
 - b. Time out performed per hospital policy.

2. Patient conditions requiring attending consultation
 - a. inability to obtain adequate sample
 - b. upon request of NP, PA or physician.
3. Education

Appropriate and relevant patient and family education/counseling in written and/or verbal format.
4. Follow-up

As indicated and appropriate to client health status and diagnosis.

E. Documentation

Post-procedure note recorded in the medical record and will include all necessary documentation including consent form. For PAs using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisites</p> <ol style="list-style-type: none"> a. Will be trained on site by a privileged provider (MD, NP or PA) b. Documentation of previous training.
<p>Proctoring period:</p> <ol style="list-style-type: none"> a. new practitioners to procedure will complete a minimum of 3 successful observed demonstrations and chart review. b. experienced practitioners will complete a minimum of 2 successful observed demonstrations and Chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
<p>Reappointment Competency Documentation</p> <ol style="list-style-type: none"> a. Evaluation of competency will include a letter from clinical director with input from attending hematologist regarding practitioners' proficiency as well as annual observation of 1 successful completion of procedure by attending hematologist and 2 chart reviews. b. Evaluation will be done by the Medical Director or Physician/NP designee.

Protocol #10: Procedure: Colonoscopy (Requires ACLS certification)

A. DEFINITION

Colonoscopy is the examination of the rectum and colon extending to the cecum and possibly terminal ileum through the use of a flexible video scope (and does encompass flexible sigmoidoscopy). It is performed as a screening measure, as a diagnostic tool and for research purposes. For the purposes of this protocol, these examinations are conducted at the 3D GI Endoscopy Center, 5B Research Unit, or designated endoscopy center at the San Francisco General Hospital and Trauma Center.

Indications:

Colonoscopy is usually indicated, but not limited to:

1. Colon cancer screening in individuals over age 50 at average-risk for development of cancer.
2. Colon cancer surveillance in individuals who have had a previous history of adenomatous polyps or cancer.
3. Colon cancer surveillance in persons with increased risk for development of cancer (inflammatory bowel disease, personal/family history of colon cancer).
4. Evaluation of the colon for symptoms or signs referable to the colon and/or terminal ileum.
5. Documentation of inflammatory disease of the rectum, colon or small intestine.
6. To determine extent and/or severity inflammatory bowel disease.
7. Presence of occult or overt blood in the stool.
8. Radiographic demonstration of possible neoplasm in the rectum or colon.
9. Performance of colonoscopic biopsies for research purposes.

Contraindications:

1. Inability to obtain informed patient consent.
2. When patient's cardiovascular status will not permit positioning in a recumbent position.
3. Perforated or suspected perforated viscous.

Therapeutic techniques:

The following table outlines endoscopic therapies associated with colonoscopy and the level of attending physician participation within the procedure room that is required if a nurse practitioner/physician assistant is performing the endoscopic procedure and such therapy is required.

	No attending physician required	Attending physician presence required, but NP/PA can perform therapy	Attending physician only
Diagnostic (no therapy)	X		
Biopsy	X		
Polypectomy for polyps < 1 centimeter (e.g. cold snare, etc.)	X		
Tattooing for tumor marking	X		
Polypectomy for polyps > 1 centimeter		X	
Argon plasma coagulation (APC) therapy		X	
Saline lift for polypectomy		X	
Placement of endoscopic clips			X
Endoscopic banding			X
Sclerotherapy			X
Inability to complete the procedure			X
Adverse event that develops during the procedure			X

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include drug allergies.
- b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
- c. Personal/family history related to the colon and colorectal disease.

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 guidelines and an attending physician must be physically present and readily available for consultation in the endoscopy center or research unit when a colonoscopy is being performed by an NP/PA.

- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS/ASSESSMENT

Determine the indication for Colonoscopy

1. Diagnostic Evaluation:
History and/or physical examination findings suggestive of colorectal pathology.
2. Screening Evaluation:
The individual is asymptomatic and 50 years of age or over.
3. Preparation:
Bowel cleaning: utilize departmental approved regimen.
Aspirin/NSAIDs/antiplatelet/anti-thrombin/Coumadin: will be determined on a case by case basis and in accordance with ASGE guidelines for the Management of Antithrombotic Agents for Endoscopic Procedures.
Iron supplementation stopped 7 days prior to exam.
No intake by mouth for 8 hours (solids) and 2 hours (clear liquids).
4. Need for antibiotic prophylaxis is assessed on a case-by-case basis utilizing current American Society for Gastrointestinal Endoscopy antibiotic prophylaxis recommendations.

D. PLAN

1. Therapeutic Plan
 - a. Discuss with patient the objectives, alternatives, limitations, risks and benefits of the procedure.
 - b. Patient consent must be obtained before the procedure is performed. A "time out" is performed prior to each procedure to verify the right test is being performed on the right patient.
 - c. Biopsied/removed tissue is labeled and sent to pathology.
 - d. Referral to physician, specialty clinics, and supportive services, as needed.
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, affiliated staff, or physician.
 - e. Problem requiring hospital admission or potential hospital admission.
 - f. Problem requiring invasive or surgical procedure.
 - g. Need for transfusion.
 - h. Review of electrocardiograms, if no prior interpretation or change from previous recording.
 - i. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.

- j. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
 - k. Any problem requiring transfer of care to the Emergency Department.
3. Education: Discharge information, instructions and follow-up appropriate to examination findings.
 4. Follow-up: Pathology results will be reviewed from patients whom biopsies or polypectomies were performed. The patient will be provided pathology results via the primary care provider, letter, telephone, or an appointment in the GI clinic.

E. RECORD KEEPING

- a. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointment and procedure information, if indicated.
- b. Document all findings, impression and recommendations in the computerized procedure database. Procedure documentation is automatically exported to electronic medical record.

F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

1. Indications for procedures.
2. Risks and benefits of procedures.
3. Related anatomy and physiology.
4. Bowel preparation procedures.
5. Informed consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. Prostate examination in males 50 years of age and older with referral of significant abnormalities to the Supervising Physician.
12. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.
13. Proof of ACLS certificate

<p>B. Protocol Specific Training</p> <ol style="list-style-type: none"> 1. View the videotapes from the ASGE Video Library: colonoscopy and polypectomy (GE-10), colonoscopy – insertion to cecum (GE-53), colonoscopy – polypectomy techniques I (GE-54), colonoscopy – polypectomy techniques II (GE-55), colonoscopy polyps and tumors of the colorectum and management of large colorectal polyps (GE-56). 2. Observe and demonstrate by repeat performance the proper set-up, usage and sterilization of the colonoscope and the proper use of the video processor. 3. Read Hospital Policy 19.8” Procedural Sedation: Moderate and Deep” and take test on Procedural Sedation. Learn the GI Division Protocol for moderate sedation, and achieve competency for administration of moderate sedation based on the SFGH privileging process. 4. Learn the use of the clinical software in order to capture procedure images and generate procedure reports. 5. Review appropriate infection control guidelines pertaining to colonoscopy.
<p>Proctoring</p> <p>Initial Proctoring Period: NP/PA’s will be proctored through direct observation by a GI attending physician credentialed in endoscopy for a minimum of 150 colonoscopy procedures with administration of procedural sedation (including the performance of at least 50 routine colonic mucosal biopsies and 50 colonoscopic polypectomies). An experienced practitioner to colonoscopy requires a minimum of 10 successful observed demonstrations (including the performance of at least 5 colonic mucosal biopsies and 5 colonoscopic polypectomies. As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent colorectal anatomy and pathology. At the conclusion of the standardized procedure training the Clinical Chief of Gastroenterology or designated Physician will assess the NP/PA’s ability to practice, including an evaluation of the NP/PA’s clinical skills in taking a history, performing an appropriate physical examination, obtaining informed consent, the ordering and interpretation of laboratory and radiographic studies pertinent to the specific clinical situation, documentation of an endoscopic procedure and initiating a treatment plan.</p> <p>Competency in Performing Standardized Procedure</p> <ol style="list-style-type: none"> a. Review of the post test of Education Module by the Clinical Chief of Gastroenterology. b. Review of 75 procedure notes by the Clinical Chief of Gastroenterology.
<p>Reappointment Competency</p> <ol style="list-style-type: none"> 1. Biannual Evaluation (every 6 months):

- a. Review will include chart review, collaboration with and eliciting information from attending physicians and advanced practice staff.
- b. Ongoing competency will include the successful observed completion of ten (10) colonoscopies, five (5) colonoscopies with mucosal biopsy's and five (5) colonoscopic polypectomies procedures.
- c. 20 chart reviews.
- d. Maintenance of ACLS Certification.
- e. Passing of Procedural Sedation test with passing score of 80%.
- f. Review of any adverse event(s) that occurred during a colonoscopy.
- g. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of a colonoscopy
- h. Successful achievement of all OPPE metrics with no identified deficiencies
- i. Documentation of required continuing medical education (CME)

Protocol #12: Procedure: Esophageal Manometry and Prolonged Ambulatory pH-Monitoring (ACLS required)

A. DEFINITION

Esophageal manometry is the clinical evaluation of esophageal contractile activity, and is performed to assess esophageal motor function (often pre-operatively) and for the diagnosis of suspected esophageal motor disorders. The study measures the strength, function, and coordination of the upper and lower esophageal sphincters (UES and LES, respectively), and the body of the esophagus in response to swallows. Recordings are made of the amplitude and coordination of contractions within the pharynx and esophagus. Ambulatory Esophageal pH monitoring (24-hour pH probe) is sometimes performed in conjunction with esophageal manometry. During this procedure, an intra-nasal catheter is placed in reference to the manometrically-defined lower esophageal sphincter, and records acid reflux events over a 24-hour period. Esophageal manometry is conducted on the GI Endoscopy Center at San Francisco General Hospital and Trauma Hospital.

Indications:

Esophageal Manometry is usually indicated, but not limited to:

1. Evaluation of suspected esophageal motor dysfunction, such as esophageal spasm, achalasia, or the 'nutcracker' esophagus.
2. Evaluation of patients with unexplained ('non-cardiac') chest pain or dysphagia.
3. Preoperative evaluation of esophageal motor function prior to esophageal/gastric surgery
4. Assisting in accurate placement of ambulatory esophageal pH probes.
5. Evaluation of patients with neuromuscular disorders affecting esophageal function and/or swallowing (e.g., scleroderma, muscular dystrophy, and strokes).
6. Evaluation of patients with symptoms that may represent reflux disease, such as chronic cough, asthma, hoarseness.

8. Preoperative evaluation of esophageal reflux prior to esophageal/gastric surgery
9. Assess reflux patients not responding to standard medical/pharmacologic therapy.

Contraindications to Esophageal Manometry/pH Monitoring:

1. Inability to obtain informed patient consent.
2. Undiagnosed potential trauma to the nasal passages, nasopharynx, oropharynx, esophagus and/or the stomach.
3. When patient's health status/physical limitations will not permit placement of a flexible catheter through the nose and/or into the esophagus.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include diet, medications, and allergies.
 - b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
 - c. Family history to include peptic ulcer disease, cancer, diabetes.

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) and an attending physician must be physically present and readily available for consultation when an esophageal manometry is being performed by an NP/PA.
 - c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS/ASSESSMENT

1. Obtain patient's medical history to determine indications for esophageal manometry and/or pH monitoring.
2. Preparation: Patient is to be NPO after midnight before the procedure.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Discuss with patient the objectives, alternatives, risks and benefits of the procedure.
 - b. Verify NPO status so that procedure can be performed in a safe and appropriate manner.
 - c. Obtain informed consent, utilizing interpreter services as necessary.

2. Patient conditions requiring Attending Consultation:
 - a. Emergent conditions requiring prompt medical intervention.
 - b. Acute decompensation of the patient.
 - c. Historical, physical or diagnostic findings that seem unusual.
 - d. A problem, which is not resolving as anticipated.
 - e. Upon request of patient, NP, PA, or physician
 - f. Initiation or adjustment of medication other than those in the formularies.
 - g. Problem requiring hospital admission or potential hospital admission.
 - h. When ordering complex imaging studies or procedures.

3. Education: Discharge information, instructions and follow-up appropriate to examination findings.

4. Follow-up: Patients will be evaluated in the appropriate gastroenterology clinic to follow up on the results of pH and manometry tests.

E. RECORD KEEPING

1. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointments and procedure information, if any.
2. Document all findings in the computerized procedure database. Procedure documentation is automatically exported to the electronic medical record

F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

1. Indications for procedures.
2. Risks and benefits of procedures.
3. Related anatomy and physiology.
4. Bowel preparation procedures.
5. Consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. Ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.
12. Review relevant literature available on the GI unit regarding esophageal Manometry / pH monitoring procedure and familiarize self with "Manometry Set-up Procedure" in the Policy and Procedure section of the GI Division Operations Manual.
13. Observe and demonstrate by repeat performance the set-up, calibration, and operational procedures for esophageal Manometry and pH catheter assembly.
14. Possession of an ACLS Certificate

Proctoring

NP/PA's will be proctored through direct observation by GI attending staff credentialed in endoscopy for a minimum of 5 esophageal manometry and pH monitoring procedures prior to performing such procedures independently. An experienced practitioner to the procedure will require a minimum of 3 successful observed demonstrations. Designation of

experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.

As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent nasopharyngeal, esophageal and stomach anatomy.

Competency in Performing Standardized Procedures

- a. Review of the post test of Education Module by the Medical Director.
- b. Review of 20 procedure notes by the Clinical Chief of Gastroenterology.

Reappointment Competency

1. Evaluation:

- a. Ongoing competency will include completion of five (5) esophageal Manometry and pH monitoring procedures every year.
- b. Review of any adverse event(s) that occurred during an esophageal manometry.
- c. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of an esophageal manometry.
- d. Successful achievement of all OPPE metrics with no identified deficiencies
- e. Documentation of required continuing medical education (CME)

Protocol #13: Procedure: Exercise Treadmill Test (ACLS required)

A. DEFINITION

This test is to use incremental exercise modality to diagnose, evaluate and assess the following:

1. Aid in the diagnosis of coronary artery disease
2. Evaluate severity of ischemia in patients with known coronary artery disease (angina, post infarction, positive angiogram, post-AC bypass or PCI).
3. Effort tolerance (EKG may or may not be normal)
4. Chronotropic competence
5. Exercise BP
6. Exercised - induced arrhythmia

Location to be performed: This test will be done in: Cardiology outpatient setting.

Patient preparation

- a. Patient must be able to walk unassisted (i.e. without cane or other aid).
- b. For patients who had chest pain, when in the Emergency Department, must have had a negative troponin test.
- c. Nothing by mouth if test is done in AM, light meal for PM.
- d. Stop smoking one hour prior to the test.
- e. Hold anti-glycemic medication prior to the test as indicated.
- f. For the purpose of diagnosis of CAD, beta-blockers should be discontinued 24-36 hours prior the test, if possible.

Performance of procedure

- a. Precautions: Never push the patient above his/her exercise capability.
- b. Contraindications
 1. Severe or critical aortic stenosis
 2. Unstable angina with rest
 3. Suboptimum treated congestive heart failure
 4. Pericarditis
 5. Uninterruptible ECG for any reason, e.g. LVH, LBBB or WPW
 6. Patient with murmur, unknown reason
 7. Uncontrolled HTN (Baseline SBP>180)

B. DATA BASE

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

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 SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify myocardial ischemia during the exercise treadmill test.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Diagnostic tests for purposes of disease identification.
 - b. Screening tests performed as part of appropriate health maintenance.
 - c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - 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, laboratory or study findings.
 - c. Uncommon, unfamiliar, unstable, and complex patient conditions
 - d. Upon request of patient, NP, PA, or physician
 - e. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
3. Education
 - a. Patient education as appropriate to procedure
 - b. 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. There will be documentation of all vital signs, blood pressure, heart rate, oxygen saturation, as well as any

symptomatology during testing. All changes in 12 lead EKG during procedure will be documented. The attending cardiologist will complete final reading and sign the report in the LCR. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisites:</p> <ul style="list-style-type: none"> a. Review of departmental policy and procedure. b. Two direct observations of procedure being performed by a qualified provider. c. Completion of a 12 lead EKG Course or completion of 12 lead EKG training by qualified Cardiology staff.
<p>Proctoring Period:</p> <ul style="list-style-type: none"> a. 3 successful observed demonstrations for provider new to this procedure. b. 2 successful demonstrations for provider experienced in this procedure. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. c. Chart review of all observed cases.
<p>Reappointment Competency Documentation:</p> <ul style="list-style-type: none"> a. Perform 2 procedures every 2 years. b. 2 chart reviews every 2 years.

Protocol #14 Procedure: High Resolution Anoscopy

A. DEFINITION

Men and women with abnormal anal pap smears will be evaluated by high resolution anoscopy (HRA) with biopsy of suspicious lesions and treatment or referral as indicated.

1. Performance of procedure:

- i. Indications: Patients with abnormal anal pap smears, anal lesion visible by gross examination or a history of anal warts or anal dysplasia.
- ii. Precautions/Contraindications: Consult an MD before performing biopsies on patients with Thrombocytopenia, Neutropenia, infection of anal canal, use of anticoagulants, history of abnormal heart valve or endocarditis.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

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 SFGH 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 before procedure is performed and obtained according to hospital policy.
- b. Time out performed per hospital policy.
- c. Diagnostic tests for purposes of disease identification.
- d. Biopsy tissue is sent to pathology.
- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
 - a. As specified under precautions.
 - b. Upon request of patient, NP, PA, or physician
 - c. Initiation or adjustment of medication other than those in the formularies.
 - d. 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. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment
Competency

<p>Prerequisite:</p> <ol style="list-style-type: none"> a. Completion of a one week course in theory and practice of cervical colposcopy from the University of California or a recognized university.
<p>Proctoring :</p> <ol style="list-style-type: none"> a. Performance of 50 high resolution anoscopy procedures (anal colposcopy with biopsy) under supervision of an experienced colposcopist. b. Review of 3 medical records.
<p>Reappointment Competency Documentation:</p> <ol style="list-style-type: none"> a. Minimum of 20 procedures that must be completed every two years. b. Minimum of 3 chart reviews needed every two years.

Protocol #15: Procedure: Incision and drainage of skin abscesses with administration of local anesthesia

A. DEFINITION

Abscesses resolve with drainage. Abscesses that do not respond to more conservative measures may need incising in order to facilitate drainage and hasten resolution.

1. Performance of procedure.
 - a. Indications:
Palpable, fluctuant skin abscesses
 - b. Precautions:
Large abscesses that require extensive incising or debridement
 - c. Contraindications:
 1. Deep abscesses that may require more extensive anesthesia
 2. Abscesses that invade the palmar or plantar spaces
 3. Suspected pseudo aneurysm (must be ruled out by further diagnostic evaluation)
 - d. Exclusions:
Abscesses on the face, neck, perirectal area, and genitalia

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, allergies.
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 SFGHMC 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 before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - e. 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. Upon request of patient, NP, PA, or physician
 - d. Initiation or adjustment of medication other than those in the formularies.
 - f. 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. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisite:</p> <ol style="list-style-type: none"> a. The NP/PA will be trained to successfully perform the procedure through instruction and proctoring by the Medical Director or his/her designee.
<p>Proctoring:</p> <ol style="list-style-type: none"> a. New practitioner to procedure, a minimum of 2 successful observed demonstrations. b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. c. Chart review of all observed procedures.
<p>Reappointment Competency:</p> <ol style="list-style-type: none"> a. The number of procedures needed to maintain proficiency will be 2 procedure every 2 years. b. The number of chart reviews needed to monitor ongoing competency for annual review will be 2 chart every 2 years.

Protocol #16: Procedure: Intraventricular Chemotherapy Administration
via Ommaya Reservoir

- A. Definition - The administration of chemotherapy via Ommaya Reservoir into cerebrospinal fluid (CSF) for treatment of previously diagnosed central nervous system (CNS) involvement by leukemia and lymphoma or other malignancies. The procedure is also used for withdrawal of CSF for laboratory analysis in patients with known CNS malignancy.
1. May be performed in the 4C Infusion Center Or Inpatient Units
 - i. Indications
 - a. Patients with surgically implanted Ommaya reservoir and recent diagnosis or history of leptomeningeal malignancy
 - b. Patients with Ommaya reservoir and meningeal signs or symptoms such as nuchal rigidity and headaches, without evidence of increased intracranial pressure.
 - c. Withdrawal of CSF may be done as part of evaluation of fever (as indicated) in patients with Ommaya reservoir.
 - ii. Precautions
 - a. Precautions: Evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, papilledema, bulging Ommaya or significant decrease in the level of consciousness; evidence of focal neurological findings.
 - iii. Contraindication: Cutaneous infection at the site of puncture.
- B. Data Base:
1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
 2. Objective Data
 - a. Physical exam appropriate to presenting symptoms.
 - b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.
- 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, and uncontrolled).

D. Plan

1. Therapeutic Treatment Plan
 - a. Obtain informed consent prior to procedure and according to hospital policy.
 - b. Time out performed according to hospital policy.
 - c. CSF may be sent for evaluation for infection or malignancy.

2. Patient conditions requiring attending consultation:
 - a. Acute decompensation of patient situation.
 - b. Unexplained physical or laboratory findings.
 - c. Initiation or adjustment of medication other than those in the formularies.

3. Education
 - a. Appropriate and relevant patient and family education/counseling in written and/or verbal format.

4. Follow-up
 - a. As indicated and appropriate to client health status and diagnosis.

E. Documentation

Post-procedure note recorded in the medical record in addition to consent forms and other procedure specific documents as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the PA 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite
Training will consist of instruction by clinical directors or physician/NP designee.
Proctoring Period
<ol style="list-style-type: none">a. Proctoring period for practitioners will be a minimum of 3 successful observed demonstrations within the proctoring period, if there are insufficient opportunities within the proctoring period, and then procedure will be supervised until the minimum requirement is met.

Reappointment

- a. A minimum of 2 procedures within a 2 year period. If no opportunities occur within a 2 year period, provider will be supervised for 1 additional procedure when the opportunity occurs.
- b. 2 chart reviews every 2 years.

Protocol # 17: Procedure: Lumbar Puncture

A. DEFINITION

A diagnostic procedure used to identify infectious, neoplastic, and autoimmune processes of the central nervous system. Lumbar puncture may also be performed to determine the intracranial pressure.

1. Location to be performed: Inpatient Units and the 4C Outpatient Infusion Center
2. Performance of Lumbar Puncture
 - a. Indications
 1. To obtain Cerebral Spinal Fluid (CSF) for diagnosis of infectious, inflammatory or neoplastic diseases
 - b. Precautions

Indications for brain CT scan prior to LP include the following

 1. Age >60 years
 2. Immunocompromised patients
 3. Known CNS lesions
 4. Recent seizure activity
 5. Abnormal level of consciousness
 6. Focal findings on neurological examination
 - c. Contraindications
 1. Increased Intracranial Pressure
 2. Soft tissue infection at the entry site
 3. Coagulopathy
 4. Known spinal cord arteriovenous malformations
 5. Patient refusal

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure to be performed including but not limited to presence of headache or meningitic symptoms, motor/sensory deficits, and new/persistent CSF leak.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-containing-products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination, assessment of papilledema, and integrity of the lumbar skin site.

- b. The procedure is performed following standard medical technique according to The Handbook of Neurosurgery by Mark Greenberg, Section 23.7.3. Lumbar Puncture.
- c. Laboratory evaluation to include CBC with platelets, PT, PTT, and INR. Imaging evaluation, including CT head to rule out a mass lesion, a posterior fossa lesion, or subarachnoid hemorrhage, as indicated by history and physical exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGHMC 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, consistent with hospital policy, obtained before procedure is performed.
- b. Timeout conducted consistent with hospital policy.
- c. Diagnostic tests on the CSF for purposes of disease identification may include chemistry, gram stain, culture and sensitivity, blood cell count and differential, and measurement of CSF pressure. Additional diagnostic tests may be sent, as indicated
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. All patients requiring this procedure will receive Attending Consultation

3. Education

- a. Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print-outs titled “Lumbar Puncture” and “Having a Lumbar Puncture” can be provided to patients to assist with pre- and post-procedural education.

4. Follow-up

As appropriate for lumbar puncture.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisite</p> <ul style="list-style-type: none">a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this procedure.b. Completion of onsite training by qualified provider if no prior experience.
<p>Proctoring</p> <ul style="list-style-type: none">a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations and 3 chart reviewsb. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations and 2 chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.c. Proctoring for 1 of the procedures may be performed on a simulated model
<p>Reappointment</p> <ul style="list-style-type: none">a. The evaluator will be an attending physician or another designated clinician that has unrestricted privileges to perform lumbar puncturesb. Ongoing Competency Evaluation<ul style="list-style-type: none">1. Three Lumbar Punctures will be needed to maintain proficiency every 2 years.2. Three chart reviews will be needed every 2 years.c. Proctoring for 1 of the procedures may be performed on a simulated model

Protocol #18 Procedure: - Lumbar puncture with the Administration of Intrathecal Chemotherapy

- A. Definition – The lumbar puncture (LP) may assist in diagnosis of central nervous system (CNS) infections, malignancies and subarachnoid hemorrhage. The LP also facilitates the intrathecal administration of chemotherapy into CSF in previously diagnosed lymphoma and leukemia patients with leptomeningeal involvement or high risk for leptomeningeal involvement.
1. Location of procedure may include 4C Infusion Center, Inpatient rooms and fluoroscopy room in Radiology.
 - a. Indications - Patients with recent diagnosis of CNS malignancy, history of CNS malignancy, therapy related complications of the CNS, or signs and symptoms of infections of the CNS, acute leukemia or lymphoma (as staging or CNS prophylaxis).
 - b. Precautions/Contraindications:
 - Patients with evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, altered mental status, or focal neurological deficits should undergo a neuroimaging study before a LP is performed and requires physician consultation.
 - New focal neurologic findings and/or lesions, or imaging studies revealing significant mass effect. Requires physician consultation.
 - Use caution with patients with a history of low back pain, sciatica pain, or lower extremity neuralgia. Any patients with prior back surgery shall be evaluated by the attending physician prior to the procedure.
 - Patients with meningeal signs or symptoms, such as nuchal rigidity and headache with or without evidence of increased intracranial pressure, fever or altered mental status should be done in the hospital after appropriate CT scanning and prior physician consultation.
 - Patients with either thrombocytopenia (platelet count less than 30,000), INR > 1.4, PTT >40 Consult with physician before performing the procedure. Patients may require additional studies or blood products to correct the platelet count and/or coagulation factor deficiencies.

B. Data Base

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-

containing products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data

- a. Physical exam appropriate to presenting symptoms.
- b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes.

D. Plan

1. Therapeutic Treatment Plan

- a. Obtain informed consent prior to procedure and according to hospital policy.
- b. Time out performed per hospital policy.
- c. Diagnostic tests for clarification of disease state or infection.
- d. Initiation or adjustment of medication per chemotherapy order writing protocol.

2. Patient conditions requiring attending physician consultation

- a. Acute decompensation of patient.
- b. Unexplained physical or laboratory findings
- c. Upon request of patient, NP, PA or physician
- d. Any precautions listed under A1b

3. Education

Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print outs titled "Lumbar Puncture" and "Having a Lumbar Puncture" can be provided to patients to assist with pre and post-procedural education.

4. Follow-up

As indicated and appropriate to client health status and diagnosis.

E. Documentation

Post-procedure note recorded in the medical record and LCR as appropriate and will include all necessary documentation. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the PA within thirty (30) days of the procedure. 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites

- a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this minor procedure.
- b. Completion of onsite training by a qualified provider if no prior experience.

Proctoring

- a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations and chart reviews.
- b. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations and chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.

Reappointment

- a. The evaluator will be the Clinical Service Chief or another designated physician that has unrestricted privileges to perform lumbar punctures.
- b. Ongoing Competency Evaluation
 - 1. 2 Lumbar Punctures will be needed every 2 years.
 - 2. 2 chart review will be needed every 2 years.

Protocol #19: Procedure: Procedural Moderate Sedation

A. DEFINITION

Procedural/Moderate Sedation/Analgesia: is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light or tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation (SFGH policy number 19.08 titled, "Procedural Sedation: Moderate and Deep") by the Nurse Practitioner/Physician Assistant during procedures in adults within a monitored setting. For the purpose of this protocol, the setting is specifically in the Gastroenterology Department. The Nurse Practitioner/Physician Assistant practices under the supervision of the Chief of Gastroenterology or designee. Practitioners producing a level of sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes, and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedure may only be done in 3D GI Service or in the 5B Research Unit.

Materials necessary for procedural sedation and rescue include:

- a. Appropriate monitoring equipment.
- b. Emergency medications and equipment for care and resuscitation, including cardiac defibrillator must be immediately available. Medications include, but are not limited to reversal agents (naloxone and flumazenil) and vasoactive medications (phenylephrine and dopamine).
- c. Supplemental oxygen and positive pressure ventilation equipment.
- d. Suction equipment/supplies.
- e. Intravenous access.

Indications:

- a. Procedural sedation may be indicated, but not limited to colonoscopy and esophagogastroduodenoscopy (EGD).

Precautions/Contraindications:

- a. Inability to obtain informed patient consent.
- b. Anticipated difficult intubation.
- c. The patient's American Society of Anesthesiologists (ASA) physical status; consultation with Anesthesia Service should be considered for patients who have an ASA score of 3 or above. A procedure requiring sedation would not be done on a patient with an ASA score above a three (3) without anesthesia assistance.
- d. When the patient's cardiovascular status will not permit positioning in a recumbent position.
- e. Undiagnosed potential trauma to the gastrointestinal tract.

B. DATA BASE

1. Subjective Data
 - a. Obtain a history within 24 hours of the procedure and sedation. If completed prior to 24 hours, an interim history must be obtained.
 - b. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
 - c. Pertinent past medical history, surgical history, hospitalizations, habits, anesthetic, allergy and drug history.
2. Objective Data
 - a. Physical exam within 24 hours of procedure and sedation. If completed prior to 24 hours, an interim physical must be obtained. The exam is to include airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight), and IV access.
 - b. Diagnostic data, as appropriate.
 - c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.
 - d. Laboratory and imaging results, as indicated, relevant to the history and physical exam.

C. DIAGNOSIS/ASSESSMENT

1. A judgment as to the appropriateness of the procedure and safety of sedation for the particular patient, that includes consideration of the patient's age, medical condition, and the procedure and sedation side effects and risks.
2. Assignment of an ASA physical status. Patients with a Physical ASA class of IV or V will not undergo moderate sedation by the Nurse Practitioner/Physician Assistant in the Gastroenterology Department.
3. Assignment of the pre-procedure Modified Aldrete Score.
4. Evidence of verification of compliance with the NPO status (adult: minimum 8 hours (solids) and 2 hours (clear liquids) before procedure to decrease risk of aspiration).
5. Assess and document the benefits of sedation against the risk of possible aspiration.
6. A responsible adult is available to take the patient home after the procedure.

D. PLAN

1. Therapeutic Treatment Plan shall follow SFGH policy number 19.08 titled "Procedural Sedation: Moderate and Deep"
 - a. Informed consent for the procedure and sedation must be obtained and documented by the nurse practitioner/physician assistant prior to the delivery of sedation. The consent form must list the procedure to be performed as well as the sedation planned.
 - b. Pre-Procedure patient education shall be given and documented, to include, but not be limited to:

1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
 2. Risks, benefits, and alternatives.
 3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
 4. Date/time of procedure.
 5. Necessity of an escort for discharge to home and/or an appropriate mode of transportation home.
- c. Re-assessment immediately prior to the procedure to include:
 1. Indication for procedure.
 2. Two patient identifiers.
 3. A "time out" documented.
 4. Immediate pre-procedure vital signs (blood pressure, heart rate and oxygen saturation).
 5. An assessment of level of movement and consciousness, and responsiveness.
 - d. The Procedure:
 1. Verify pre-procedure assessment and monitoring guidelines.
 2. Administer appropriate medications as indicated.
 3. Continuously assess the patient's response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, ETCO₂, EKG rhythm, and pain level).
 5. Reversal agents, if indicated.
 - e. Post-procedure
 1. Monitor level of consciousness, respiratory (RR, SaO₂) and cardiovascular parameters, and pain level.
 - f. Termination of Treatment
 1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.
2. Patient conditions requiring Attending Consultation
 - a. Physical ASA status 3 or above.
 - b. Aspiration.
 - c. Acute decompensation of patient situation.
 - d. Unexplained historical, physical or laboratory findings.
 - e. Upon request of patient, NP, PA, or physician.
 - f. Problem requiring hospital admission or potential hospital admission.
 3. Education

Patient will be instructed on signs and symptoms of complications. A 24 hour emergency advice number will be given to the patient for any post-procedural problems. Examination findings/pathology results will be provided to the patient by the primary care provider, telephone, or during an appointment in the GI Clinic.

4. Follow-up
 - A. If the patient is transferred to the recovering unit:
 1. The patient must be accompanied by trained and/or licensed personnel.
 2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:
 - a. Pertinent medical history
 - b. The procedure performed.
 - c. The condition of the patient; including pain score.
 - d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
 - e. Any significant clinical events occurring during and post-procedure.
 - f. Any additional physician orders relating to the post-procedural/moderate sedation care.
 - B. Any patient receiving a reversal agent (narcan or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re-sedation. In addition an Unusual Occurrence Report must be completed. See Hospital Policy 19.08 for other criteria requiring submission of an unusual occurrence report.
 - C. The outpatient is discharged "to home":
 1. By a specific discharge order from a physician or nurse practitioner/physician assistant; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.
 2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
 3. Outpatients who are discharged to home must be accompanied by a responsible adult and have an appropriate mode of transportation.

E. RECORD KEEPING

Patient visit, consent forms, other procedure specific documents, and a post procedure note will be recorded in the Medical record as appropriate. The patient status and compliance with discharge criteria must be documented in the patient's medical record by the physician, nurse practitioner, physician assistant, or registered nurse discharging the patient. Document all findings in the computerized procedure database. Procedure documentation is automatically exported to the Lifetime Clinical Record (LCR).

F. Summary of prerequisites, proctoring & reappointment of competency

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

1. Indications for procedures.

2. Risks and benefits of procedures.
 3. Related anatomy and physiology.
 4. Bowel preparation procedures.
 5. Informed consent process.
 6. Use of required equipment.
 7. Steps in performing procedures.
 8. Ability to interpret results and formulate follow-up plans.
 9. Documentation.
 10. Ability to recognize a complication.
 11. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.
- B. Training Program
1. Completion of the SFGH Procedural Sedation Test with a passing score of 90%. 2. Completion of (BLS) training.
 3. Completion of the Registered Nursing Moderate Sedation Education Module.
 4. Furnishing License and/or DEA number.

Proctoring

- A. Direct observation by GI attending staff credentialed in moderate sedation for a minimum of 30 procedures with moderate sedation, while an experienced practitioner to moderate sedation requires a minimum of 10 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
- B. Successful completion of Education Module post test.
- C. Review of 30 procedure notes by the Chief of Gastroenterology.

Reappointment

- A. Ongoing competency will include the successful observed completion of three procedures every 2 years.
- B. Direct observation of one patient clinic encounter will be conducted by the Medical Director or other designated attending physicians every 2 years.
- C. Maintenance of BLS Certification.
- D. Passing of Procedural Sedation test with a passing score of 90%

Protocol #20: Procedure: 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. Exchange transfusion is the withdrawal of blood prior to a transfusion to keep hemoglobin unchanged.

1. Location to be performed: Inpatient hospital units, Hematology/Oncology Clinic, 4C Infusion Center and the Positive Health Clinic. Exchange transfusions will only be done in the 4C Infusion Center.
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.
 4. Exchange transfusions for sickle cell patients with the following, but not limited to: acute chest syndrome, stroke, severe infection, severe anemia, preoperatively, during pregnancy and to prevent recurrent acute chest pain.
 - b. Precautions
 1. Blood and blood components must be given according to SFGH guidelines.
 2. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.
 - c. Contraindications
Absolute: none
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 evaluation.
 - c. All Point of Care Testing (POCT) will be performed according to SFGH 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. (SFGH 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

3. Education

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

4. Follow-up

As appropriate for patients 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, ICIP, LCR and other patient data bases, as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisite:</p> <ol style="list-style-type: none">a. Successful completion of the San Francisco General Hospital and Trauma Center 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.
<p>Proctoring:</p> <ol style="list-style-type: none">a. Read and Sign the SFGH Administrative Policy and Procedure 2.3 “Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options”.b. Review of SFGH Transfusion Guidelines in Laboratory manual.c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.
<p>Reappointment:</p> <ol style="list-style-type: none">a. Completion of the two education modules and completion of the two examinations with a passing score of 80%.b. Performance of 2 transfusion orders every 2 years and 2 medical record reviews every 2 years.c. Review of any report from the Transfusion Committee.

Protocol #21: Procedure: Ordering Chemotherapy

- A. Definition: Chemotherapy is the use of anti-cancer, immunotherapy and growth factor drugs to treat malignancies. Selection of specific drugs or protocols is based on results of prior and on-going clinical trials.
1. Location for ordering chemotherapy: Hematology/Oncology Clinic and the 4C Infusion Center.
 2. Policy – The standardized procedures enables the NP/PA to initiate or change, in consultation with the attending physician(s) as appropriate, chemotherapy regimens. The NP/PA shall also write chemotherapy orders
- B. Data Base:
1. Subjective Data
 - a. Screening: 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.
 - b. Continuity: review of symptoms and history relevant to the disease process or presenting complaint and relevant to treatment.
 - c. Pain history to include onset, location, and intensity.
 2. Objective Data
 - a. Physical exam consistent with history and clinical assessment of the patient.
 - b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.
- 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 (ie. Stage of cancer)
- D. Plan
1. Chemotherapy orders procedure
 - Verify patient height and weight and calculate BSA, CrCl and other needed parameters according to protocol guidelines
 - Confirm doses and dose parameters specific to chemotherapy protocols.
 - Order pre-chemotherapy checklist labs as per hospital protocol
 - Write anti-emetics and pre-medication orders appropriate to chemotherapy protocol.
 - Write chemotherapy orders in consultation with the Attending Physician as appropriate.
 2. Client conditions requiring consultation
 - a. Acute decompensation of patient situation

- b. Unexplained physical or laboratory findings
- c. Upon request of patient, NP, PA or physician
- d. Problem requiring hospital or potential hospital admission

3. Education

- a. Instruction and directions regarding the taking of the medications.
- b. Education on why medication was chosen, expected outcomes, side effects, and precautions.

4. Follow-up

Patients shall be closely monitored, as indicated, for excessive toxicities appropriate to the drug and/or regimen, progression of disease, or development of new or exacerbation of concurrent medical problem that would contraindicate receiving treatment or necessitate an appropriate change in the regimen.

E. Record Keeping

Chemotherapy orders are written on the standard SFGHMC Chemotherapy Order Sheet and will include all necessary documentation according to hospital policy. Patient visit, consent forms and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistant, using protocols for supervision the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within 30 days after completion of proctoring period. The physician shall select for review those cases that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisite, Proctoring, and Reappointment Competency

<p>Prerequisites</p> <p>Training will include a weekly didactic meeting with the clinical director during the three month proctoring period and may be extended depending upon the evaluation of the clinical director or Heme Onc attending at the completion of proctoring.</p>
<p>Proctoring</p> <ul style="list-style-type: none"> a. All NPs/PAs who are recently hired will have their chemotherapy orders cosigned for the duration of their proctoring period, 3 months for full time employees and 6 months for part time employees. b. Experienced practitioner will have 2 chemotherapy orders reviewed by clinical director. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
<p>Reappointment</p>

- a. Evaluation will be done by the Medical Director or designated Physician.
- b. Ongoing competency evaluation.
 - 1. Three chemotherapy orders reviewed every 2 years.
 - 2. Three chart reviews needed every 2 years.

Protocol #22: Procedure: Skin Biopsies

A. DEFINITION

Removal of a small portion of abnormal skin to be treated in a laboratory. There are three types of skin biopsy:

- Shave biopsy: the outer part of the suspect area is removed.
- Punch biopsy: a small cylinder of skin is removed using a punch tool.
- Excision biopsy: the entire area of abnormal growth is removed.

1. Performance of procedure:

a. Indications

1. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.

b. Precautions

1. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
2. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
3. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.

c. Contraindications: None

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

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.
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGH 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 before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Biopsy tissue is sent to pathology if indicated.
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician 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. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
3. Education
Pre-procedure and post procedure education as appropriate and relevant in verbal or written format.
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. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisites</p> <ul style="list-style-type: none"> a. Onsite training of procedures by a qualified provider. b. Review of aseptic technique c. Review of departmental policy and procedure
<p>Proctoring Period</p> <ul style="list-style-type: none"> a. New practitioner to procedure, a minimum of 2 successful observed demonstrations and chart reviews of each procedure b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstration and chart review of each procedure.

Designation of experienced practitioner requires documentation of
1) previous proctoring and 2) ongoing performance assessment
within the past two years.

Reappointment Competency

- a. Evaluator will be the Medical Director or other qualified provider
- b. Competency
 - 1. Perform 1 procedures of each type every 2 years.
 - 2. 1 chart review of each type every 2 years.

Protocol #23: Procedure: Thoracentesis

- A. **DEFINITION:** Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid. This procedure can be done in the Inpatient hospital units.
1. Performance of procedure
Indications
 - a. For the purposes of this protocol, thoracentesis may be used to determine the cause of a pleural effusion or
 - b. To relieve the symptoms of non-acute respiratory distress
Contraindications
 - a. Infection in the tissues near the puncture site.
 - b. Acute respiratory compromise
 - c. Coagulopathy
 - d. Significant pulmonary parenchymal disease
- B. **DATA BASE**
1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
 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 SFGH 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 before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.

- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
All patients needing procedure

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. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum 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 patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisite</p> <ul style="list-style-type: none"> a. Onsite training by a qualified provider.
<p>Proctoring Period</p> <ul style="list-style-type: none"> a. New provider to procedure, a minimum of 3 successful observed demonstrations and 3 chart reviews b. Experienced provider to procedure, a minimum of 2 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. c. Proctoring for 1 of the procedures may be performed on a simulated model
<p>Reappointment Competency</p> <ul style="list-style-type: none"> a. The evaluator will be an Attending Physician or another clinician that has unrestricted privileges to perform thoracentesis b. Ongoing competency evaluation. <ul style="list-style-type: none"> 1. Perform a minimum of 3 procedures every 2 years.

2. Three chart reviews every 2 years.
c. Proctoring for 1 of the procedures may be performed on a simulated model

Procedure #24: Procedure: Waived Testing

A. DEFINITION

Waived testing relates to common laboratory tests that do not involve an instrument and are typically performed by providers at the bedside or point of care.

1. Location where waived testing is to be performed: Adult Medical Clinic, Specialty Clinics on Ward 92, 4C Infusion Center, 5B Research Unit, Occupational Health Services, Positive Health Clinic, Ward 17 Renal Dialysis Center and Inpatient Units.
2. The following non-instrument based waived tests are currently performed at SFGH:
 - a. Fecal Occult Blood Testing (Hemocult ®)
Indication: Assist with detection or verification of occult blood in stool.
 - b. Vaginal pH Testing (pH Paper)
Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.
 - c. SP® Brand Urine Pregnancy
Indication: Assist with the diagnosis of pregnancy.
 - d. Chemstrip® Urine Dipstick
Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

1. Subjective Data
Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed
2. Objective Data
Each waived test is performed in accordance with approved SFGH policies and procedures specific for each test as well as site-specific protocols and instructions for:
 - a. Indications for testing
 - b. Documentation of test results in the medical record or LCR
 - c. Actions to be taken (follow-up or confirmatory testing, Attending consultation, referrals) based on defined test results.
 - d. Documentation or logging of tests performed

C. DIAGNOSIS

Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.

D. PLAN

1. Testing

- a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
- b. Use gloves and other personal protective equipment, as appropriate.
- c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.

Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.

- d. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?

2. Test Results requiring Attending Consultation

- a. Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

3. Education

- a. Inform patient of test results and need of additional tests, as necessary

4. Follow-up

- a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

Test and control results will be recorded in the medical record as per site-specific protocols (may be in paper charts or entered in electronic data bases).

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,

Proctoring:

Successful completion of Health stream quizzes for each of the waived tests the practitioner is performing at SFGH, achievement of passing scores of at least 80% on each module.

Reappointment Competency Documentation:

Renewal required every two years with documentation of successful completion of the required Health stream quizzes. Provider must have passed each required module with a score of 80%.

Protocol #26: Procedure: Contraceptive Implant Insertion

A. DEFINITION

The transdermal contraceptive implant is placed under the skin of the upper arm via a preloaded inserter and remains effective for five years. Insertion is performed under local anesthetic using aseptic technique.

1. Location to be performed will be all appropriate sites within the DGIM department.
2. Performance of procedure:
 - a. Indications
 - i. Women desires long acting, reversible contraceptive.
 - b. Precautions
 - i. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.
 - ii. May have drug interactions with anti-HIV medications and some herbal products.
 - iii. See drug precautions/interactions in contraceptive implant prescribing information.
 - c. Contraindications
 - i. Known or suspected pregnancy
 - ii. Current or past history of thrombotic disease
 - iii. Hepatic tumors, active liver disease
 - iv. Known, suspected or history of breast cancer
 - v. Undiagnosed abnormal genital bleeding
 - vi. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to presenting complaint or procedure/surgery to be performed, including sexual history to rule out preexisting pregnancy.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, including over-the-counter and herbal remedies, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam, including a negative pregnancy test.
 - c. All Point of Care Testing (POCT) will be performed according to

ZSFG Admin 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 before procedure is performed and obtained according to hospital policy.
- b. Timing of insertion: see prescribing information.
- c. Implant insertion as described in prescribing information.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Difficult insertions.
- b. Acute decompensation of patient situation.
- c. Upon request of NP, PA or physician

3. Education

Discharge information and instructions for care of site, expected side effects, precautions and urgent/emergent symptoms.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring, and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

- a. Completion of a company sponsored training program

Proctoring:

- a. Direct observation of 2-3 successful insertions by a qualified provider for providers new to this procedure.
- b. Direct observation by a qualified provider of 4-2 insertion for an experienced provider (as defined by proctoring at another institution with

ongoing performance assessment documented within the past 2 years).
c. Chart review of all observed cases.

Reappointment Competency Documentation:
a. A minimum of 6 insertions every 2 years.
b. 1 chart review needed every 2 years.

Protocol #27: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm and remains effective for five (5) years. Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications
Woman desires removal of implant or implant is expired.
 - b. Precautions: See prescribing information.
 - c. Contraindications: See prescribing information.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - 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 Admin 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 before procedure is performed and obtained according to hospital policy.
 - b. Diagnostic tests for purposes of disease identification.
 - c. Timing of removal: See prescribing information
 - d. Removal: as described in prescribing information
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
 - a. Acute decompensation of patient situation.
 - b. Difficult Implant removal.
 - c. Upon request of patient, affiliated staff or physician
 - d. If patient desires removal and rod is not readily palpable.
3. Education
Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.
4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Requirements to be completed prior to initiation of proctoring and provision of direct patient care:</p> <ol style="list-style-type: none"> a. Completion of a company sponsored training class
<p>Proctoring Period:</p> <ol style="list-style-type: none"> a. Performance of a minimum of 6<u>3</u> removals for a new provider and 2 removals for a provider who has prior experience with independent removal. b. Proctor must be a qualified provider. c. Chart review of all observed cases. <u>d. Proctor must be a qualified provider.</u>
<p>Reappointment Competency Documentation:</p> <ol style="list-style-type: none"> a. Performance of 8<u>6</u> removals every 2 years. b. <u>2</u>1 chart review needed every two<u>2</u> years.