DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
CLINICAL SERVICE
RULES AND REGULATIONS
~~2021~~2023

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The Pricilla Chan and Mark Zuckerberg
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I. DENTISTRY/ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

1. The full scope of practice of the Dentistry/Oral and Maxillofacial Surgery Clinical Service covers:

    - Patient Assessment
    - Anesthesia in Outpatient Clinic
    - Dentoalveolar Surgery
    - Oral and Craniomaxillofacial Implant Surgery
    - Surgical Correction of Maxillofacial Skeletal Deformities
    - Cleft and Craniofacial Surgery
    - Trauma Surgery
    - Temporomandibular Joint Surgery
    - Diagnosis and Management of Pathologic Conditions
    - Reconstructive Surgery
    - Cosmetic Maxillofacial Surgery

    Except for the clinical areas of cleft and craniofacial surgery and cosmetic (soft tissue) maxillofacial surgery, the full scope is practiced extensively by this Dentistry/Oral and Maxillofacial Surgery Clinical Service.

2. General Dentistry scope of service is indicated by the accepted definition of dentistry:

    "*Dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of disease disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by a dentist, within the scope of his/her education, training, and experience, in accordance with the ethics of the profession and applicable law."*

    Currently, the Dentistry/Oral and Maxillofacial Surgery Service provides limited general dental care. However, there is adequate facility and equipment leaving open the potential for resumption of this type of care. Additionally, general dentists have been appointed to the Courtesy Staff.

3. Chief of Dentistry / Oral & Maxillofacial Surgery Clinical Service Job Description (See APPENDIX E)

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, Article II, *Medical Staff Membership* as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION OF ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE

Refer to Appendix D – Clinic Matrix Organization Chart in Oral and Maxillofacial Surgery Service

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Oral & Maxillofacial Surgery Clinical Service is in accordance with ZSFG Bylaws Article II, *Medical Staff Membership*, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Dentistry/Oral & Maxillofacial Surgery Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

1) **Practitioners Performance Profiles**
   Refer to Appendix C - OMS Performance Improvement and Patient Safety Plan – Section IV

2) **Staff Status Change**
   The process for Staff Status Change for members of the Dentistry/Oral & Maxillofacial Surgery Clinical Services is in accordance with ZSFG Bylaws, Rules and Regulations.

3) **Modification/Changes to Privileges**
   The process for Modification/Change to Privileges for members of the Dentistry/Oral & Maxillofacial Surgery Clinical Services is in accordance with ZSFG Bylaws, Rules and Regulations.

C. AFFLIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals to ZSFG through the Dentistry/Oral & Maxillofacial Surgery Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations.

D. STAFF CATEGORIES

The Dentistry/Oral & Maxillofacial Surgery Clinical Service staff fall into the same categories which are described in Article III – *Categories of the Medical Staff* of the

ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

The Dentistry/Oral & Maxillofacial Surgery Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations as well as these Clinical Service Rules and Regulations. Applicants must indicate on the privilege form the procedures for which they have demonstrated competence and wish to have.

GROUP A: GENERAL DENTISTRY
Applicants for general dentistry privileges must satisfy all of the following criteria except the requirements for training in oral maxillofacial surgery, board eligibility or certification, ACLS and current DEA certificate

GROUP B: ORAL & MAXILLOFACIAL SURGERY
The criteria for oral and maxillofacial surgery are:

1. Graduation from a school of dentistry which is accredited by the American Dental Association Commission on Dental Accreditation or listed in the World Directory of Dental Schools as published by the World Organization of Health.
2. Completion of residency in oral and maxillofacial surgery from a program accredited by the American Dental Association Commission on Dental Accreditation.
3. Possession of a valid, current dental or medical license in the state of California.
4. Possession of a valid, current DEA.
5. Current professional liability insurance, if not insured either through the University of California as a faculty member or through the City & County of San Francisco in an amount considered appropriate for the type and scope of practice by this hospital's medical staff and governing body on an individual basis.
6. Completion of a BLS and ACLS course within the last two years.
7. Must provide proof of Admissibility or Certification by the American Board of Oral & Maxillofacial Surgery.
8. If the applicant received his/her training in a country other than the United States of America, and has an academic or clinical appointment in the Department of Oral and Maxillofacial Surgery at the University of California San Francisco, then requirements #1 and #2 are satisfied.
9. If the applicant wishes privileges in Outpatient General Anesthesia, the applicant must have a valid General Anesthesia permit in the State of California after the probationary year, and the request is approved by the Chief of Anesthesia.
10. Absence of a history or involvement in malpractice suits, or arbitrations, or settlements, OR, in the case of an applicant with this history, evidence that the history of malpractice claims does not demonstrate probably ongoing substandard professional performance.
11. Absence of physical or mental impairments which may interfere with the ability to practice dentistry and/or medicine.

12. Absence of a history of professional disciplinary action, OR, in the case of an applicant with this history, evidence that this history does not demonstrate probably ongoing substandard professional performance.

13. Absence of history of criminal conviction or indictment; OR, in the case of an applicant with this history, evidence that this history does not demonstrate probable substandard professional or ethical performance. A conviction within the meaning of these criteria includes a plea or verdict of guilty or a conviction following a plea of non-contender.
14. Completion of an application form and absence of intentional falsification or omission by the applicant.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Dentistry/Oral & Maxillofacial Surgery Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Dentistry/Oral & Maxillofacial Surgery Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations as well as the Clinical Service Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of the Oral & Maxillofacial Surgery Clinical Service. The initial determination of privileges shall be guided by the applicant's education, training and experience.

All new privileges are normally proctored for up to one year or until competency has been verified. During the proctoring period, all cases must have the approval of a member of the active staff of the Dentistry/Oral & Maxillofacial Surgery Service. Supervision of procedures done in the operating room will be at the discretion of the Chief of Service. If the applicant completed the oral & maxillofacial surgery training program of the University of California San Francisco within five years of application, the applicant will be exempt from case approval and supervision of procedures during the proctoring period.

D. TEMPORARY PRIVLEGES

Temporary Privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V: *Clinical Privileges,* Rules and Regulations and accompanying manuals.

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

All medical staff members initially granted privileges shall complete a period of proctoring. Proctoring (monitoring) requirements for the Dentistry/Oral & Maxillofacial Surgery Clinical Service shall be the responsibility of the Chief of the Service or his designee.

The initial determination of privileges shall be guided by the applicant's education, training and experience. All new privileges are probationary for one year. During the probationary period, all cases must have the approval of a member of the active staff of the Dentistry/Oral & Maxillofacial Surgery Service. Supervision of procedures done in the operating room will be at the discretion of the Chief of Service. If the applicant completed the oral & maxillofacial surgery training program of the University of California San Francisco within five years of application, the applicant will be exempt from case approval and supervision of procedures during the probationary period.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Dentistry/Oral & Maxillofacial Surgery Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations and accompanying manuals.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Dentistry/Oral & Maxillofacial Surgery Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations and accompanying manuals.

V. EDUCATION

The Dentistry/Oral and Maxillofacial Surgery Clinical Service offers ongoing high quality educational and training programs for their members through ward rounds, M&M Conferences, Clinicopathologic Conferences, Journal Club, Human Anatomy Dissections in the laboratory, ZSFG Maxillofacial Trauma Grand Rounds, and UCSF Grand Rounds.

Members of the Dentistry/Oral and Maxillofacial Surgery Clinical Service are required to obtain a minimum of 50 CME units every two years.

VI. ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

SUPERVISION OF RESIDENTS (See Appendix D - OMS Housestaff Manual)

1. Dentoalveolar surgery
   - Limited supervision by attending surgeons
2. Maxillofacial Trauma Surgery
   - Direct attending surgeons' supervision, except for closed reduction of fractures and repair of non-complex facial lacerations.

The following items require direct attending supervision

3. Intravenous Moderate Sedation and OPD General Anesthesia
4. Oral and Craniofacial Implant Surgery
5. Surgical Correction of Maxillofacial Skeletal Deformities
6. Temporomandibular Joint Surgery
7. Management of Pathological Conditions
8. Reconstructive Surgery

Limited supervision means independent decision-making and provision of care by Residents with appropriate attending consultation.

Direct supervision indicates attending surgeon responsibility for the preoperative, intraoperative and postoperative care of each patient. Also, the attending must be consulted by Resident(s) prior to any invasive procedure or material change in the treatment plan. The medical record must show that the attending surgeon was directly involved in the care of each patient.

VII. ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

A. Consultation for patient care is provided 24 hours per day by:
   1. Consultation request form delivered to the Clinic (lN1)
   2. Telephone request by calling the Clinic at Ext. 8104 or 6539
   3. Direct referral to oral and maxillofacial surgery residents
   4. Paging the on-call resident – page number may be obtained from the hospital telephone operator.

B. Non-emergency consultation shall be answered within 24 hours.

C. A written consultation report shall be placed in the patient's chart at the time of patient evaluation. This report shall be dated and signed. In urgent situations the consulting resident or attending shall contact the requesting physician by telephone.

D There is attending surgeon coverage 24 hours per day. After clinic hours, the on-call attending may be contacted through the hospital telephone operator or the telephone/pager number on the monthly "on-call" schedule, available at key locations within the hospital.

VIII. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the ZSFG Dentistry/Oral & Maxillofacial Surgery Clinical Service.

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

A. GENERIC CLINICAL INDICATORS FOR ORAL AND MAXILLOFACIAL SURGERY IN INPATIENT OR OUTPATIENT FACILITIES

Each indicator will be used as a marker, which will be further evaluated by assigned Q.A. Officers in the context of the clinical circumstances. These indicators are not random unknown events or occurrences but rather indices of risks and complications known to be associated with management of the various clinical conditions, covered by the Scope of Practice.

The presence of clinical indicators does not necessarily reflect on the quality of care. Rather, the presence of such indicators may indicate that a treatment modality is of concern after a critical threshold has been reached. What that threshold is will depend on several factors, including the nature of the indicator, the clinical status of the patient receiving care and the patient population for the condition being treated.

These indicators are divided into three groups. These indicators are considered generic to the performance of oral and maxillofacial surgery. When a clinical indicator is selected for review, known risks and complications associated with therapy will be included.

1. Admission after hospital ambulatory surgery
   Comments and Exceptions:
   - Patient informed that additional inpatient management may be required.

2. Performance of additional procedures not specified in consent form.
   Comments and Exceptions:
   - Disparity between preoperative consent form and operative report.

3. Unplanned and/or avoidable removal, injury, or repair of an organ or structure during surgery or invasive procedure; loss of instruments and/or supplies (i.e., sponges and needles)

4. Unplanned return to the Operating Room.

5. Medical and/or surgical complications occurring during the operative and post-operative period
   a. Development of neurological deficit which was not present on admission, other than those accepted as a normal course of the patient's surgical management (e.g. excision of mandibular and maxillary third molars, mandibular resection, sagittal split osteotomy)

6. Surgical and other invasive procedures which do not meet criteria for necessity and appropriateness.
   a. Pathology or imaging reports does not match preoperative diagnosis
   b. Nondiagnosis or normal tissue removed and criteria for necessity or appropriateness not met
   c. No tissue removed, and criteria for necessity and appropriateness not met
   d. Procedure and details of operative report do not match the preoperative diagnosis.
   Comments and Exceptions:
   - Surgical case review committee has developed and approved specific criteria for non-tissue producing cases following individual service consultation, and for the intentional removal of excessive redundant normal tissue.

7. Acquired drug sensitization

8. Transfer from general care to intensive care unit (inpatient only)
   a. Complication
   b. Utilization problem
   Comments and Exceptions:
   - Scheduled prior to surgery or other special procedure.

9. Hospital, Surgery Center, or office-incurred patient incident
   a. Falls, slips and/or patient accidents
   b. Intravenous infusion problems (e.g., calculation error or overloads)

c. Medication error or problem (e.g., drug type or dosage, contrast material reaction)
d. Skin problem (e.g., rash, infiltrations, threatened or new decubitus ulcer)
e. Equipment failure
f. Other incidents (e.g., procedural errors, electric shock or burn, actual or attempted suicide, lost or damaged property)

10. Abnormal laboratory, radiographic or other test results not addressed by surgeon
Comments and Exceptions:
– As monitored by the medical staff

11. Discharge to home with
a. Blood pressure on day of discharge:
Systolic: Less than 80 or greater than 180
Diastolic: Less than 50 or greater than 110
b. Core temperature on day of discharge greater than 101 degrees
c. Pulse: Less than 50 or greater than 120 within 24 hours of discharge
d Intravenous (IV) fluids or drugs on the day of discharge (excludes keeping the IV in place, antibiotics, chemotherapy or TPN)
e. Significant purulent or bloody drainage of postoperative wounds within 24 hours prior to discharge.

12. Patient and/or family dissatisfaction.
Comments and Exceptions:
– As monitored by post surgery random sampling

13. Subsequent visit to emergency room for complications or adverse results related to previous hospitalization or outpatient surgery.
Comments and Exceptions:
– Planned return for wound checks or suture removal
– Patient not previously hospitalized at this hospital

B. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

See Appendix C – OMS Performance Improvement and Patient Safety Plan

C. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

Annual Performance Improvement & Patient Safety (PIPS) Reports are presented to the PIPS Committee.

1. Policy for Attending Staff Review
The activities of the attending staff are:
a. Teaching –predoctoral and postdoctoral (residents) students
b. Private Practice – intramural or extramural
c. Research - clinical and laboratory
d. Continuing education courses – faculty or attending
e. Committee work

2. Basis for reviews are:
   a. Monitoring progress notes by Chief of Service
   b. Operating room visits by Chief of Service, when that attending is managing a case
   c. Participation on rounds
   d. Participation in and case discussion during monthly department meetings
   e. Biannual review of reappointment
   f. Since most of the attending surgeons are members of the UCSF faculty, they are also subject to the scrutiny of the University's Academic Senate for merit increases and promotions.

3. Policy for Housestaff Review:
   a. Review of medical records on discharge
   b. Presence of attending surgeon for all invasive procedures
   c. Ward rounds, directed by attending~~s~~ surgeon
   d. UCSF Grand Rounds, Clinicopathologic Conference, Morbidity and Mortality conference – presentations and active participation by residents – Tuesday A.M.
   e. ZSFG Maxillofacial Trauma Grand Rounds – residents' presentations – first and fourth Friday of each month - A.M
   f. Formal Resident's evaluation by attending~~s~~ surgeons at end of rotations.

D. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to IX C. Above

X. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws *Committees of the Medical Staff*, 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.

The Dentistry/Oral & Maxillofacial Surgery Clinical Services 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, a quorum is constituted by at least three (3) voting members of the Active Staff for the purpose of conducting business.

XI. ADOPTION AND ADMENDMENT

The revised Dentistry/Oral & Maxillofacial Surgery Clinical Service Rules and Regulations ~~will~~ shall be adopted and revised by a majority vote of all Active members of the Dentistry/Oral & Maxillofacial Surgery Clinical Service annually at one of its monthly meetings.

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APPENDIX A – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PRIVILEGE FORM

Privileges for San Francisco General Hospital

Requested Approved

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.

OMFS ORAL & MAXILLOFACIAL SURGERY 2009

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

_____ _____ **8.0 CORE PRIVILEGES**

_____ _____ 8.10 GENERAL DENTISTRY

Evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and conditions of the oral cavity, and maxillofacial area, to include dental surgery on the teeth as a treatment for dental caries and traumatic injuries, prosthetic therapy, routine endodontic therapy, routine orthodontic therapy, routine periodontal therapy, intraoral biopsy, simple and surgical exodontias.
PREREQUISITES: A current dental license, oral surgery permit, or special permit from the Dental Board of California.
PROCTORING: Five (5) operative cases and 10 retrospective reviews of operative cases.
REAPPOINTMENT: Twenty (20) operative procedures in the previous two years.

_____ _____ 8.20 ORAL & MAXILLOFACIAL SURGERY

Diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region, excluding surgical management of malignant lesions and the parotid gland. This includes local anesthesia blocks of head and neck sensory nerves, history and physical examinations, dentoalveolar surgery, implantology, major infections of the oral and maxillofacial region, orthognathic surgery, pathologic surgery, preprosthetic surgery, soft and hard tissue trauma surgery, reconstructive surgery, splint and surgical treatment of sleep apnea, and temporomandibular joint surgery.
PREREQUISITES: A current dental license, oral surgery permit or special permit from the Dental Board of California or medical license from the Medical Board of California, and Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00
PROCTORING: Five (5) observed operative procedures and 10 retrospective reviews of operative procedures.
REAPPOINTMENT: Twenty (20) operative procedures in the previous two years.

_____ _____ **8.30 SPECIAL PRIVILEGES**

_____ _____ 8.31 BENIGN & MALIGNANT PAROTID GLAND TUMORS & MALIGNANT TUMORS OF THE JAWS & ASSOCIATED SOFT TISSUES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00. In addition to that for core privileges, additional training in oncological surgery and/or retrospective review of ten (10) cases.
PROCTORING: Two (2) operative procedures.
REAPPOINTMENT: Five (5) operative procedures in the previous two years.

_____ _____ 8.32 MODERATE SEDATION

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00. The dentist or oral and maxillofacial surgeon must have completed the appropriate residency or clinical experience (Hospital Policy 19.8 SEDATION) and have completed the educational module and post test as evidenced by a satisfactory score on the examination, and submission of a signed Physician Attestation Form to the Medical Staff

Services Department.
PROCTORING: Review of 5 cases.
REAPPOINTMENT: Review of 5 case done in the previous two years or completion of the educational module and post test as evidenced by a satisfactory score on the examination, and a signed Physician Attestation Form submitted to the Medical Staff Services Department.

_____ _____ 8.33 DEEP SEDATION/GENERAL ANESTHESIA
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00. Completion of a dental anesthesia or medical anesthesia or oral and maxillofacial surgery residency training program and Board Admissible or Certified or Re-certified by the respective professional association. Additionally, a current general anesthesia permit from the Dental Board of California is required for providers, who practice exclusively under a dental license, oral surgery permit or special permit.
PROCTORING: Observation of 5 cases.
REAPPOINTMENT: Review of 10 cases in the previous two years.

_____ _____ 8.34 LASER SURGERY
Incisional biopsy, excisional biopsy and ablation of congenital and acquired lesions of the oral and maxillofacial region and associated soft tissues.
PREREQUISITES: Appropriate training. Viewing of the laser safety video prepared by the ZSFG Laser Safety Committee, and baseline eye examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Two (2) observed procedures.
REAPPOINTMENT: Two (2) cases in the previous two years, and viewing of the laser safety video prepared by the ZSFG Laser Safety Committee and documentation of eye examination within the previous 6 months.

I hereby request clinical privileges as indicated above.

_____ _____
Applicant date

FOR DEPARTMENTAL USE:

_____ Proctors have been assigned for the newly granted privileges.
_____ Proctoring requirements have been satisfied.

_____ Medications requiring DEA certification may be prescribed by this provider.
_____ Medications requiring DEA certification will not be prescribed by this provider.

_____ CPR certification is required.
_____ CPR certification is not required.

APPROVED BY:

_____ _____
Division Chief date

_____ _____
Service Chief date

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DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
SAN FRANCISCO GENERAL HOSPTIAL
REQUEST FOR PRIVILEGES COVER SHEET

NAME_____

I am requesting the specific attached marked privileges. I understand that I may request additional or reduced privileges in the future. In making application to the Dentistry/Oral & Maxillofacial Surgery Clinical Service for these privileges, I acknowledge having read and agree to abide by the following procedures:

1. I have indicated the requested privileges on the attached form. I understand that the granting of privileges will require written evidence of competence by my training program director and the Department of the Dentistry/Oral & Maxillofacial Surgery Service at an institution in which I currently hold such privileges. It is my responsibility to provide the name or names of appropriate individuals to contact at the end of the privilege form. As a general dentist without residency training, I will provide written evidence of competence by the Dean of my dental school and Chair of the Department of Restorative Dentistry, in lieu of a training program director.

2. I understand that my application will be reviewed by a departmental review committee only after receipt of all requested materials. Additional materials or information may be requested from me after preliminary review. I may be requested to meet with the committee in person. Upon the recommendation of the service committee, my application will be forwarded to the Chief of Service. The process of approval beyond that point is delineated in the Bylaws and Rules and Regulations of the Medical Staff. Approval by the Chief of Service, the Credentials Committee, the Chief of Staff and Executive Director of the Hospital and the Governing Body is sufficient for me to begin the exercise of requested privileges.

3. I understand that all privileges granted are proctored. The nominal period of proctoring is one year. During the period of proctoring one or two members of the active staff of the service will be assigned as my proctor(s). The function of the proctor is to evaluate the care given to patients by me. The level of involvement of proctors may vary at the discretion of the proctor. It is my obligation to promptly notify my proctor(s), or the attending oral and maxillofacial surgeon on-call, upon admission of my patients.

4. I understand that it is my responsibility to maintain a current list of all hospital patients on the form provided, and to insure that the proctor indicates successful completion of the review process by his/her signature on that form within one week of patient discharge. It is my responsibility to provide the original copies of the proctoring form to the service at 3, 6, 9 and 12 months after initiation of proctoring. I understand that no prompting for this requirement will be given and that failure to do so may result in a report of no proctoring activity being sent to the Credentials Committee. This may results in a delay in granting permanent privileges.

5. I may petition my proctor(s) for completion of the proctoring period with regard to certain procedures or classes of procedures which have been repeatedly observed with satisfactory evaluations. The decision to conclude the proctoring period rests with the service review committee and with the Chief of Service.

6. I understand that if certain requested privileges have not been sufficiently proctored during the initial year, these may be continued into a second year upon a special request by the Service Chief, and approval of the Credentials Committee. If not completed after 18 months, and there is still insufficient evidence to grant full privileges in certain areas, these privileges will be withdrawn. I understand, therefore, that it is in my best interest to request only those privileges which I can reasonably expect to perform on a regular basis.

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DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
SAN FRANCISCO GENERAL HOSPTIAL
PRIVILEGE CRITERIA

GROUP I: GENERAL DENTISTRY

Dentistry is the evaluation, diagnosis, prevention, and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body: provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and the law.

Applicants for general dentistry privileges must satisfy all of the following criteria except the requirements for training in oral maxillofacial surgery, board eligibility or certification, ACLS and current DEA certificate

GROUP II: ORAL & MAXILLOFACIAL SURGERY

Oral and Maxillofacial Surgery (OMS) is the specialty of dentistry which include the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the bone and soft tissues of the oral and maxillofacial region. The term "maxillofacial" refers to the area that encompasses the maxilla and the face.

The criteria for oral and maxillofacial surgery are:

1. Graduation from a school of dentistry which is accredited by the American Dental Association Commission on Dental Accreditation or listed in the World Directory of Dental Schools as published by the World Organization of Health.
2. Completion of residency in oral and maxillofacial surgery from a program accredited by the American Dental Association Commission on Dental Accreditation.
3. Possession of a valid, current dental or medical license in the state of California.
4. Possession of a valid, current DEA.
6. Current professional liability insurance, if not insured either through the University of California as a faculty member or through the City & County of San Francisco in an amount considered appropriate for the type and scope of practice by this hospital's medical staff and governing body on an individual basis.
6. Completion of a BLS and ACLS course within the last two years.
7. Must provide proof of Admissibility for examination or Certification by the American Board of Oral & Maxillofacial Surgery.
8. If the applicant received his/her training in a country other than the United States of America, and has an academic or clinical appointment in the Department of Oral and Maxillofacial Surgery at the University of California San Francisco, then requirements #1 and #2 are satisfied.
9. If the applicant wishes privileges in Outpatient General Anesthesia, the applicant must have a valid General Anesthesia permit in the State of California after the probationary year and approval by the Chief of Anesthesia.
10. Absence of a history or involvement in malpractice suites, or arbitration's, or settlements, OR, in the case of an applicant with this history, evidence that the history of malpractice claims does not demonstrate probably ongoing substandard professional performance.
11. Absence of physical or mental impairments which may interfere with the ability to practice dentistry and/or medicine.
12. Absence of a history of professional disciplinary action, OR, in the case of an applicant with this history, evidence that this history does not demonstrate probably ongoing substandard professional performance.

13. Absence of history of criminal conviction or indictment; OR, in the case of an applicant with this history, evidence that this history does not demonstrate probable substandard professional or ethical performance. A conviction within the meaning of these criteria includes a plea or verdict of guilty or a conviction following a plea of non-contender.
14. Completion of an application form and absence of intentional falsification or omission by the applicant.

The Pricilla Chan and Mark Zuckerberg
San Francisco General Hospital and Trauma Center
1001 Potrero Ave
San Francisco, CA 94110

Appendix B - HOUSE STAFF COMPETENCIES

REFER TO CHN INTRANET SITE, HOUSE STAFF COMPETENCIES LINK

The Pricilla Chan and Mark Zuckerberg
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APPENDIX C - DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN

Currently Held at Dentistry/OMS Service

The Pricilla Chan and Mark Zuckerberg
San Francisco General Hospital and Trauma Center
1001 Potrero Ave
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APPENDIX D – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY HOUSESTAFF MANUAL

Currently Held at Dentistry/OMS Service

APPENDIX E - CHIEF OF DENTISTRY / ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF DENTAL/ORAL/MAXILLOFACIAL SURGERY SERVICE
JOB DESCRIPTION
September 11, 2007

Chief of Dental/Oral/Maxillofacial Surgery Clinical Service

Position Summary:

The Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of 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 Dentistry/Oral/Maxillofacial Surgery Clinical Service reports directly to the Associate Dean at ZSFG and the Chairperson, UCSF Department of Oral and Maxillofacial Surgery. 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 Qualifications:

The Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service 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 Dentistry/Oral/Maxillofacial Surgery Clinical Service 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 the DPH;

In collaboration with the Executive Administrator 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 services provided by the Department;

In collaboration with the Executive Administrator 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.

Dentistry/Oral & Maxillofacial Surgery Clinical Rules and Regulations
Revised: ~~January 10~~November 13, ~~2021~~2023

N.B. 1 The changes in privileges are editorial only and reflect established changes over the past four years.

2. Table of Contents – to be renumbered to correlate with changes in document.

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

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: ___

I. Policy Statement

A. It is the policy of the San Francisco 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). Membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, Psychologists, 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 _____ Department Office and on file in the Medical Staff Office.

II. Functions to be Performed

Each practice area will vary in the functions that will be performed, such as a clinical, ambulatory and specialty clinic care setting, or inpatient care in a unit-based hospital setting. The NP/PA conducts physical exams, diagnoses, and treats illness, orders and interpret tests, counsels on preventative health care, assists in surgery, performs invasive procedures, and furnish medications/issue drug orders as established by state law.

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. NPs 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 NP 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). While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (documents supervising agreement between supervising physician and PA).

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is the outpatient _____Clinic and Inpatient units at ___
   2. Role in the outpatient and inpatient setting may include performing physical exams, diagnosing, and treating illnesses, ordering, and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications.

B. Supervision
   1. Overall Accountability: The NP/PA is responsible and accountable to the _____
   2. A consulting physician, which may include attendings and fellows, will be available to the NP/PA by phone, in person, or by other electronic means always.
   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, 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.

IV. Scope of Practice

Protocol #1

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
   1. Active California Registered Nurse/ Physician Assistant license.
   2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.

3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) by an approved 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 within 12 months of hire for NPs**.**
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Practice Agreement. Copies of Practice Agreement must be kept at each practice site for each PA.

B. Specialty Training
   1. Specialty requirements
      a. NP specialty certification as an ANP, FNP, ACNP
      b. ____

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

   Initial: at the conclusion of the standardized procedure training, the Medical Director and supervising clinical provider(s) will assess the NP/PA's ability to practice clinically.

   1. Length of proctoring period will be three (3) months. The term may be shortened or lengthened at the discretion of the supervising clinical provider; however, the proctoring period shall not exceed the six (6) months CCSF probationary period. At the end of the proctoring term, the NP/PA will be generally supervised by Chief of ____, _____ Service Attending, or designated clinical provider.
   2. The evaluator will be the Chief of ____ or designated clinical provider.
   3. The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
      a. All cases are presented to the evaluator
      b. Medical Record review is conducted for out-patient discharge medication
      c. Medical Record review may be conducted retrospectively by the clinical supervisor.
      d. Proctoring will include a minimum evaluation of five (5) chart reviews and direct observations, with at least one case representing each core protocol, discharge

of inpatients, and furnishing medications/drug orders, if applicable.

e. Procedural skills are incorporated into the competency assessment orientation

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

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

VI. Development and Approval of Standardized Procedure

A. Method of Development
Standardized procedures are developed collaboratively by the NPs/PAs, 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
The CIDP, Credentials, Medical Executive Committee, and Joint Conference Committee must approve all standardized procedures prior to its implementation.

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

D. Revisions
The CIDP, Credentials, Medical Executive Committee, and Joint Conference Committee must approve all revisions to standardized procedures prior to implementation.

DIRECTIONS: Include protocols after this section of the document. Use page breaks between each protocol.

City and County of San Francisco

Department of Public Health

London Breed
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Gabriel Ortiz, MD, PhD
Chief of Staff

Committee on Interdisciplinary Practice
Standardized Procedures Summary of Changes for **October 2023**

Standardized Procedure Name:	Influenza Vaccination Screening and Administration RN
Department:	ZSFG Nursing
Date of last approval:	Sept 2022
Summary of SP updates:	Updates to Prerequisites, Proctoring, and Competency requirements (page 7)
Update #1:	1. Deleted prerequisites o E-Learning education module is assigned to RN staff annually o Administration of IM injections is within the RN scope of practice, is part of RN prelicensure programs, and documentation of IM administration competency is captured during orientation to their care area at ZSFG 2. Deleted proctoring period o EHR order entry is part of the RN orientation to hospital o Unnecessary as Nurse Manager is responsible for ensuring all RN orientations are completed prior to working independently in their care area 3. Updated competency requirements o Changed to "Completes annual flu education module" inclusive of: screening workflow, attestation of SP review, and attestation of order entry policy review ▪ This is assigned to RNs annually ▪ SF Learning is the source of documentation (removed "annual performance appraisal" as this is a duplicative process and "Nurse Manager or their designee will be the evaluator" as this also duplicative re: already included in the Annual Performance Appraisal process)

Standardized Procedure	OB/GYN SP

Name:	
Department:	OB/GYN
Date of last approval:	Jan 2019 with additional protocols approved in Apr 2020 and June 2020
Summary of SP updates:	Grammatical and formatting changes. Updates to be inclusive of SB 697. Protocol updates.
Update #1:	Changes that apply to entire SP 1. Changed "woman/women" to "people/person" re: gender inclusive language 2. Changed "LCR" to electronic medical record (EMR)" re: LCR no longer used in DPH, nonspecific term 3. Changes related to PA practice related to SB 697 4. Changed "physician and other supervisor" to "supervising clinical provider" as APPs can serve in this role 5. Changed "needed" to "must be"
Update #2:	Changes by section • Section II (page 1): o Moved "The NP/CNM/PA conducts physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care, performs invasive procedures and furnishes medications/issue drug orders as established by state law" from further in document to first paragraph re: provides general information about professional scope and is related to the previous sentence o Moved Certified Nurse Midwife to first in list of APPs • Section II (page 2): Removed granular information about PA academic training and continuing education requirements re: redundant as the professional is licensed is required AND these are not listed for any other APP • Section III • B.1 Updated clinic names to Obstetric, Midwifery, and Gynecology Clinic and 6G • VI.3 Deleted OPPE • VII.D.1 Deleted "accompanies by the dated and signed approval sheet" re: no longer our process
Update #3:	Changes by Protocol • Protocol 3 o B.1.c patient-centered assessment per MD author's request (page 11) o D.1.a.2 added trichomonas and deleted VZV titer (page 12)

	o D added patient education (page 12) o F added information about the management of HIV-infected pregnant people (page 13) • Protocol 4 o A added Healthy Workers and Healthy San Francisco o D.1.c.ii added "and refills, if applicable" (page 15) • Protocol 8 deleted prerequisite (page 27) • Protocol 9 deleted prerequisite (page 30) • Protocol 11 removed brand name Nexplanon (page 34) • Protocol 13 deleted prerequisite (page 41) • Protocol 19 o Changed "amniotic fluid" to "deepest vertical pocket (DVP) of amniotic fluid" (page 58 and 59) o Removed from proctoring "If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Obstetrics Medical Director or his/her physician designee(s) within 24 hours." (page 59) o Changed reappointment to "1 peer chart review every 2 years" and deleted "Limited third trimester obstetric ultrasound…signed by a physician attending within 24 hours" (page 60) • Protocol 21 o A. and A.2.i Added "13 weeks 6 days" (page 64) o B.2.b added trichomonas and replaced "RPR" with "syphilis test" (page 65) o D.1.a added "if desired" (page 65) o D.1.j added "when clinically indicated" o Prerequisite: removed information about Health Workforce Pilot Project curriculum and added Abortion training curriculum (page 67) o Proctoring: Changed "performances" to "abortions" (page 67) o Deleted appendix 1 • Protocol 22 o D.2.a changed "status 3" to "class III" (page 73) o D.4.B deleted reference to retired Unusual Occurrence platform and hospital policy, added reference to SAFE (page 74) o Prerequisite: changed passing score to 80% re: hospital standard (page 75)

	○ Reappointment: changed passing score to 80% re: hospital standard (page 75)

Approved
~~9/2022~~

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

COMMITTEE ON INTEDISCIPLINARY PRACTICE

STANDARDIZED PROCEDURE - REGISTERED NURSE

TITLE: Influenza Vaccination Screening and Administration

1. Policy Statement

   A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Registered Nurses, Pharmacists, Physician Assistants, Physicians and administrators and other affiliated staff and must conform to the Nurse Practice Act, Business and Professions Code Section 2725.

   B. A copy of the signed procedures will be kept in an operational manual located in the Nurse Manager Office of each unit covered by this protocol and on file in the Medical Staff Office.

2. Functions to be performed

   The Registered Nurse based upon the nursing process determines the need for a standardized procedure. The RN provides 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 RN to seek physician consultation.

3. Circumstances under Which RN May Perform Function

   A. Setting
   The Registered Nurse may perform the following standardized procedure functions in the ZSFG 4A Skilled Nursing Facility, Units H22/25, H24/26, H32/38, H34/36, H42/44, H48, H52, H54/56, H58, H62/64, H66/68, H76/78, PACU, 7B, 7C, 7L and Psychiatric Emergency Service consistent with their experience and training.

   B. Scope of Supervision Required:
      1. The RN is responsible and accountable to the Nurse Manager of the unit and to the Medical Provider for the patient's primary team.
      2. Overlapping functions are to be performed in areas which allow for a consulting physician to be available, at all times, to the RN, by phone or in person, including but not limited to the clinical area.

3. Physician consultation is to be specified in the protocols and under the following circumstances:
    - Questions regarding interpretation of a contraindication
    - Patient questions unable to be addressed by nursing expertise

4. List of Protocols that will be used in the practice area
    - Protocol #1 Influenza Vaccination Screening and Administration

5. Requirements for the Registered Nurse

    A. Experience and Education
        1. Active California Registered Nurse license.
        2. Current Basic Life Support certification from an approved American Heart Association provider.

    B. Special Training
        1. None

    C. Evaluation of the Registered Nurse competence in performance of standardized procedures.
        1. Initial:
        At the conclusion of the standardized procedure training the Nurse Manager or designee will assess the RN's ability to perform the procedure:
        a. Clinical Practice
            - Length of proctoring period will be consistent with the RNs orientation period in their specific unit
            - A minimum of 1 observation will be conducted
            - Evaluator will be the RN preceptor, Charge RN or Nurse Manager

        2. Annual:
        Nurse Manager or designee will evaluate the RN's competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation or chart review may be used. The standardized procedures will be a required Unit Based Competency for annual review.

        3. Follow-up:
        Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, or designee at appropriate intervals until acceptable skill level is achieved. This may include chart reviews.

6. Development and Approval of Standardized Procedures

A. Method of Development
Standardized procedures are developed collaboratively by the registered nurses, nurse managers, physicians and administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval
All standardized procedures must be approved by the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee and the Joint Conference Committee prior to use.

C. Review Schedule
The standardized procedure will be reviewed every three years or as practice changes, by the registered nurses, nurse managers and medical directors.

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

Protocol #1
TITLE: Influenza Vaccination Screening and Administration

A. DEFINITION

During the annual flu season, the RN completes influenza screening, provides education and administers the vaccine.

1. Location to be performed: ZSFG 4A Skilled Nursing Facility, Units H22/25, H24/26, H32/38, H34/36, H42/44, H48, H52, H54/56, H58, H62/64, H66/68, H76/78, PACU, 7B, 7C, 7L and Psychiatric Emergency Service

2. Performance of procedure:

a. Adult Indications: Annually during Flu season any patient older than 6 months of age seen at ZSFG will be offered the inactivated influenza vaccine unless there are documented contraindication(s) and/or a documented immunization for that year.

b. Pediatric patient Indications (≥ 6 months old and < 9 years old) initial vaccination requires two doses at least four weeks apart.

c. Adult Contraindications (≥ 18 years old)

- Previous administration of Influenza vaccine during existing Flu season
- Previous adverse reaction to vaccination or component
- Fever >/= 38 degrees Celsius in the last 48 hours
- History of Guillain Barre Syndrome

c. Pediatric Contraindications (≥ 9 years old and < 18 years old)

- Previous administration of Influenza vaccine during current Flu season
- Previous adverse reaction to vaccination or component
- History of Guillain Barre Syndrome

d. Pediatric Contraindications (≥ 6 months old and < 9 years old)

- Previous adverse reaction to vaccination or component
- History of Guillain Barre Syndrome
- Previous administration of Influenza vaccine during current Flu season for patients that have already been vaccinated with 2 doses during a prior season

- Less than 4 weeks since first influenza vaccination in patients who have not been vaccinated with a series of 2 doses during a prior season

B. DATA BASE

1. Subjective Data (Adult ≥ 18 years)
   a. Patient/decision maker declaration of previous administration of Influenza vaccine during existing Flu season.
   b. Patient/decision maker declaration of prior reaction to vaccination or component.
   c. Patient/decision maker declaration of history of Guillain Barre Syndrome

   Subjective Data (Pediatric patients ≥ 9 years old and < 18 years old)
   a. Patient/decision maker declaration of previous administration of Influenza vaccine during existing Flu season
   b. Patient/decision maker declaration of prior reaction to vaccination or component
   c. Patient/decision maker declaration of history of Guillain Barre Syndrome

   Subjective Data (Pediatric patients ≥ 6 months old and < 9 years old)
   a. Patient/decision maker declaration of prior reaction to vaccination or component
   b. Patient/decision maker declaration of history of Guillain Barre Syndrome
   c. Patient/decision maker declaration of prior administration during existing Flu season for a patient that was already vaccinated with a series of 2 doses 4 weeks apart during a prior season
   d. Patient/decision maker declaration of less than 4 weeks since first influenza vaccination in a patient who has not been vaccinated with a series of 2 doses during a prior season

2. Objective Data (Adult ≥ 18 years)
   a. Fever ≥ 38 degrees Celsius in the last 48 hours
   b. Documentation in the medical record of a prior administration of the Influenza vaccine during existing Flu season, prior reaction the vaccination or component, or history of Guillain Barre Syndrome

   Objective Data (Pediatrics ≥ 9 years old and < 18 years old)

a. Documentation in the medical record of a prior administration of the Influenza vaccine during existing Flu season, prior reaction the vaccination or component, or history of Guillain Barre Syndrome

Objective Data (≥ 6 months old and < 9 years old)

a. Documentation in the medical record of a prior reaction to the vaccination or component or history of Guillain Barre Syndrome
b. Documentation of prior administration during existing Flu season for a patient that was already vaccinated with a series of 2 doses 4 weeks apart during a prior season
c. Documentation of less than 4 weeks since first influenza vaccination in a patient who has not been vaccinated with a series of 2 doses during a prior season

C. Determination of Administration

Screening of patient considering subjective and objective data to determine administration qualifications

D. PLAN

1. Screen Patient for Influenza Vaccination on admission to hospital during declared Flu season
   a. Review chart for documented objective contraindications
   b. If no temperature taken within 48 hours, take the patient's temperature
   c. Talk to patient/decision maker for subjective contraindications
   d. For patients that qualify, offer vaccination and document accepts or declines vaccination in the screen.
   e. For patients that are not responsive, unable to engage, the screen may occur later during admission
   f. When a patient qualifies for a vaccination with pending or active transfusion orders (Blood, Platelets, of FFP), delay administration of vaccine to avoid confusion with a possible transfusion reaction.

2. Patient conditions requiring Physician Consultation
   a. Questions regarding interpretation of a contraindication
   b. Patient questions unable to be addressed by nursing expertise

3. Education

Prior to vaccination, patients/decision maker will be provided education via Vaccine Information Sheets (VIS).

4. Administration of Vaccination
    a. RN to enter age appropriate order for Influenza Vaccination using the mode "per protocol no co-sign required" for patients that qualify and accept vaccination and do not require further physician consultation.
        i. Inactivated Influenza vaccine (IIV) is given IM for infants starting at 6 months of age (minimum age) through adulthood. There is no upper age limit. IIV is the preferred inpatient formulation for influenza vaccination.
    b. Timing of administration will occur prior to discharge.
    c. RNs are not authorized to place orders for Live Attenuated Influenza Vaccine.

5. Follow-up
    As appropriate for procedure performed.

E. RECORD KEEPING
Vaccination lot number, expiration date, and location of injection will be documented in the medical record

F. Summary of Prerequisites, Proctoring and Competency Documentation

~~Prerequisite:~~ ~~a. Completion of a training module on flu vaccination~~ ~~b. For RN staff in orientation: completion of 1 IM injection~~ ~~c. Review of Protocol~~ ~~d. Review of Administrative Policy: Order Entry~~
~~Proctoring Period:~~ ~~a. For RNs in orientation: observe placement of order in EHR for "ordered per protocol, no signature required"~~ ~~b. Nurse Manager or RN designee will provide supervision~~
~~Annual~~ Competency Requirements ~~Documentation~~: a. Completes annual Flu education module inclusive of: • screening workflow • Attestation of Standardized Procedure Review ~~a.~~• Attestation of Order Entry Policy Review. ~~b. Annual performance appraisal~~ ~~c. Nurse Manager or their designee will be the evaluator~~
~~Any additional comments:~~

Medical Director or Division Chief Approval or Service Chief Approval

Lisa Winston, MD
Infection Control

Author: Dana Freiser RN
Nursing Director: ~~Leslie Holpit RN~~ Christina Bloom

CIDP Approval Date: 8/16/2022
Credentials Approval Date: 9/06/2022
MEC Approval Date: 9/15/2022
Gov. Body Approval Date: 9/27/2022

Zuckerberg San Francisco General Hospital
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE NURSE PRACTITIONER / PHYSICIAN ASSISTANT/ CERTIFIED NURSE-MIDWIFE

PREAMBLE

Title: OBSTETRICS AND GYNECOLOGY

I. Policy Statement

A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse-Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, Clinical Psychologists 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 within the OB/GYN service.

II. Functions To Be Performed

Each practice area will vary in the functions that will be performed, such as primary care in a specialty clinic care setting or inpatient care in a unit-based hospital setting. The NP/CNM/PA conducts physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care, performs invasive procedures and furnishes medications/issue drug orders as established by state law.

A Certified Nurse-Midwife (CNM) is a registered nurse with 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 people during the antepartum, intrapartum, postpartum, and interconceptual periods. A CNM provides family planning, conducts deliveries and cares for the newborn and infant.

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 Practice Agreement~~Delegation of Services Agreement~~ (document~~s~~ supervising agreement between supervising physician and PA).

~~A Certified Nurse-Midwife (CNM) is a registered nurse with 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 people during the antepartum, intrapartum, postpartum, and interconceptual periods. A CNM provides family planning, conducts deliveries and cares for the newborn and infant.~~

~~The NP/CNM/PA conducts physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care, performs invasive procedures and furnishes 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 all sites within the OB/GYN service. If indicated for patient and/or provider safety, sites may also include the patient's home, a community location, or another safe, private location.

B. Supervision

1. Overall Accountability:
   The NP/CNM/PA is responsible and accountable to the Medical Director of the Obstetric, Midwifery, and Gynecology Clinic ~~Women's Health Center~~, Medical Director of Obstetrics, and the Medical Director of ~~Women's Option Center~~6G.
2. A consulting physician, who may be an attending, senior resident, or fellow, 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. Uncommon, unfamiliar, unstable, and complex patient conditions.
   e. Upon request of patient, affiliated staff, or physician.
   f. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.

IV. Scope of Practice

1. Health Care Management: Acute/Urgent Care
2. Health Care Management: Well Woman Care
3. Health Care Management: Prenatal Care
4. Furnishing Medications/Drug Orders
5. Discharge of Inpatients
6. eConsult Review
7. Colposcopy and Cryotherapy
8. Endocervical Polyp Removal
9. Endometrial Biopsy
10. Episiotomy and Perineal Laceration Repair
11. Contraceptive Implant Insertion
12. Contraceptive Implant Removal
13. Intrauterine Device Insertion
14. Intrauterine Devise Removal: Non-visualized Strings
15. Pre-op Evaluation for Second Trimester Abortion

16. Trigger Point Injections for Pelvic Pain
17. Limited Obstetric Ultrasound: <14 Weeks Gestational Age
18. Limited Obstetric Ultrasound: ≥14 Weeks Gestational Age Assessment
19. Limited Obstetric Ultrasound: Third Trimester Assessment of Cardiac Activity, Presentation, and Amniotic Fluid
20. Waived Testing
21. First-Trimester Aspiration Abortion
22. Procedural Sedation
23. Vulvar Skin Biopsy
24. CNM First-Assist for Cesarean-Section

V. Requirements for the Nurse Practitioner / Certified Nurse-Midwife/Physician Assistant

A. Basic Training and Education
1. Active California Registered Nurse, Nurse Practitioner, Certified Nurse-Midwife/or Physician Assistant license.
2. Successful completion of an education program, which conforms to the Board of Registered Nurses (BRN) requirements for licensure or to the Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP/CNM) or 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 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.
8. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center ~~Delegation of Service~~ Practice Agreement ~~(DSA).~~ Copies of ~~DSA~~ Practice Agreement must be kept at each practice site for each PA.

B. Specialty Training
1. Specialty requirements FNP, ANP, WHNP, OB/GYN NP, CNM or Physician Assistant.

VI. Evaluation

A. 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 other supervisors~~supervising clinical provider~~, as applicable~~ will assess the NP/CNM/PA's ability to practice.
   a. Clinical Practice
      - Length of proctoring period will be 3 months.
      - The evaluator will be the Medical Director, Chief of Service, designated supervising ~~physician~~clinical provider~~, and/or designated peer~~.
      - The method of evaluation in clinical practice will be 3 observations and associated chart reviews representing each core procedure (HCM acute/urgent care, HCM well woman care, HCM prenatal care, furnishing, and discharge of inpatients), with no less than 10 observations/chart reviews in total. Additional, procedurally specific requirements are listed in individual protocols.

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

3. ~~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.~~

4. Biennial Reappointment: Medical Director, designated physician, and/or designated peer must evaluate the NP/CNM/PA's clinical competence as described in each procedure and perform at least 1 chart review which may represent multiple core procedures.

~~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 that 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, Pharmacists, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

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

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

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

Protocol #1: Health Care Management – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions in all appropriate sites within the OB/GYN Service.

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.

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 consultation as per Preamble, section IIIb3
   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, affiliated staff or physician

f. With the exception of labor-related diagnoses, 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 that by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

Protocol #2: Health Care Management – Well ~~Woman~~ Person Care

A. DEFINITION

This protocol covers health care maintenance and promotion, management of common acute illness and chronic stable illnesses related to well person~~woman~~, gynecologic, reproductive, and breast care in all sites within the OB/GYN service.

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. 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. 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 consultation as per Preamble, section IIIb3,
   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, affiliated staff, or physician
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 #3: Health Care Management – Prenatal Care

A. DEFINITION

This protocol covers the procedure for the routine prenatal care of essentially healthy ~~women~~people. 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 OB/GYN service.

B. DATA BASE

1. Subjective Data
   a. Complete appropriate history.
   b. Symptoms relevant to the prenatal health process.
   c. Patient-centered assessment of patient's preference re: mode of prenatal care and desire for racially/ethnically/linguistically-concordant prenatal provider.

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 as indicated
      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 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. 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, VZV titer, CBC, ferritin,

hemoglobinopathy evaluation, HBsAG, RPR, HIV, Hep C antibody, pap smear (if indicated), clean catch urine culture, chlamydia, gonorrhea, trichomonas, 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. If patient is RH Negative repeat antibody screen and order Rhogam at 28 weeks or earlier if vaginal bleeding.
4. Order and review all imaging studies as appropriate.

b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.
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, IIIb3:
   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 (as per established departmental guidelines, including diagnosis-specific criteria)
   e. Upon request of patient, affiliated staff, or physician.
   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. Preparation for labor, postpartum, and infant care.
   f~~e~~. Stages of labor.
   g~~f~~. Pain management during labor and delivery.
   hg. ~~———~~Infant nutrition: breast or formula feeding.
   i~~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 People (HIVE) and pregnant people for whom traditional clinic-based care does not suffice (Team LILY)~~MANAGEMENT OF HIV-INFECTED PREGNANT WOMEN PEOPLE AT THE BAY AREA PERINATAL AIDS CENTER (BAPAC)/HIVE~~

NPs, PAs and CNMs in 5M may participate in care for patients in these clinical service areas with co-management by an attending OBGyn physician.~~Obstetric and HIV care of BAPAC/HIVE patients by the BAPAC nurse practitioner will be co-managed by the BAPAC attending, Reproductive Infectious Disease fellow and/or other OB attending designee.~~

G. RECORD KEEPING

a. Patient visit, consent forms, and other procedure specific documents will be recorded in ~~LCR/~~EMR as appropriate.

Protocol #4: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners and nurse-midwives 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 PA 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 a BRN furnishing certificate and an appropriate DEA license. Schedule II - III medications need a patient specific protocol. The practice site (clinic or inpatient), scope of practice of the NP/CNM/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formularies used will be: San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Jail Health Services, ~~San Francisco Health Plan,~~ Medi-Cal, Healthy Workers, Healthy San Francisco, 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. Appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current

medication, allergies, current treatments, and substance abuse history.
b. Pain history to include onset, location, and intensity.

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. Nurse Practitioners and Nurse Midwives may order Schedule II - III controlled substances for patients with patient specific protocols. The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   c. 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 and refills, if applicable
      viii. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation as per Preamble, section IIIb2.
    a. Problem which is not resolved after reasonable trial of therapies.
    b. Unexplained historical, physical or laboratory findings.
    c. Uncommon, unfamiliar, unstable, and complex patient conditions
    d. Upon request of patient, affiliated staff, or physician.

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/CNMs and all drug orders written by PAs will be recorded in the electronic medical record (\EMR)~~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.~~

Protocol #5: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from the Birth Center at Zuckerberg San Francisco General Hospital and Trauma Center.

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

2. Objective Data
    a. Physical exam consistent with history and clinical assessment of the patient.
    b. Review medical record: in-hospital progress notes, consultations to ensure 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 EMR.

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. Ensure that appropriate follow-up arrangements (appointments/studies) have been made.

2. Patient conditions requiring Consultation as per preamble, section IIIb2.

    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, affiliated staff, or physician.

3. Education
    a. Review inpatient course and need for outpatient 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. ~~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 that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

Protocol #6: eConsult Review

A. DEFINITION

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

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

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

3. Proctoring: A review of the eConsult consultation decisions will be performed by the designated physician or peer proctor concurrently for the first 20 eConsults (minimum). More eConsult reviews may be required depending on performance.

4. Reappointment Competency:
   A review of five eConsult consultations every 2 years by the consulting physician or other supervisor.

5. Location to be performed: all sites with the OB/GYN service.

B. DATA BASE

1. Subjective Data
   a. History: appropriate history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments and review of systems relevant to the presenting disease process as

provided by the referring provider on the electronic referral. eConsult review will be confined to data found in the submitted eConsult form. Data contained in the paper or electronic medical record, but not in the eConsult, is specifically excluded from the eConsult review. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

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

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

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

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
   a. Unexplained historical, physical or laboratory findings
   b. Uncommon, unfamiliar, unstable, and complex patient conditions
   c. Upon request of the referring affiliated staff, or physician

d. Problem requiring hospital admission or potential hospital admission
e. When recommending complex imaging studies or procedures for the referring provider to order
f. Problem requiring emergent/urgent surgical intervention
g. As indicated per the algorithms developed by the Medical Director

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

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

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

E. RECORD KEEPING
All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the EMR upon scheduling and after consultation visit and follow up visits.

Protocol # 7: Procedure: Colposcopy and Cryotherapy

A. DEFINITION

PeopleWomen with abnormal Pap smears or suspicious lesions in the lower genital tract will be evaluated by colposcopy with biopsy of suspicious lesions and treatment or referral as indicated. Cryotherapy is a treatment for cervical dysplasia or large condylomatous lesions.

1. Location to be performed: All appropriate sites with the OB/GYN service.

2. Performance of procedure:
   i. Indications
   Patients with certain abnormal cervical cancer screening results, cervical, vaginal or vulvar lesions visible by gross examination, may be referred for colposcopy. Cryotherapy can be used in peoplewomen < 40 years old to treat high grade dysplasia (CIN 2 or 3) in peoplewomen with satisfactory colposcopy, no dysplasia on endocervical curettage (ECC) and when the lesion can be completely covered by cryo probe during treatment. Cryotherapy can also effectively treat large condylomatous lesions found in the vulvar or perianal area
   ii. Precautions/Contraindications
   Consult an MD before performing biopsies on patients used anticoagulants or with a clotting disorder. Women People who are pregnant who require biopsy due to lesion suspicious for malignancy should be referred to an MD. ECC should not be perfomed during pregnancy. Cryotherapy of the cervix should not be performed in pregnant womenpeople, women people with unsatisfactory colposcopy, dysplasia found on ECC or in women people with large cervical lesions that cannot be completely covered by the cryo probe.

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. Patient consent obtained before procedure is performed.
   b. Time out performed per hospital policy
   c. Diagnostic tests for purposes of disease identification.
   d. The procedure is performed following standard medical technique.
   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 consultation as per section, IIIb2.
   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, affiliated staff or physician
   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 EMR~~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 a. One week course (14 hours) in theory and practice of cervical colposcopy. Certificate of course completion required.
Proctoring Period a. New practitioner to procedure, a minimum of 25 colposcopies at least 10 of which include biopsy and a minimum of 3 cryotherapy. b. Experienced practitioner to procedure must show documentation of 25 proctored studies at previous institution and be proctored for a minimum of 5 colposcopies and 1 cryotherapy. c. Proctor must be a qualified colposcopist.
Reappointment Competency: a. Evaluation will be done by a qualified colposcopist b Minimum number of 4 procedures must be completed every two years. c. Minimum number of 2 chart reviews needed every two years.

Protocol #8: Procedure: Endocervical Polyp Removal

DEFINITION: Evaluation of a cervical polyp seen on pelvic speculum exam by removing the polyp for pathological diagnosis.

1) Location to be performed: all appropriate sites with the OB/GYN service,

2) Performance of procedure:
   1. Indications
      Endocervical polyp seen on pelvic speculum examination
   2. Precautions
      Consult a GYN attending or senior resident if polyp is especially large, abnormal-appearing or site of origin is unclear; or if the patient is anticoagulated or has a history of a bleeding disorder.
   3. 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 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. 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 Consultation, as per Preamble, section IIIb2.
   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. 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~~ 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

~~Prerequisite:~~ ~~6 months prior experience in women's health care experience, training or expertise is required.~~
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider or at another site with documentation of competency
Proctoring Period: a. Observation of a minimum of 1 (one) procedure for both new and experienced providers. b. Charts of all observed cases during initial proctoring will be reviewed.
Reappointment Competency: a. Minimum number of 2 procedures must be completed every two years. b. Minimum number of 2 chart reviews needed every two years.

Protocol #9: Procedure: Endometrial Biopsy

A. DEFINITION

Evaluation of the endometrium by obtaining tissue for pathological diagnosis.

1. Location to be performed: all appropriate sites with the OB/GYN service.

2. Performance of procedure:
   a. Indications
      ~~Women~~ People considered at risk for endometrial cancer including but not limited to: abnormal uterine bleeding, endometrial cells on Pap Smear, postmenopausal bleeding, obesity, family history of hereditary nonpolyposis colon cancer, 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~~ people with extreme retroversion or anteversion of the uterus. Also consult with physician when the 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 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. The procedure is performed following standard medical technique.
   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 Consultation, as per Preamble, IIIb2.
   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, affiliated staff, or physician
   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~~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

~~Prerequisite:~~ ~~6 months prior experience, in women's health care~~
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider or training at another site with documentation of competency
Proctoring Period: a. Observation of a minimum of 3 procedures for a new provider and 1 procedure for a provider who has prior experience with independent endometrial biopsy. b. Chart review of all observed cases.
Reappointment Competency: a. Perform 6 procedures every 2 years. b. 2 chart reviews needed every two years.

:

Protocol #10: Procedure: Episiotomy & Perineal Laceration Repair

A. DEFINITION
   1. Episiotomy-A surgical incision of the perineal body done in order to facilitate delivery of the fetus by enlarging the outlet.
   2. Laceration-Spontaneous tear in the perineal body, peri-urethral area or walls of the vagina.
      a. Peri-urethral laceration of the area surrounding the urethra.
      b. Peri-clitoral laceration of the area surrounding the clitoris.
      c. Labial- laceration of the labia majora or minora.
      d. 1st degree laceration involving the vaginal mucosa, posterior fourchette, perineal skin.
      e. 2nd degree laceration includes above and the perineal muscles.
      f. Sulcus tears- 2nd degree lacerations involving the vaginal walls.

   3) Location to be performed: Birth Center, H22.

   4) Performance of procedure:
      Indications
      a. Episiotomy is performed in circumstances when the condition of the fetus (as indicated by decelerations of the fetal heart rate or shoulder dystocia) requires shortening the time to delivery.
      b. Repair of episiotomy is indicated after performance of episiotomy.
      c. Repair of lacerations by the nurse-midwife is indicated when there is active bleeding from minor lacerations or for all second degree lacerations.

B. DATA BASE
   1. Subjective Data
      Pt. history reviewed prior to admission in labor including medication allergies. Focused review of symptoms relevant to episiotomy or repair as needed.

   2. Objective Data
      a. Prior to NSVD: position and station of fetus, force and control of maternal expulsion efforts, estimated time to delivery, fetal heart tracing, clinical assessment of perineum (elasticity of tissue, length of perineal body)

b. Following NSVD: status of vagina, vulva, perineum, and rectum; quantified blood loss, maternal vital signs. The uterine cervix is to be assessed if indicated by bleeding and/or if clinical situation suggests risk for cervical laceration.

C. DIAGNOSIS

Assessment of subjective and objective data to identify need for episiotomy (based on indicators identified above) and need for repair of laceration, as indicated by type of laceration and extent of bleeding.

D. PLAN

1. Therapeutic Treatment Plan
   a. Performance of episiotomy and their repair or repair of lacerations is conducted using sterile technique.
   b. Local anesthesia of area using up to 25 cubic centimeters of 1% lidocaine is provided before episiotomy and/or repair, whenever indicated. The maximum total dose should not exceed 4.5 mg/kg and the maximum total dose of 300 mg should not be exceeded (prior doses e.g. with epidural need to be considered).
   c. During recovery period, Tylenol 650mg every six hours, Ibuprofen 600mg every 6 hours, oxycodone 5 mg-10 mg every 3 hours for pain unrelieved by ibuprofen or acetaminophen, and stool softeners as appropriate (See Furnishing/Drug Order SP).

2. Patient conditions requiring consultation, as per Preamble, IIIb2.
   a. Extensions of episiotomy or lacerations into rectal mucosa or rectal sphincter.
   b. Cervical lacerations
   c. Inability to assess origin of vaginal bleeding and/or control hemorrhage
   d. Evidence of perineal or vaginal hematoma (pain, bruising, swelling)
   e. Breakdown of repair
   f. Evidence of infection at site of repair-malodorous discharge, fever, pain, edema
   g. Unexplained historical, physical or laboratory findings
   h. Uncommon, unfamiliar, unstable, and complex patient conditions

3. Education

a. Wound care of episiotomy/laceration reviewed with client
b. Signs and symptoms of normal healing, infection and wound breakdown reviewed at discharge
c. Bowel habits

4. Pain management–reference therapeutic treatment plan above

5. Follow-up
   a. Assessment of perineum postpartum day 1 & 2
   b. Assessment of healing of perineum at 4-week post partum outpatient visits if indicated. Earlier assessment may be neededindicated for complex repairs.

E. RECORD KEEPING
CNM completes delivery note, including indication for and performance of procedures. Postpartum notes include evaluation of repair site as needed.

F. Summary of Prerequisite, Proctoring and Reappointment Evaluation of Competency

Prerequisite No special training is required for performance of this procedure. Education and training in conduct of episiotomy and laceration repair is basic to all nurse-midwifery programs accredited by the BRN and American College of Nurse-Midwives (ACNM). This standardized procedure does not cover a new skill or practice but is developed in compliance with SB 1738.
Proctoring Period Initial: Within 3 months of hire the Medical Director, designated physician, and/or designated peer will assess the CNM's ability to practice. This assessment is based upon concurrent observation of a minimum of 3 cases of vaginal delivery, including episiotomy and/or repair of laceration, with chart review.
Reappointment Competency a. Evaluator: Medical Director, designated physician, and/or designated peer b. Ongoing competency evaluation. 1. 5 procedures needed every 2 years. 2. 1 chart review every 2 years.

Protocol #11: Procedure: Contraceptive Implant Insertion

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: all appropriate sites with the OB/GYN service

2. Performance of procedure:
   a. Indications
      Pt desires contraceptive implant
   b. Precautions
      See contraceptive implant ~~(Nexplanon)~~ drug precautions/interactions in prescribing information.
   c. Contraindications:
      1. Known or suspected pregnancy
      2. Hepatic tumors, active liver disease
      3. Known, suspected or history of breast cancer
      4. Hypersensitivity to any components of implant

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 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.
   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. 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. Timing of insertion: See prescribing information
   e. Insertion as described in prescribing information
   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 consultation, as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Difficult insertions
   c. Upon request of patient, affiliated staff or physician

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~~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

Prerequisite: a. Completion of a company sponsored training class
Proctoring Period: a. Performance of a minimum of 3 insertions for a new provider and 2 insertions for a provider who has prior experience with independent insertion. b. Proctor must be a qualified provider. c. Chart review of all observed cases.
Reappointment Competency Documentation: a. Performance of 6 insertions every 2 years. b. 1 chart review needed every two years.

Protocol #12: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm 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 ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained 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.. Timing of removal: See prescribing information
   e. Removal: as described in prescribing information

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 consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Unable to palpate implant or difficult implant removal.
   c. Upon request of patient, affiliated staff or physician

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 EMR~~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 6 removals every 2 years. b. 1 chart review needed every two years.

Protocol # 13. Procedure: Intrauterine Device Insertion

A. DEFINITION

Intrauterine devices offer a highly effective, safe and long lasting contraception. Both insertion and Removal can be performed by the NP/CNM/PA with insertion subject to the criteria described below.

1. Location to be performed: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Patient desires intrauterine device.
   b. Precautions
      See IUD (Mirena/Skyla/Paragard/Liletta) prescribing information
   c. Contraindications
      1. Pregnancy or suspicion of pregnancy
      2. Acute pelvic inflammatory disease or current behavior suggestive of a high risk for pelvic inflammatory disease.
      3. Post-partum endometritis or post abortal endometritis.
      4. Known or suspected uterine or cervical malignancy
      5. Genital bleeding of unknown etiology.
      6. Wilson's disease (for ParaGard IUD (TM).
      7 Allergy to any component of ParaGard IUD, Mirena, Skyla, or Liletta IUD.
      8 An IUD in the uterus that has not been removed.
      9. Uterine anomaly

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. 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. A cervical or intrauterine block may be placed.
   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 consultation as per Preamble section IIIb2.
   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, affiliated staff, or physician
   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 EMR~~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:~~ ~~6 months experience in women's health care.~~
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider or at another site with documentation of competency
Proctoring Period: a. Observed performance of a minimum of 3 procedures for a new provider and 2 procedures for a provider who has prior experience with independent IUD insertion. b. Observed performance of a minimum of 3 cervical and 3 intrauterine blocks for a new provider and 2 cervical and 2 intrauterine blocks for a provider who has prior experience with independent cervical blocks. b. Chart reviews of all observed cases.
Reappointment Competency: a. Perform 6 procedures every two years. b. 1 chart review needed every two years.

Protocol # 14. Procedure: IUD Removal: Non-visualized Strings
criteria described below.

A. DEFINITION

IUD strings are not visible at the external cervical os at IUD when desiring removal. Removal can be performed by the NP/CNM/PA with MD assistance for removal subject to the criteria below.

1. Location to be performed: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Patient desires intrauterine device removal, IUD strings not visualized at cervical os.
   b. Precautions
      Test for pregnancy if suspicion of pregnancy
   c. Contraindications
      1. Allergy to any component
      2. Acute pelvic inflammatory disease
      3. Known or suspected uterine or cervical malignancy

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. Procedure:
If IUD strings are not visualized at exernal os, strings may be identified by intracervical instrumentation with cytobrush or thin (alligator) forceps. If strings still not identified, a physician-assisted pelvic ultrasound is used to visualize IUD. If the IUD is confirmed within the uterus and there is no concern for pregnancy, a paracervical or intrauterine block is placed, tenaculum is placed on external cervix, and thin (alligator) forceps used to remove the IUD under ultrasound guidance.
d. Diagnostic tests for the purpose 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 consultation as per Preamble section IIIb2.
a. Acute decompensation of patient situation.
b. Unexplained historical, physical or laboratory findings
c. Uncommon, unfamiliar, unstable, and complex patient conditions
d. If moderate traction does not remove the embedded IUD, refer for hysteroscopic removal
e. Upon request of patient, affiliated staff, or physician
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 EMR~~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: 1 year experience with IUD insertions.
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider
Proctoring Period: a. Observed performance of a minimum of 6 IUD removals of non-visualized strings. b. Chart reviews of all observed cases.
Reappointment Competency: a. Perform 6 procedures every two years. b. 1 chart review needed every two years.

Protocol #15: Procedure: Pre-operative Evaluation for Second Trimester Abortion

A. DEFINITION

1. Pre-operative evaluation:
   The evaluation of patients before abortion procedures, including patient history, physical examination and evaluation of surgical risks. Informed consent is obtained following hospital policy.

2. Dilator placement:
   The placement of intracervical osmotic dilators using sterile technique and local anesthesia.

3. Mechanical dilation:
   The use of graduated dilators to open the cervix.

4. Location to be performed: ~~Women's Options Center~~ (6G).

B. DATA BASE

1. Subjective Data
   a. Patient history including: gynecological history (including history of sexually transmitted infections and abnormal Pap smears)
   b. Obstetric history (including number of vaginal deliveries, number of cesarean deliveries, previous abortions, miscarriages, ectopic pregnancies and any associated complications)
   c. Past medical history
   d. Past surgical and anesthesia history, including any associated complications.
   e. Social history (including substance use, homelessness and intimate partner violence)
   f. Allergies
   g. Medications

2. Objective Data
   a. Physical examination including:
      1. Review of vital signs
      2. Airway assessment
      3. Auscultation of heart and lungs
      4. Examination of abdomen
      5. Palpation of uterine fundus as measure of gestational duration
      6. Inspection of perineum
      7. Speculum examination of vagina and cervix.
      8. Cervical specimen collection for gonorrhea and chlamydia testing.

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

Nearly all patients who present to ~~the Women's Option Center~~6G are requesting pregnancy termination services. A primary goal of the initial pre-operative evaluation is to determine the gestational duration of the pregnancy accurately. Additionally, an accurate medical history and focused physical examination is performed to identify any significant medical problems that might complicate the ~~pregnancy termination~~abortion procedure. Psychosocial assessment includes determination that the termination is voluntary and that the patient does not have any risk factors that could affect their safety.

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. Treatment Procedure
      Depending on gestational duration, almost all patients having a second-trimester abortion will have dilators inserted one or two days before her procedure. After testing for gonorrhea and chlamydia, sterile technique will be used, including cleansing of the cervix, administering a paracervical block ~~will be administered~~, placing a tenaculum ~~placed~~ on the anterior lip of the cervix and inserting ~~then~~ dilators ~~inserted~~ into the cervical os. ~~Generally, the number of medium laminarias to be inserted = gestational duration in weeks – 10; however t~~The number of osmotic dilators may be adjusted based on Dilapan or laminaria sizes used and other factors, including patient comfort. After all dilators are inserted the tenaculum is removed, the cervix inspected for hemostasis and a 4X4 gauze sponge placed in the vagina to hold the dilators in place. In some cases, should the cervix not admit sufficient dilators, pre-dilator mechanical dilation may be needed and/or pharmacologic adjuvants may be used.
   d. Diagnostic tests for purposes of disease identification.

2. Patient conditions requiring consultation, as per Preamble section III b2.

1. Inability to obtain accurate measurements for gestational duration estimation
2. History of cardiovascular disease, including uncontrolled hypertension
3. Current pulmonary compromise or a history of severe pulmonary disease
4. Active or recent hepatic or renal disease
5. Insulin-dependent diabetes
6. Coagulation disorders or anti-coagulation therapy
7. Inability to give informed consent
8. Previous cesarean deliveries with ultrasound findings suspicious for accretae or other abnormal placentation
9. Termination requested for fetal or maternal indications beyond 24 weeks 0 days
10. Patients with complicated or active/recent chronic medical and/or psychiatric problems in case additional diagnostic procedures or consultations need to be ordered
11. Inability to identify cervix or difficulty inserting dilators adequate for the gestational duration
12. Morbid obesity
13. Upon request of affiliated staff or physician
14. Problem requiring hospital admission or potential hospital admission
15. Rupture of membranes during dilator insertion.

3. Education (primarily reviewed with the counselor and RNs)
   a. Explain to the patient that the dilator insertion is the first part of the abortion. Explain to the patient that she they should not undergo osmotic dilator insertion if they areshe is unsure about theirher decision to terminate the pregnancy.
   b. Explain the dilator insertion procedure, expected discomforts and possible complications (including bleeding, infection and ruptured membranes).
   c. Explain what the patient can expect overnight before t-heir abortion procedure.
   d. Give patient precautions and telephone numbers to call in case of emergency overnight.

5. Follow-up
   a. All patients return to the clinic the day of their scheduled D&E. Post-abortion follow up may be scheduled at the clinic of the patient's choice.
   b. All women patients mustshould have at least one telephone number at which they can be reached. Women Patients without access to a telephone mustshould leave some

method by which they can be reached in case of emergency. ~~Women~~ Patients can request complete confidentiality, in which case if the clinic needs to call them a code word is used (usually a code name) and no mention is made of the clinic. If a patient with dilators in place does not show up for their scheduled abortion procedure, at least three attempts are made to reach them ~~he~~ by telephone. If they are ~~she is~~ unreachable by telephone, all appropriate parties will be contacted to reach them~~her~~.

E. RECORD KEEPING

All patients complete a self-administered medical history form. This form is reviewed and signed by the NP/CNM/PA evaluating the patient for an abortion. As described above, additional medical history and the physical examination are recorded on the standardized abortion Pregnancy Consultation and Evaluation form. For ~~women~~ patients with any complex medical problems that may influence surgical risk (as described above), physician consultation is obtained and this is documented in the patient's medical record. The number of dilators and gauze sponges placed in the cervix and vagina respectively are recorded on the Epic History and Physical ~~Pre-Operative~~ Note for Abortion and clinic communication form. ~~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 that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. Summary of Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Training in paracervical blocks, mechanical dilation and osmotic dilator placement. b. One-on-one, directly supervised on-the-job training in mechanical dilation and dilator insertion.
Proctoring Period: a. A minimum of 5 observed procedures with 3 chart reviews. b. If proficiency is demonstrated after 5 procedures, the NP/CNM/PA can independently perform the procedure. If proficiency is not demonstrated after 5 procedures, the NP/CNM/PA will continue to be proctored until competence is achieved. The proctoring should be completed within the first 6 months of

initial granting of new privileges and must be completed within the first year (12 months) of initial granting of new privileges.
Reappointment Competency: a. 5 procedures must be completed every two years. b. 2 chart reviews ~~needed~~ must be completed every 2 years.

Protocol #16: Procedure: Trigger Point Injections for Pelvic Pain

A. DEFINITION

Relief of chronic myofascial pain by injecting local anesthesia or saline into areas of tenderness called "trigger points". Injection of trigger points has been found to be 60 to 90% successful in relieving myofascial pain.

1. Location to be performed: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Identification of a trigger point on examination in a chronic pelvic pain patient presenting with myofascial pain. Trigger points will be identified in the abdomen, groin and perineum and injections are limited to subcutaneous and soft tissues. No internal (vaginal) injections will be given.
   b. Precautions
      Avoid injection into blood vessel by aspirating after insertion of needle.
   c. Contraindications
      Allergy to local anesthetic.

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Explain procedure to patient
   b. Patient consent obtained before procedure is performed and obtained according to 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.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Upon request of patient, affiliated staff, or physician
   c. 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 EMR~~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 Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Training will provided by an experienced provider.
Proctoring Period: a. Proctoring by a qualified provider.

b. New practitioner to procedure: observation of a minimum of 2 injections for each site. c. Practitioner who has prior experience with independent performance of this procedure: observation of a minimum of 1 injection for each site. d. Chart review of all observed cases.
Reappointment Competency : a. Minimum of 2 procedures every 2 years. b. Minimum number of 1 chart review every two years.

Protocol # 17: Procedure: LIMITED OBSTETRIC ULTRASOUND <14 Weeks Gestational Age

A. DEFINITION

A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service

2. Performance of procedure:
   a. Indications for limited obstetric ultrasound include a need to identify:
      - Intrauterine pregnancy
      - Fetal number
      - Fetal cardiac activity
      - Gestational duration
   b. Precautions: None
   c. Contraindications: Previously diagnosed multiple gestation

B. DATA BASE

1. Subjective Data
   a. Review history of last menstrual period
2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS

Diagnosis must be supported by diagnostic images obtained

D. PLAN

1. Review patient identification, procedure to be conducted, adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation**:**
   - Multiple gestation
   - No evidence of cardiac activity
   - Gestational age assessment not correlated to other subjective and objective data

- Vaginal bleeding
- Abdominal pain
- Inability to confirm intrauterine location of pregnancy
- Inability to obtain adequate image for diagnostic interpretation
- Unclear or abnormal findings

4. Education
   Discuss findings with patient; establish need for follow-up consultation; examination or referral; give discharge information and instructions
5. Follow up
   As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR b. Recent (within 5 years) experience in limited obstetric ultrasound at gestational age <14 weeks (including ≥ 30 ultrasound exams), and/or privileges to perform limited obstetric ultrasound at gestational age <14 weeks granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising ZSFG physician who has been designated as an evaluator by the Director of Obstetrics.
Proctoring: Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently performing limited obstetric ultrasonography. These exams must be of gestational sacs, embryos, or fetuses at <14 weeks' gestation and must include assessment of the location and dating of pregnancy, cardiac motion and fetal number. Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review and sign the clinical report before the patient is discharged. If the evaluator is an NP/CNM/PA, all reports will additionally be reviewed by the Director

of Obstetrics or his/her physician designee(s) within 24 hours.
Reappointment Competency: Clinicians will be evaluated for continued competency through consultant (as per Preamble section III2b) chart review. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.
Any additional comments: If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed. All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.

Protocol #18: Procedure: LIMITED OBSTETRIC ULTRASOUND: ≥14 Week Gestational Age Assessment

A. DEFINITION

A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service

2. Performance of procedure:
   a. Indications for limited obstetric ultrasound include a need to identify:
      - Gestational age (≥14 weeks gestation)
      - Placental location
   b. Precautions: None
   c. Contraindications: Previously diagnosed multiple gestation

C. DATA BASE

1. Subjective Data
   a. Review of history of last menstrual period
2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS

1. Diagnosis must be supported by diagnostic images obtained

D. PLAN

1. Review patient identification, procedure to be conducted, and adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation**:**
   - Multiple gestation
   - No evidence of cardiac activity
   - Gestational age assessment not correlated to other subjective and objective data
   - Inability to confirm intrauterine location of pregnancy
   - Vaginal bleeding

- Abdominal pain
- Increased risk for accreta (previa and previous cesarean delivery at >16 weeks' gestation)
- Inability to obtain adequate image for diagnostic interpretation
- Unclear or abnormal findings
- BPD close to 58 mm or when inconsistent measurements between the BPD and FL might allow or disallow a pregnancy termination (6G only)

4. Education
   Discuss findings with patient, establish need for follow-up consultation, examination or referral, and give discharge information and instructions
5. Follow-up
   As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR b. Recent (within 5 years) experience in limited obstetric ultrasound for ≥14 weeks' gestational age assessment (including ≥ 30 ultrasound exams), and/or privileges to perform limited obstetric ultrasound for ≥14week gestational age assessment granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising ZSFG physician who has been designated as an evaluator by the Director of Obstetrics.
Proctoring: Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently using limited obstetric ultrasonography to date a ≥14week pregnancy. Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review and sign

the clinical report prior to the patient's discharge. If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Director of Obstetrics or his/her physician designee(s) within 24 hours.
Reappointment Competency Documentation: Clinicians will be evaluated for continued competency through consultant chart review. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.
Any additional comments: If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed. All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.

Protocol #19: Procedure: LIMITED OBSTETRIC ULTRASOUND: Third Trimester Assessment of Cardiac Activity, Presentation, and Amniotic Fluid

A. DEFINITION

A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service
2. Performance of procedure:
   i. Indications for limited third trimester obstetric ultrasound include a need to identify:
      - Fetal cardiac activity
      - Fetal presentation
      - ~~Amniotic fluid volume~~ Deepest vertical pocket (~~/~~DVP) of amniotic fluid
   ii. Precautions: None

B. DATA BASE

1. Subjective Data
   a. Review history of last menstrual period
2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS

2. Diagnosis must be supported by diagnostic images obtained

D. PLAN

1. Review patient identification, procedure to be conducted, adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation**:**
   - No evidence of cardiac activity
   - Fetal position other than cephalic (if ≥35 weeks gestation)
   - ~~Amniotic fluid index outside of normal range (≤5 or ≥24) or~~ D~~d~~eepest vertical pocket <2 or ≥8
   - Fetal heart rate of <110 beats per minute

- Inability to obtain adequate image for diagnostic interpretation
- Unclear or abnormal findings

4. Education
   Discuss findings with patient, establish need for follow-up consultation, examination or referral, give discharge information and instructions
5. Follow-up
   As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR b. Recent (within 5 years) experience in limited obstetric ultrasound in the third trimester (including ≥ 30 ultrasound exams), and/or privileges to perform limited obstetric ultrasound in the third trimester granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising ZSFG physician who has been designated as an evaluator by the Director of Obstetrics.
Proctoring: Clinicians must perform a minimum of 5 ultrasounds (including fetal presentation and ~~amniotic fluid volume~~DVP) to demonstrate competency prior to independently performing limited third trimester obstetric ultrasonography. Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review ~~and sign~~ the clinical report prior to the patient's discharge. ~~If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Obstetrics Medical Director or his/her physician designee(s) within 24 hours.~~
Reappointment Competency Documentation: Clinicians will be evaluated for continued competency through 1

~~consultant~~ peer chart review every 2 years. ~~Limited third trimester obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.~~

Any additional comments:

If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed.

~~All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.~~

Protocol #20**:** 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: any in- or outpatient location providing emergency or primary care

2. The following non-instrument based waived tests are currently performed at ZSFG:
   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, yeast 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 ZSFG 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.
   c. Actions to be taken (follow-up or confirmatory testing, physician 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 consultation
   a. Follow established site-specific protocols or instructions. When in doubt, consult as per Preamble, section IIIb2.

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 NP/CNM/PA 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 quizzes 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 quizzes. Provider must have passed each required module with a score of 80%.

PROTOCOL #21: First-Trimester Aspiration Abortion:

A. DEFINITION

First-trimester aspiration abortion includes manual and electric vacuum procedures for ~~women~~ people with an intrauterine pregnancy confirmed by ultrasound for gestational ages 5.0 weeks through 13 weeks ~~2~~.6 ~~weeks~~days.

1) Location to be performed: San Francisco General Hospital: 6G, 5M, ED.

2) Performance of procedure:
   i. Indications: ~~Women~~ People desiring aspiration abortion in the first trimester for a normal or abnormal intrauterine pregnancy confirmed by ultrasound between 5.0 and ~~12.6~~13 weeks 6 days~~'~~ gestation.
   ii. Contraindications
      a. ASA classes 3 and 4
      b. Hemodynamic instability or other evidence suggesting a problem that might require hospital admission.

3) Supervision
   i. Overall Accountability:
   The NP/CNM/PA is responsible and accountable to the Medical Director of 6G~~the Women's Options Center~~.
   ii. An in-house attending gynecologist will be available to the NP/CNM/PA in person, by phone or by other electronic means at all times.

B. DATA BASE

1. Subjective Data
   a. Obtain patient's/caregiver's description of:
      Last menstrual period history
      Medical history
      Obstetrical history
      Gynecologic history, including history of STIs
      Surgical history
      Current medications; allergies; tobacco, alcohol and illicit drug use
      Contraception history and counseling
      Contraception plans after abortion
      Psychosocial factors as indicated after counseling assessment

2. Objective Data
    a. Perform physical assessment to include:
        - Limited pelvic ultrasound to assess gestational duration and confirm intrauterine pregnancy (if not already completed)
        - Review of vital signs
        - Vaginal and cervical exam
        - Uterine position and size
        - Airway assessment
    b. Obtain/review the following laboratory tests as indicated:
    GC/CT/trichomonas screening
    ~~RPR~~Syphilis test
    Hemoglobin, CBC or hemoglobin/hematocrit
    Type and hold (or Type and Screen if clinically indicated)
    Qualitative or quantitative beta HCG if clinically indicated
    HIV according to patient's preference
    Cervical cancer screening
        - Review pelvic ultrasound results for gestational dating and confirmation of intrauterine pregnancy
    c. All Point of Care Testing (POCT) will be performed according to ZSFG POCT Policy and Procedure 16.20.

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. Obtain separate patient consents for abortion and procedural sedation (and any long-acting reversible contraceptive method if desired) before procedure 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.
    f. Provide local anesthesia via paracervical block, with additional pain control via oral medications, intravenous medications and/or procedural sedation to be administered according to patient preference, hospital- and department-specific protocols
    g. Perform first-trimester manual or electric vacuum aspiration

procedure
h. Visual inspection of products of conception, with specimens sent to Pathology as per protocol
i. Provide Rh immunoglobulin (RhoGAM) to Rh-negative patients when clinically indicated
j. Provide contraception as appropriate

3. Patient Conditions Requiring Pre-Operative Attending Consultation
    1. Difficulty determining gestational duration
    2. Unexplained historical, physical or laboratory findings
    3. Known or suspected cervical or uterine abnormalities
    4. Evidence or suspicion of ectopic pregnancy
    5. Suspected molar pregnancy
    6. Suspected uterine or pelvic infection
    7. Client requests care by an anesthesiologist for uterine evacuation
    8. Client hemoglobin less than 8 gm/dL
    9. Upon request of patient, NP, CNM or physician

4. Patient Conditions Requiring Intra- or Post-Operative Attending Consultation
    a. Evidence or suspicion of uterine perforation during procedure
    b. Difficulty obtaining adequate cervical dilation
    c. Excessive pain during procedure
    d. Intra- or post-operative hemorrhage
    e. Cervical laceration requiring repair
    f. Evidence of hemodynamic instability or other evidence suggesting the need for potential hospital admission
    g. Respiratory distress.

5. Procedures for Provision of Emergency Care
    a. For any acute deterioration in patient condition, the in-house Gynecology attending will be paged to assume care of the patient.
    b. If emergency services are required in the interim, the protocols of ~~the Women's Options Center~~6G will be implemented, which include paging the Airway STAT pager or the MERT, or calling a Code Blue.

6. Education
    a. Instruct patient/family/caregiver to:
    Limit physical activity for 24 hours
    Implement pelvic rest for ~~2~~ 1 week~~s~~
    Resume or initiate contraception prescribed

Call or go to ED with fever or chills, heavy bleeding (soaking 2 or more pads per hour for more than 2 hours), abdominal pain unrelieved by medications

7. Follow up
   Follow-up appointment to be scheduled, if indicated.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure-specific documents will be recorded in the medical record and EMR~~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 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

Prerequisite: Consistent with Section 2725.4 of CA Business and Professions Code, completion of the ~~Health Workforce Pilot Project curriculum and clinical competencies (see Appendix)~~Early Abortion Training curriculum, which includes guidelines, core competencies, and training plan. (https://aptoolkit.org/)
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of training on site related to unit workflow, documentation and protocols b. Observation of~~e~~ 5 procedures performed by a qualified provider
Proctoring Period: a. Actual number of ~~performances~~ abortions needed to be directly observed: 30 b. Any qualified provider can do the proctoring c. Until proctoring has been completed and procedural sedation protocol has also been successfully proctored, all procedures must be supervised by an attending physician who holds privileges for both abortion and procedural sedation.
Appointment/Reappointment Competency Documentation: a. Minimum number of procedures that must be completed in two years: 10

b. Is direct observation of procedure needed? No
c. Chart Review: 3/year
d. Successful renewal of procedural sedation protocol at time of reappointment or ongoing supervision of all procedures by attending physician

~~Appendix 1 – Health Workforce Pilot Project #171 Curriculum~~

~~Curricular Overview can be found here:~~

~~http://www.ansirh.org/research/pci/hwpp/hwpp-curriculum-and-competency-resources.php~~

~~First-trimester abortion competencies can be found here:~~

~~http://www.ansirh.org/wp-content/uploads/2014/05/ANSIRH_CoreCompetencies.pdf~~

~~Table of Contents for Curriculum can be found here:~~
~~http://www.ansirh.org/training/workbook.php~~

~~Includes the following subjects:~~

~~Early Abortion Training Workbook~~

~~ANSIRH's *Early Abortion Training Workbook* was developed for use in a clinical setting where an experienced trainer or provider is available to lead a discussion of its didactic context and exercises. It is intended to help clinicians learn to identify key elements of informed consent counseling, recognize major psychosocial issues of importance for women who seek abortions, understand the basic steps involved with first-trimester vacuum aspiration abortions and early medical abortion service provision, and identify common complications related to first-trimester abortion care.~~

~~Now in its fourth edition, the workbook is currently in use at top medical schools around the world. It is designed for use with *Management of Unintended and Abnormal Pregnancy*.~~

~~Supplementary training tools and resources~~

~~Additional downloadable chapters:~~

- ~~Chapter 11: Evaluation~~
- ~~Chapter 12: Becoming a Trainer~~
- ~~Chapter 13: Office Practice Integration~~

~~Chapter 11: Evaluation—Instruments~~

- ~~Skills Inventory~~
- ~~Trainee Agreement and Consent~~
- ~~Procedure Log~~
- ~~Training Program Evaluation~~
- ~~Daily Evaluation Card~~
- ~~Observed Performance Assessment~~
- ~~Clinician Feedback Form for Clinic Staff~~
- ~~Clinic Services Satisfaction Survey~~
- ~~Basic Ultrasound Evaluation~~
- ~~New Trainer Skills Evaluation~~

~~Chapter 13: Office Practice—Tools~~

- ~~Abortion Medication Fact Sheet~~
- ~~Abortion Reimbursement Rates~~
- ~~Abortion Scheduling Template~~
- ~~Additional Security Drills~~
- ~~Bomb Threat Report Form~~
- ~~Chart Review Form for Medication Abortion~~
- ~~Comparison of Medication and Aspiration Abortion~~
- ~~Contraceptive Options Fact Sheet~~
- ~~Danco (Mifeprex) Patient Agreement~~
- ~~Disruption/Violence Report for Patients or Visitors~~
- ~~Disruption/Violence Report for Staff~~
- ~~Early Medication Abortion Using Methotrexate and Misoprostol~~
- ~~Ectopic Pregnancy Fact Sheet~~
- ~~Emergency Contraception Fact Sheet~~
- ~~FP Insurance Letter~~
- ~~Insurance Proposal~~
- ~~Interpreter Agreement~~
- ~~IV Sedation Client Information and Consent~~
- ~~Medication Abortion Chart Review~~
- ~~Medication Abortion Consent Form (English)~~
- ~~Medication Abortion Consent Form (Spanish)~~
- ~~Medication Abortion Log~~
- ~~Medication Abortion Follow-Up Log~~
- ~~Medication Abortion Visit~~
- ~~Mifeprex Alternative Treatment Patient Information and Consent~~
- ~~MVA Chart Review~~
- ~~MVA Consent Form~~
- ~~MVA Procedure Notes~~
- ~~MVA Pre-Procedure Notes~~
- ~~Phone Script~~
- ~~Pre-Abortion Patient Instructions~~

- ~~Post-Abortion Patient Instructions~~
- ~~Rho(o) Immune Globulin Client Information Form~~
- ~~Sample Complication Log~~
- ~~Spreadsheet Tool~~
- ~~Talking About your Work with Others~~
- ~~Transfer Agreement~~
- ~~Unwrapping Sterile Packs (Poster)~~
- ~~Values Clarification Workshop~~
- ~~What to Expect After Taking Mifeprex~~
- ~~When a Small Amount of Pregnancy Tissue was Obtained~~
- ~~Working with an Interpreter Training Tool~~
- ~~Wrapping Instruments (Poster)~~
- ~~Reprocessing Vaginal Ultrasound Probe (Poster)~~

Protocol # 22: Procedure: Procedural Sedation/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 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 (ZSFG policy number 19.08 titled, "Procedural Sedation: Moderate and Deep") by the Nurse Practitioner/Certified Nurse Midwife/Physician Assistant during procedures within 6G~~the Women's Options Center~~. The nurse practitioner (NP)/certified nurse-midwife (CNM)/physician assistant (PA) practices under the supervision of the Medical Director or designee. Practitioners inducing a level of moderate 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. Procedures may only be performed in the designated areas for procedural sedation within 6G~~the Women's Options Center~~, which are adequately equipped and staffed, according to departmental and hospital policy.

Materials necessary for procedural sedation and rescue include:

a. Appropriate monitoring equipment.
b. Emergency medications and equipment for care and resuscitation, including a cardiac defibrillator, must be immediately available. Medications include, but are not limited to, reversal agents (naloxone and flumazenil) and vasoactive medications (phenylephrine).
c. Supplemental oxygen and positive pressure ventilation equipment.
d. Suction equipment/supplies.
e. Intravenous access.

Indications:

Procedural sedation may be indicated for first-trimester abortion and other minor gynecologic procedures, such as difficult intrauterine device placement or endometrial biopsy.

Contraindications:

a. Regarding the patient's American Society of Anesthesiologists (ASA) class, the Anesthesia Service must be consulted for patients who have an ASA score of 3 or greater. A procedure requiring sedation would not be performed on a patient with an ASA score above a three (3) without anesthesia assistance.

b. Anticipated difficult intubation.

Precautions:
a. Inability to obtain informed patient consent.

B. DATA BASE
1. Subjective Data
   a. Obtain a history within 24 hours of the procedure and sedation, or if earlier, an interim history must be completed.
   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, or if earlier, an interim physical must be completed. The exam is to include an airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight)
   b. Diagnostic data, as appropriate.
   c. All Point of Care Testing (POCT) will be performed according to ZSFG 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 which~~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 NP/CNM/PA in ~~6G the Women's Options Center (WOC.).~~
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 ZSFG 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 NP/CNM/PA prior to the delivery of sedation. Consent forms must be completed for the procedure to be performed as well as for the planned sedation.

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 adult escort for discharge to home in an appropriate mode of transportation.
c. Re-assessment 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, cardiac rhythm, heart rate, oxygen saturation and end-tidal carbon dioxide).
    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, rhythm, and pain level). Vital signs will be documented no less frequently than every 5 minutes beginning with the first administration of sedation.
    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. ~~ASA~~ ASA class III ~~status 3~~ or greater.
    b. Aspiration.
    c. Acute decompensation of patient.
    d. Unexplained historical, physical or laboratory findings.
    e. Upon request of patient, NP, CNM, 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.

4. Follow-up
   A. If the patient is transferred to the recovery 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 orders relating to the post-procedural/moderate sedation care.
   B. Any patient receiving a reversal agent (naloxone 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 the submission of an unusual occurrence report~~a SAFE report must be submitted.
   C. The outpatient is discharged “to home”:
      1. By a specific discharge order from a physician or NP/CNM/PA; 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.

E. RECORD KEEPING
   Patient visit, consent forms, and other procedure-specific documents will be recorded in the medical record ~~and LCR~~ and EMR as appropriate. The patient status and compliance with discharge criteria must be documented in the patient’s medical record by the physician, NP/CNM/PA or registered nurse discharging the patient. Document all

findings in the computerized procedure database, usually the PACS system.

F. Summary of prerequisites, proctoring & reappointment of competency

Prerequisites

A. Training Program
   1. Completion of the ZSFG Procedural Sedation module and Test with a passing score of 890%.
   2. Completion of Basic Life Support (BLS) training.
   3. Furnishing License and DEA number.

Proctoring

The NP/CNM/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.
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.

A. Direct observation by WOC attending staff credentialed in moderate sedation for a minimum of 30 procedures under moderate sedation. An experienced practitioner who previously had moderate sedation privileges at another institution requires a minimum of 10 successful observed demonstrations.
B. Review by WOC attendings of 30 procedure notes.

Reappointment

A. Ongoing competency will be demonstrated by observation by the Medical Director or designee of three procedures every 2 years.
B. Maintenance of BLS Certification.
C. Passing of Procedural Sedation test with a passing score of 890%.

Protocol #23: Procedure: Vulvar Skin Biopsy (Excision, Punch)

A. DEFINITION

Removal of a small portion of abnormal vulvar skin to be evaluated in the pathology laboratory. Punch biopsy or small excisional biopsy *not requiring suturing* can be performed in the outpatient clinic; ~~women~~ people whose skin requires suturing should have the excisional biopsy performed by a physician.

1. Location to be performed: is in the outpatient OB-GYN Clinic.

2. Performance of procedure:
   i. Indications
      - Papular or exophtic lesions, except genital warts
      - Thickened lesions to differentiate VIN vs. lichen simplex chronicus (LSC)
      - Hyperpigmented lesions, unless obvious nevus or lentigo
      - Ulcerative lesions, unless obvious herpes, syphilis or chancroid
      - Lesions that worsen or don't respond with treatment
   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 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. Biopsy tissue is sent to pathology as appropriate.
   f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   g. 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. Problem requiring hospital admission or potential hospital admission.

3. Education
   Preprocedure 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 and EMR~~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 Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Practitioner will have on-site training at ZSFG or at another site with documentation of competency.
Proctoring: a. Proctoring period will be 6 months in length. b. Practitioner must have a minimum of 5 successful observed demonstrations, including either type of biopsy, but at least 2 of each type. c. Will require a minimum of 3 chart reviews.
Reappointment Competency: a. Evaluator will be the Medical Director or other qualified physician. b. Competency evaluation. 2 chart reviews needed to monitor competency every 2 years.

Protocol # 24: Procedure: CNM First-Assist for Cesarean-Section

A. DEFINITION

As the first-assistant in a cesarean-section, the CNM provides primary assistance to the main surgeon. This role involves providing retraction, exposure, and hemostasis as well as other functions determined by the main surgeon.

1. Location to be performed: ZSFG
2. Performance of procedure:
   i. Indications
      This protocol addresses the surgical care of patients whom a physician has consented for cesarean-section (emergent or non-emergent).
   ii. Precautions/Contraindications
      Unless emergent staffing needs require it, CNMs will not serve as first-assist for patients with a history of two or more cesarean-sections. In these cases, they may serve as second-assist if needed.

B. DATA BASE

1. Subjective Data
   a. Antepartum and labor history
   b. Pertinent past medical history, surgical history, family history, hospitalizations, current medications, allergies
2. Objective Data
   a. Physical exam
   b. Laboratory and imaging evaluation, as indicated
   c. Fetal status
   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 related to fetal and maternal status as well as any pertinent medical problems.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained by physician before procedure is performed.
   b. Time out performed per hospital policy.
   c. The procedure is performed following standard surgical technique under direct supervision of the attending physician**.**
   d. The first-assistant's role may include but is not limited to:
      - Positioning, preparing, and draping the patient

- Using surgical instruments and devices
- Providing exposure
- Handling and dissection of tissues
- Closing and suturing wounds
- Providing hemostasis
- Initiating emergency actions as indicated

2. Patient conditions requiring consultation as per section, IIIb2.
   All operative care under this protocol is rendered in direct consultation with and under direct supervision by the attending physician.

3. Education
   Post-operative care and instructions.

4. Follow-up
   Post-operatively, the patient's care, including any complications, is managed by the Provider team.

E. RECORD KEEPING
Consent forms and other procedure specific documents will be recorded in the medical record as appropriate.

F. Summary of Prerequisite, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: <u>One</u> of the following: 1. Completion of the UCSF Nurse-Midwifery Education Program First-Assist for Cesarean-Section training module 2. Surgical first-assist certification [certified registered nurse first assistant (CRNFA), certified surgical assistant (CSA), or certified surgical first assistant (CSFA)] 3. Documentation of surgical first-assist privileges (or approved standardized procedures) held at another institution within the past two years
Proctoring Period: a. New practitioner to procedure: 3 cases in which there are two surgeons present, including the OB attending who is available to directly assist the CNM. More than 3 cases of this nature may be required if determined by the OB attending. These cases will be followed by 3 cases in which the CNM acts independently as

the first-assist. b. Experienced practitioner to procedure (must show documentation of first-assist privilege/standardized procedure held at another institution within the past two years): 3 cases in which the CNM acts independently as the first-assist. c. Proctor must be an OB attending physician.
Reappointment Competency: a. Perform 4 procedures every two years. b. Ongoing feedback will be provided by the OB attending physician as well as through the departmental quality review process.

Triennial Review 2019
CIDP: 12/05/2018
CC: 1/07/2019
MEC: 1/17/2019
JCC: 1/22/2019

Additional location added 4/2020
CIDP email approval: 4/02/2020
CC: 4/06/2020
MEC: 4/13/2020
JCC: 4/21/2020

Additional new protocol #24 CNM Surgical First Assist SP added
CIDP: 5/06/2020
CC: 6/01/2020
MEC: 6/08/2020
JCC: 6/23/2020