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

PREAMBLE

Title: Department of Medicine

I. Policy Statement

A. It is the policy of San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in 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 1M Clinic room 1M 13, Cardiology 5G1, Cardiac Catheterization Lab, Unit 5B Nurse Lounge, GI Fellows Conference Room, Hematology/Oncology Administration Office, GI Conference Room 3D22, Occupational Health Clinic, HERO Medical record system and on file in the Medical Staff Office.

II. Functions To Be Performed

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

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

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the

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

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

III. Circumstances Under Which NP/PA May Perform Function

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

B. Supervision
   1. Overall Accountability:
      The NP/PA is responsible and accountable to: site Medical Director, Chief of Service, designated physician and other supervisors as applicable.
   2. A consulting physician, who may include attendings, chief residents and fellows, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
      a. Acute decompensation of patient situation
      b. Problem that is not resolved after reasonable trial of therapies.
      c. Unexplained historical, physical, or laboratory findings.

d. Upon request of patient, affiliated staff, or physician.
e. Initiation or change of medication other than those in the formulary (ies).
f. Problem requiring hospital admission or potential hospital admission.
g. Acute, severe respiratory distress.
h. An adverse response to respiratory treatment, or a lack of therapeutic response.
i. Problem requiring invasive or surgical procedure.
j. Need for transfusion.
k. Review of electrocardiograms, if no prior interpretation or change from previous recording.
l. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.
m. Upon oncology providers seeing a newly diagnosed oncology patient in outpatient clinic.
n. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
o. Conditions severe enough to warrant partial or total disability work status prescription.
p. Any problem requiring transfer of care to the Emergency Department.

4, For cardiology and GI providers only: NP/PA management of medical emergencies, including cardio-pulmonary arrest, shock and life-threatening bleeding shall include initial evaluation and stabilization of the patient through the utilization of Advanced Cardiac Life Support (ACLS), alerting the supervising physician and activation of the Code Blue Team by dialing X61122.

IV. Scope of Practice

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

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

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
1. Active California Registered Nurse/Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification. Nurse Practitioners hired prior to the current Board requirement will be “grandfathered” in when up for reappointment.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider. Please note other certification may be required for specific procedures and ACLS may be required for procedures performed by cardiology and GI providers.
5. Possession of a National Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each

practice site for each PA.

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

VI. Evaluation

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

   2. Biennial Reappointment: Medical Director, and/or designated physician must evaluate the NP/PA's clinical competence through five (5) chart reviews, with at least one case representing each

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

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

4. Ongoing Professional Performance Evaluation (OPPE)

   Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.

5. Physician Assistants:
   a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are 1) Examination of the patient by Supervising Physician the same day as care is given by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

VII. Development and Approval of Standardized Procedure

A. Method of Development
   1. Standardized procedures are developed collaboratively by the Nurse Practitioners, Physician Assistants, Nurse Midwives, Registered Nurses, Pharmacists, Physicians, and Administrators and must conform to the eleven steps of the standardized

procedure guidelines as specified in Title 16, CCR Section 1474.

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

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

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

Protocol #1: Core Functions – Primary Care/Inpatient Units

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

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

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g. stable, unstable, or controlled, uncontrolled). Refine diagnoses as information becomes available and adjust treatment plans accordingly.

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

c. Immunization update.
d. Referral to specialty clinics and supportive services, as needed.
e. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS (only relevant for GI and cardiology providers).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Uncommon, unfamiliar, unstable, and complex patient conditions
   e. Upon request of patient, NP, PA, or physician
   f. Initiation or change of medication other than those in the formulary/ies.
   g. Problem requiring hospital admission or potential hospital admission.
   h. Patients on Chemotherapy, referrals for radiation therapy.
   i. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.

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

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

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). The electronic medical record (EMR) will be used to obtain and record patient information as required and appropriate. For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

Protocol #2: Core Functions – Primary Care

A. DEFINITION

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

B. DATA BASE

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

4. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g. stable, unstable, or controlled, uncontrolled). Refine diagnoses as information becomes available and adjust treatment plans accordingly.

D. PLAN

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

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

4. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Uncommon, unfamiliar, unstable, and complex patient conditions
   e. Upon request of patient, NP, PA, or physician
   f. Initiation or change of medication other than those in the formulary/ies.
   g. Problem requiring hospital admission or potential hospital admission.
   h. Patients on Chemotherapy, referrals for radiation therapy.
   i. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.

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

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

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). The electronic medical record (EMR) will be used to obtain and record patient information as required and appropriate. For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

Protocol #3: Discharge of Inpatients

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

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

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

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

D. PLAN
1. Treatment
   a. Review treatment plan with patient and/or family.
   b. Initiation or adjustment of medications per Furnishing/Drug Orders protocol.
   c. Assure that appropriate follow-up arrangements (appointments/studies) have been made.
   d. Referral to and communication with primary care, specialty clinics, skilled nursing facility providers, and support services, as needed.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA or physician.
   c. Initiation or change of medication other than those in the formulary.

3. Education
   a. Review inpatient course and what will need follow-up.
   b. Provide instructions on:
      - follow-up clinic appointments
      -outpatient laboratory/ diagnostic tests

-discharge medications
-signs and symptoms of possible complications

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

E. RECORD KEEPING

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

Protocol #4: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license. All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. If the PA has completed the education module, the certification must be attached to the PA's Delegation of Service Agreement.

Nurse practitioners may order Schedule II - V controlled substances when in possession of a DEA license. Schedule II - III controlled substances may be ordered for, but not limited to, the following conditions: patients presenting with acute and chronic pain and patients presenting with ADHD or other mental health-related disorders requiring the use of controlled substance II The practice site,, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol.

The formular/ies to be use are: San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal (including Contract Drug List and formularies of managed care Medi-Cal plans), Healthy San Francisco, Medicare Part D plans, AIDS Drug Assistance Program, Blue Cross, Blue Shield, California Care, Pacific Care, Health Net, Healthy Families, United Healthcare, and Medicare Part D formularies. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

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

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

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

D. PLAN
   1. Treatment
      a. Initiate, adjust, discontinue, and/or renew drugs and devices.
      b. When ordering respiratory treatments a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device, and frequency of treatments. Patient response will be monitored and documented.
      c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR/eCW, or in the Medication Administration Record (MAR). The protocol will include the following:
         i. Location of practice
         ii. Diagnoses, illnesses, or conditions for which medication is ordered
         iii. Name of medications, dosage, frequency, route, quantity, amount of refills authorized and time period for follow-up.
      d. To facilitate patient receiving medications from a pharmacist provide the following:
         i. name of medication
         ii. strength
         iii. directions for use
         iv. name of patient and date of birth
         v. name of prescriber and title
         vi. date of issue
         vii. quantity to be dispensed
         viii. license no., furnishing no., and DEA no. if applicable

   2. Patient conditions requiring Consultation

a. Acute decompensation of patient situation
b. Problem that is not resolved after reasonable trial of therapies
c. Unexplained historical, physical, or laboratory findings
d. Upon request of patient, nurse practitioner, physician assistant, or physician
e. Initiation or change of medication other than those listed or approved by the formulary (ies)
f. Problem requiring hospital admission or potential hospital admission
g. Uncommon, unfamiliar, unstable, and complex patient conditions
h. When requesting specialty consultation
i. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.
j. Acute, severe respiratory distress
k. An adverse response to respiratory treatment, or lack of therapeutic response.
l. Failure to improve pain and symptom management.

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

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

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record\LCR\MAR as appropriate. When a physician assistant writes a drug order for a controlled substance, the supervising physician must sign and date the chart containing such a drug order within seven (7) days.

Protocol #5*:* Routine Occupational Health Screening

A. DEFINITION

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

1. Employment pre-placement, promotion and fitness-for-duty evaluations
   a. Includes specific medical certifications such as California DMV Class A/B License, medical clearance for respirator use

2. Specific medical surveillance programs for occupational hazards (physical, chemical and biological)
   a. Includes pertinent preventive interventions such as immunizations and N95 respirator fit-testing, including UCSF campus employees.

B. DATA BASE

1. Subjective Data
   a. Screening: age- and examination/job-appropriate history that can include but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
   b. Ongoing/Continuity: review of symptoms and history relevant to the patient's age, health history, examination type and job class
   c. Pain history obtained to include onset, location, and intensity

2. Objective Data
   a. Job description and other relevant qualification requirements/guidelines
   b. Physical examination consistent with health history and examination type
   c. Laboratory and imaging evaluation, as indicated, relevant to history and examination type
   d. Previous medical records and clinical consultation reports, as needed
   e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

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

duties

D. PLAN

1. Action/Intervention
   a. Age- and examination- appropriate screening/diagnostic testing or referral to primary health care system for consultation (as needed to complete occupational assessment)
   b. Age- and examination/job-appropriate preventive interventions, including but not limited to:
      1) Education as described below
      2) Immunizations

2. Patient conditions requiring Physician consultation
   a. Acute decompensation of patient situation, including hostile or threatening patient behavior
   b. Any problem requiring transfer of care to an Emergency Department or specialist Physician
   c. Unexplained historical, physical, or laboratory findings
   d. Upon request of patient, NP, PA or Physician.
   e. Conditions severe enough to warrant partial or total disability work status prescription

5. Education
   a. Regarding occupational hazards and personal protection/safety measures
   b. Regarding relevant health issues
   c. Regarding relevant administrative/regulatory procedures

4. Follow-up
   a. As indicated to complete assessment and disposition

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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

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

A. DEFINITION

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

1. Diagnosis and treatment of occupational injury or illness

2. Assessment and appropriate intervention following potentially significant occupational exposure to hazards (e.g. tuberculosis, human body fluids, chemical agents etc.).

B. DATA BASE

1. Subjective Data
   a. Initial visit: Age- and incident-appropriate history that can include but is not limited to: history of current problem and detailed mechanism of injury or exposure, current symptoms, past medical history including relevant hospitalizations/injuries/immunizations, past surgical history, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
   b. Subsequent visits: Interval history to include current symptoms, response to treatment, impact of injury/illness on function
   c. Pain history obtained to include onset, location, and intensity

2. Objective Data
   a. Focused physical examination
   b. Focused diagnostic testing
   c. Review of relevant past medical records, exposure data
   d. Job description or other knowledge of essential job duties
   e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

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

D. PLAN

1. Treatment
    a. Pharmaceutical agents (see Furnishing Medications/Drug Orders Protocol)
        1. As needed to cure or relieve injury/illness symptoms or conditions
        2. As needed prophylaxis following exposure to hazards

    b. Referrals as clinically indicated
        1. To primary care clinician (for non-occupational conditions)
        2. To Emergency Department
        3. To Physician specialist
        4. To mental health clinician
        5. To nurse case manager or claims adjuster (for issues of disability benefit management)
    c. Prescription of appropriate work and other activity restrictions
    d. Education as described below

2. Patient conditions requiring Physician consultation
    a. Acute decompensation of patient situation, including hostile or threatening patient behavior
    b. Any problem requiring transfer of care to an Emergency Department or specialist clinician
    c. Unexplained historical, physical, or laboratory findings
    d. Problem that is not resolved after reasonable trial of therapies
    e. Unexplained historical, physical, or laboratory findings
    f. Upon request of patient, NP, PA or Physician.
    g. Initiation or change of medication other than those in the formulary (ies).
    h. Conditions severe enough to warrant partial or total disability work status prescription
3. Education
    a. Regarding injury/illness diagnosis, treatment options, prognosis, activity restrictions/disability, follow-up plan
    b. Regarding risk of exposure to specific hazard, prevention/prophylaxis options, follow-up plan
    c. Regarding workers' compensation and other disability benefit programs

4. Follow-up
    a. As indicated to complete assessment and disposition

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| Prerequisites |
| --- |
| a. Onsite training of procedures by a qualified provider. |

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| b. Review of departmental policy and procedure |
| Proctoring Period<br>a. 5 chart reviews and 1 direct observation of both protocol #5 and #6<br>b. |
| Reappointment Competency<br>a. 5 chart reviews to cover both Occupational Health protocol #5 and #6 |

Protocol #7: Procedure: Abdominal Paracentesis

A. Definition - Abdominal paracentesis is a procedure that entails inserting a trocar and cannula through the abdominal wall under local anesthetic for aspiration of peritoneal fluid (ascites). The term ascites denotes the accumulation of fluid in the peritoneal cavity.

1. Locations to be performed: Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Outpatient Infusion Center, 3D GI Clinic, , and Inpatient units.
2. Performance of Procedure: (When possible any paracentesis should be performed bedside with ultrasound guidance or have fluid localized by radiology and transport patient on same bed used for marking. Procedure may be performed without ultrasound or ragiologic guidance.)
    i. Indications:
        a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhosis related, for example).
        b. Pt with ascites, fever, abdominal pain (to evaluate for spontaneous bacterial peritonitis).
        c. Symptomatic treatment of tense ascites.
    ii. Precautions;
        a. Patients with INR greater than 2.0 should receive FFP prior to procedure Patients with platelets less than 20 should receive platelet infusion prior to procedure
        b. Intra-abdominal adhesions or suspicion for loculated fluid.
        c. Pregnancy
        d. Necessity for ultrasound guided paracentesis if any conditions listed above are present.
        e. Peritoneal dialysis
    iii. Contraindications:
        a. Fibrinolysis or DIC.
        b. Cellulitis at puncture site
        c. Acute abdomen requiring surgical intervention.

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

exam.

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

D. Plan
1. Therapeutic Treatment Plan.
   a. Informed consent obtained prior to procedure and according to hospital policy.
   b. Time out performed according to hospital policy.
   c. Diagnostic tests for purpose of identifying disease etiology. Sent for cytology as relevant.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders Protocol.
   e. Referral to specialty clinic, supportive services for provider as needed.
2. Patient conditions requiring attending consultation
   a. All patients with any condition listed in precaution section.
   b. Acute decompensation of patient.
   c. Upon the request of the patient, PA, NP or physician.

3. Education
   a. Appropriate and relevant patient and family education in written and/or verbal format.
   b. Contact information for follow up should needle puncture site result in leaking ascitic fluid.
4. Follow-up
   a. As indicated and appropriate for procedure performed.

E. Record Keeping
Patient visit, consent forms, and other documents will be included in the medical record, and other patient data bases, as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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| Prerequisite:<br>1. Training by a privileged provider or documentation of previous training. |
| Proctoring:<br>1. Providers new to procedure must complete a minimum of 4 observed successful procedures and 4 chart reviews prior to completion of proctoring period. One of the procedures may be performed on a simulated model |

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| 2. Experienced providers must complete a minimum of 2 successful procedures prior to completion of proctoring period.<br>Designation of experienced practitioner requires documentation of<br>1) Previous proctoring and 2) ongoing performance assessment within the past two years. |
| Reappointment Evaluation:<br>1. To maintain ongoing competency a minimum of 4 procedures every 2 years must be met. One of the procedures may be performed on a simulated model. If requirements not met, provider will be proctored through 1 successful procedure.<br>2. Four chart reviews every two years.<br>3. Evaluation must be done by Medical Director or designated physician. |

Protocol #8: Procedure: Arthrocentesis & Intraarticular Injections

A. DEFINITION

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

1. Location to be performed: Inpatient Units, Adult Medical Clinic and Medical Specialty Clinics on Ward 92 and the Emergency Department.

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

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique.
   c. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

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

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the electronic medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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| Prerequisite:<br>a. The NP/PA will observe a qualified provider 1 time if experienced and if new, 2 times.<br>b. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. |
| Proctoring Period<br>A minimum of 2 successful observed demonstrations and 2 chart reviews. |
| Reappointment Competency:<br>An attending physician or designated qualified provider will be the evaluator.<br>Provider must:<br>1. Perform a minimum of 4 procedures every 2 years<br>2. 2 chart reviews needed every 2 years. |

Protocol #9: Procedure: Bone Marrow Aspiration and Biopsy

A. Definition – Bone marrow may be removed by aspiration or needle biopsy under local anesthesia and both are often used concurrently to obtain the best possible marrow specimens.

1. Procedure may be performed in the 4C Infusion center and Inpatient Units.

2. Performance of procedure:
   a. Indications:
      - To diagnose cytopenias, hematological malignancies, granulomas, and aplastic, hypoplastic, and pernicious anemias.
      - To diagnose primary and metastatic tumors.
      - To determine the cause of infection.
      - To aid in the staging of disease, such as Hodgkin's disease.
      - To evaluate the effectiveness of chemotherapy and help monitor myelosuppression.

   b. Relative contraindications include infection at the site of biopsy, thrombocytopenia less than 30K or uncorrected coagulopathy.

B. Data Base

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

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory including CBC and coags, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

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

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

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

3. Education
   Appropriate and relevant patient and family education/counseling in written and/or verbal format.

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

E. Documentation
Post-procedure note recorded in the medical record and will include all necessary documentation including consent form. For PAs using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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| Prerequisites<br><br>a. Will be trained on site by a privileged provider (MD, NP or PA)<br>b. Documentation of previous training. |
| Proctoring period:<br><br>a. new practitioners to procedure will complete a minimum of 3 successful observed demonstrations and chart review.<br>b. experienced practitioners will complete a minimum of 2 successful observed demonstrations and Chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. |
| Reappointment Competency Documentation<br><br>a. Evaluation of competency will include a letter from clinical director with input from attending hematologist regarding practitioners' proficiency as well as annual observation of 1 successful completion of procedure by attending hematologist and 2 chart reviews.<br>b. Evaluation will be done by the Medical Director or Physician/NP designee. |

Protocol #10: Procedure: Colonoscopy (Requires ACLS certification)

A. DEFINITION

Colonoscopy is the examination of the rectum and colon extending to the cecum and possibly terminal ileum through the use of a flexible video scope (and does encompass flexible sigmoidoscopy). It is performed as a screening measure, as a diagnostic tool and for research purposes. For the purposes of this protocol, these examinations are conducted at the 3D GI Endoscopy Center, 5B Research Unit**,** or designated endoscopy center at the San Francisco General Hospital and Trauma Center.

Indications:

Colonoscopy is usually indicated, but not limited to:

1. Colon cancer screening in individuals over age 50 at average-risk for development of cancer.
2. Colon cancer surveillance in individuals who have had a previous history of adenomatous polyps or cancer.
3. Colon cancer surveillance in persons with increased risk for development of cancer (inflammatory bowel disease, personal/family history of colon cancer).
4. Evaluation of the colon for symptoms or signs referable to the colon and/or terminal ileum.
5. Documentation of inflammatory disease of the rectum, colon or small intestine.
6. To determine extent and/or severity inflammatory bowel disease.
7. Presence of occult or overt blood in the stool.
8. Radiographic demonstration of possible neoplasm in the rectum or colon.
9. Performance of colonoscopic biopsies for research purposes.

Contraindications:

1. Inability to obtain informed patient consent.
2. When patient's cardiovascular status will not permit positioning in a recumbent position.
3. Perforated or suspected perforated viscous.

Therapeutic techniques:

The following table outlines endoscopic therapies associated with colonoscopy and the level of attending physician participation within the procedure room that is required if a nurse practitioner/physician assistant is performing the endoscopic procedure and such therapy is required.

| | No attending physician required | Attending physician presence required, but NP/PA can perform therapy | Attending physician only |
|---|---|---|---|
| Diagnostic (no therapy) | X | | |
| Biopsy | X | | |
| Polypectomy for polyps < 1 centimeter (e.g. cold snare, etc.) | X | | |
| Tattooing for tumor marking | X | | |
| Polypectomy for polyps > 1 centimeter | | X | |
| Argon plasma coagulation (APC) therapy | | X | |
| Saline lift for polypectomy | | X | |
| Placement of endoscopic clips | | | X |
| Endoscopic banding | | | X |
| Sclerotherapy | | | X |
| Inability to complete the procedure | | | X |
| Adverse event that develops during the procedure | | | X |

B. DATA BASE
   1. Subjective Data
      a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include drug allergies.
      b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
      c. Personal/family history related to the colon and colorectal disease.

   2. Objective Data
      a. Physical exam appropriate to the procedure to be performed.
      b. The procedure is performed following standard medical technique according to the departmental guidelines and an attending physician must be physically present and readily available for consultation in the endoscopy center or research unit when a colonoscopy is being performed by an NP/PA.

c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS/ASSESSMENT

Determine the indication for Colonoscopy

1. Diagnostic Evaluation:
   History and/or physical examination findings suggestive of colorectal pathology.
2. Screening Evaluation:
   The individual is asymptomatic and 50 years of age or over.
3. Preparation:
   Bowel cleaning: utilize departmental approved regimen.
   Aspirin/NSAIDs/antiplatelet/anti-thrombin/Coumadin: will be determined on a case by case basis and in accordance with ASGE guidelines for the Management of Antithrombotic Agents for Endoscopic Procedures.
   Iron supplementation stopped 7 days prior to exam.
   No intake by mouth for 8 hours (solids) and 2 hours (clear liquids).
4. Need for antibiotic prophylaxis is assessed on a case-by-case basis utilizing current American Society for Gastrointestinal Endoscopy antibiotic prophylaxis recommendations.

D. PLAN

1. Therapeutic Plan
   a. Discuss with patient the objectives, alternatives, limitations, risks and benefits of the procedure.
   b. Patient consent must be obtained before the procedure is performed. A "time out" is performed prior to each procedure to verify the right test is being performed on the right patient.
   c. Biopsied/removed tissue is labeled and sent to pathology.
   d. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring attending consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical, or laboratory findings.
   d. Upon request of patient, affiliated staff, or physician.
   e. Problem requiring hospital admission or potential hospital admission.
   f. Problem requiring invasive or surgical procedure.
   g. Need for transfusion.
   h. Review of electrocardiograms, if no prior interpretation or change from previous recording.
   i. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.

j. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
k. Any problem requiring transfer of care to the Emergency Department.

3. Education: Discharge information, instructions and follow-up appropriate to examination findings.

4. Follow-up: Pathology results will be reviewed from patients whom biopsies or polypectomies were performed. The patient will be provided pathology results via the primary care provider, letter, telephone, or an appointment in the GI clinic.

E. RECORD KEEPING
a. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointment and procedure information, if indicated.
b. Document all findings, impression and recommendations in the computerized procedure database. Procedure documentation is automatically exported to electronic medical record.

F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

Prerequisites

A. Specialty Training
The NP/PA will be able to demonstrate knowledge of the following:
1. Indications for procedures.
2. Risks and benefits of procedures.
3. Related anatomy and physiology.
4. Bowel preparation procedures.
5. Informed consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. Prostate examination in males 50 years of age and older with referral of significant abnormalities to the Supervising Physician.
12. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.
13. Proof of ACLS certificate

B. Protocol Specific Training

1. View the videotapes from the ASGE Video Library: colonoscopy and polypectomy (GE-10), colonoscopy – insertion to cecum (GE-53), colonoscopy – polypectomy techniques I (GE-54), colonoscopy – polypectomy techniques II (GE-55), colonoscopy polyps and tumors of the colorectum and management of large colorectal polyps (GE-56).
2. Observe and demonstrate by repeat performance the proper set-up, usage and sterilization of the colonoscope and the proper use of the video processor.
3. Read Hospital Policy 19.8" Procedural Sedation: Moderate and Deep" and take test on Procedural Sedation. Learn the GI Division Protocol for moderate sedation, and achieve competency for administration of moderate sedation based on the SFGH privileging process.
4. Learn the use of the clinical software in order to capture procedure images and generate procedure reports.
5. Review appropriate infection control guidelines pertaining to colonoscopy.

Proctoring

Initial Proctoring Period: NP/PA's will be proctored through direct observation by a GI attending physician credentialed in endoscopy for a minimum of 150 colonoscopy procedures with administration of procedural sedation (including the performance of at least 50 routine colonic mucosal biopsies and 50 colonoscopic polypectomies). An experienced practitioner to colonoscopy requires a minimum of 10 successful observed demonstrations (including the performance of at least 5 colonic mucosal biopsies and 5 colonoscopic polypectomies. As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent colorectal anatomy and pathology. At the conclusion of the standardized procedure training the Clinical Chief of Gastroenterology or designated Physician will assess the NP/PA's ability to practice, including an evaluation of the NP/PA's clinical skills in taking a history, performing an appropriate physical examination, obtaining informed consent, the ordering and interpretation of laboratory and radiographic studies pertinent to the specific clinical situation, documentation of an endoscopic procedure and initiating a treatment plan.

Competency in Performing Standardized Procedure

a. Review of the post test of Education Module by the Clinical Chief of Gastroenterology.
b. Review of 75 procedure notes by the Clinical Chief of Gastroenterology.

Reappointment Competency

1. Biannual Evaluation (every 6 months):

a. Review will include chart review, collaboration with and eliciting information from attending physicians and advanced practice staff.
b. Ongoing competency will include the successful observed completion of ten (10) colonoscopies, five (5) colonoscopies with mucosal biopsy's and five (5) colonoscopic polypectomies procedures.
c. 20 chart reviews.
d. Maintenance of ACLS Certification.
e. Passing of Procedural Sedation test with passing score of 80%.
f. Review of any adverse event(s) that occurred during a colonoscopy.
g. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of a colonoscopy
h. Successful achievement of all OPPE metrics with no identified deficiencies
i. Documentation of required continuing medical education (CME)

Protocol #12: Procedure: Esophageal Manometry and Prolonged Ambulatory pH-Monitoring (ACLS required)

A. DEFINITION

Esophageal manometry is the clinical evaluation of esophageal contractile activity, and is performed to assess esophageal motor function (often pre-operatively) and for the diagnosis of suspected esophageal motor disorders. The study measures the strength, function, and coordination of the upper and lower esophageal sphincters (UES and LES, respectively), and the body of the esophagus in response to swallows. Recordings are made of the amplitude and coordination of contractions within the pharynx and esophagus. Ambulatory Esophageal pH monitoring (24-hour pH probe) is sometimes performed in conjunction with esophageal manometry. During this procedure, an intra-nasal catheter is placed in reference to the manometrically-defined lower esophageal sphincter, and records acid reflux events over a 24-hour period. Esophageal manometry is conducted on the GI Endoscopy Center at San Francisco General Hospital and Trauma Hospital.

Indications:

Esophageal Manometry is usually indicated, but not limited to:

1. Evaluation of suspected esophageal motor dysfunction, such as esophageal spasm, achalasia, or the 'nutcracker' esophagus.
2. Evaluation of patients with unexplained ('non-cardiac') chest pain or dysphagia.
3. Preoperative evaluation of esophageal motor function prior to esophageal/gastric surgery
4. Assisting in accurate placement of ambulatory esophageal pH probes.
5. Evaluation of patients with neuromuscular disorders affecting esophageal function and/or swallowing (e.g., scleroderma, muscular dystrophy, and strokes).
6. Evaluation of patients with symptoms that may represent reflux disease, such as chronic cough, asthma, hoarseness.

8. Preoperative evaluation of esophageal reflux prior to esophageal/gastric surgery
9. Assess reflux patients not responding to standard medical/pharmacologic therapy.

Contraindications to Esophageal Manometry/pH Monitoring:

1. Inability to obtain informed patient consent.
2. Undiagnosed potential trauma to the nasal passages, nasopharynx, oropharynx, esophagus and/or the stomach.
3. When patient's health status/physical limitations will not permit placement of a flexible catheter through the nose and/or into the esophagus.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include diet, medications, and allergies.
   b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
   c. Family history to include peptic ulcer disease, cancer, diabetes.

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines) and an attending physician must be physically present and readily available for consultation when an esophageal manometry is being performed by an NP/PA.
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS/ASSESSMENT
   1. Obtain patient's medical history to determine indications for esophageal manometry and/or pH monitoring.
   2. Preparation: Patient is to be NPO after midnight before the procedure.

D. PLAN
   1. Therapeutic Treatment Plan
      a. Discuss with patient the objectives, alternatives, risks and benefits of the procedure.
      b. Verify NPO status so that procedure can be performed in a safe and appropriate manner.
      c. Obtain informed consent, utilizing interpreter services as necessary.

   2. Patient conditions requiring Attending Consultation:
      a. Emergent conditions requiring prompt medical intervention.
      b. Acute decompensation of the patient.
      c. Historical, physical or diagnostic findings that seem unusual.
      d. A problem, which is not resolving as anticipated.
      e. Upon request of patient, NP, PA, or physician
      f. Initiation or adjustment of medication other than those in the formularies.
      g. Problem requiring hospital admission or potential hospital admission.
      h. When ordering complex imaging studies or procedures.

   3. Education: Discharge information, instructions and follow-up appropriate to examination findings.

4. Follow-up: Patients will be evaluated in the appropriate gastroenterology clinic to follow up on the results of pH and manometry tests.

E. RECORD KEEPING

1. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointments and procedure information, if any.
2. Document all findings in the computerized procedure database. Procedure documentation is automatically exported to the electronic medical record

F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

1. Indications for procedures.
2. Risks and benefits of procedures.
3. Related anatomy and physiology.
4. Bowel preparation procedures.
5. Consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. Ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.
12. Review relevant literature available on the GI unit regarding esophageal Manometry / pH monitoring procedure and familiarize self with “Manometry Set-up Procedure” in the Policy and Procedure section of the GI Division Operations Manual.
13. Observe and demonstrate by repeat performance the set-up, calibration, and operational procedures for esophageal Manometry and pH catheter assembly.
14. Possession of an ACLS Certificate

Proctoring

NP/PA’s will be proctored through direct observation by GI attending staff credentialed in endoscopy for a minimum of 5 esophageal manometry and pH monitoring procedures prior to performing such procedures independently.An experienced practitioner to the procedure will require a minimum of 3 successful observed demonstrations. Designation of

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| experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.<br><br>As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent nasopharyngeal, esophageal and stomach anatomy.<br><br>Competency in Performing Standardized Procedures<br>a. Review of the post test of Education Module by the Medical Director.<br>b. Review of 20 procedure notes by the Clinical Chief of Gastroenterology. |
| Reappointment Competency<br>1. Evaluation:<br>a. Ongoing competency will include completion of five (5) esophageal Manometry and pH monitoring procedures every year.<br>b. Review of any adverse event(s) that occurred during an esophageal manometry.<br>c. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of an esophageal manometry.<br>d. Successful achievement of all OPPE metrics with no identified deficiencies<br>e. Documentation of required continuing medical education (CME) |

Protocol #13: Procedure: Exercise Treadmill Test (ACLS required)

A. DEFINITION

This test is to use incremental exercise modality to diagnose, evaluate and assess the following:

1. Aid in the diagnosis of coronary artery disease
2. Evaluate severity of ischemia in patients with known coronary artery disease (angina, post infarction, positive angiogram, post-AC bypass or PCI).
3. Effort tolerance (EKG may or may not be normal)
4. Chronotropic competence
5. Exercise BP
6. Exercised - induced arrhythmia

Location to be performed: This test will be done in: Cardiology outpatient setting.

Patient preparation

a. Patient must be able to walk unassisted (i.e. without cane or other aid).
b. For patients who had chest pain, when in the Emergency Department, must have had a negative troponin test.
c. Nothing by mouth if test is done in AM, light meal for PM.
d. Stop smoking one hour prior to the test.
e. Hold anti-glycemic medication prior to the test as indicated.
f. For the purpose of diagnosis of CAD, beta-blockers should be discontinued 24-36 hours prior the test, if possible.

Performance of procedure

a. Precautions: Never push the patient above his/her exercise capability.
b. Contraindications
    1. Severe or critical aortic stenosis
    2. Unstable angina with rest
    3. Suboptimum treated congestive heart failure
    4. Pericarditis
    5. Uninterruptible ECG for any reason, e.g. LVH, LBBB or WPW
    6. Patient with murmur, unknown reason
    7. Uncontrolled HTN (Baseline SBP>180

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify myocardial ischemia during the exercise treadmill test.

D. PLAN

1. Therapeutic Treatment Plan
    a. Diagnostic tests for purposes of disease identification.
    b. Screening tests performed as part of appropriate health maintenance.
    c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:
    a. Acute decompensation of patient situation.
    b. Unexplained historical, physical, laboratory or study findings.
    c. Uncommon, unfamiliar, unstable, and complex patient conditions
    d. Upon request of patient, NP, PA, or physician
    e. Initiation or adjustment of medication other than those in the formularies.
    f. Problem requiring hospital admission or potential hospital admission.

3. Education
    a. Patient education as appropriate to procedure
    b. Discharge information and instructions.

4. Follow-up
    As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. There will be documentation of all vital signs, blood pressure, heart rate, oxygen saturation, as well as any

symptomatology during testing. All changes in 12 lead EKG during procedure will be documented. The attending cardiologist will complete final reading and sign the report in the LCR. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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|---|
| Prerequisites:<br>a. Review of departmental policy and procedure.<br>b. Two direct observations of procedure being performed by a qualified provider.<br>c. Completion of a 12 lead EKG Course or completion of 12 lead EKG training by qualified Cardiology staff. |
| Proctoring Period:<br>a. 3 successful observed demonstrations for provider new to this procedure.<br>b. 2 successful demonstrations for provider experienced in this procedure. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.<br>c. Chart review of all observed cases. |
| Reappointment Competency Documentation:<br>a. Perform 2 procedures every 2 years.<br>b. 2 chart reviews every 2 years. |

Protocol #14 Procedure: High Resolution Anoscopy

A. DEFINITION
Men and women with abnormal anal pap smears will be evaluated by high resolution anoscopy (HRA) with biopsy of suspicious lesions and treatment or referral as indicated.

1. Performance of procedure:
   i. Indications: Patients with abnormal anal pap smears, anal lesion visible by gross examination or a history of anal warts or anal dysplasia.
   ii. Precautions/Contraindications: Consult an MD before performing biopsies on patients with Thrombocytopenia, Neutropenia, infection of anal canal, use of anticoagulants, history of abnormal heart valve or endocarditis.

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

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

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

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

2. Patient conditions requiring Attending Consultation
   a. As specified under precautions.
   b. Upon request of patient, NP, PA, or physician
   c. Initiation or adjustment of medication other than those in the formularies.
   d. Problem requiring hospital admission or potential hospital admission.)

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisite:<br>a. Completion of a one week course in theory and practice of cervical colposcopy from the University of California or a recognized university. |
| Proctoring :<br>a. Performance of 50 high resolution anoscopy procedures (anal colposcopy with biopsy) under supervision of an experienced colposcopist.<br>b. Review of 3 medical records. |
| Reappointment Competency Documentation:<br>a. Minimum of 20 procedures that must be completed every two years.<br>b. Minimum of 3 chart reviews needed every two years. |

Protocol #15: Procedure: Incision and drainage of skin abscesses with administration of local anesthesia

A. DEFINITION

Abscesses resolve with drainage. Abscesses that do not respond to more conservative measures may need incising in order to facilitate drainage and hasten resolution.

1. Performance of procedure.
    a. Indications:
    Palpable, fluctuant skin abscesses
    b. Precautions:
    Large abscesses that require extensive incising or debridement
    c. Contraindications:
        1. Deep abscesses that may require more extensive anesthesia
        2. Abscesses that invade the palmar or plantar spaces
        3. Suspected pseudo aneurysm (must be ruled out by further diagnostic evaluation)
    d. Exclusions:
    Abscesses on the face, neck, perirectal area, and genitalia

B. DATA BASE

1. Subjective Data
    a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
    b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
    a. Physical exam appropriate to the procedure to be performed.
    b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
    c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
    d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical, or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.
3. Education - Discharge information and instructions.
4. Follow-up - As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisite:<br>a. The NP/PA will be trained to successfully perform the procedure through instruction and proctoring by the Medical Director or his/her designee. |
| Proctoring:<br>a. New practitioner to procedure, a minimum of 2 successful observed demonstrations.<br>b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.<br>c. Chart review of all observed procedures. |
| Reappointment Competency:<br>a. The number of procedures needed to maintain proficiency will be 2 procedure every 2 years.<br>b. The number of chart reviews needed to monitor ongoing competency for annual review will be 2 chart every 2 years. |

Protocol #16: Procedure: Intraventricular Chemotherapy Administration via Ommaya Reservoir

A. Definition - The administration of chemotherapy via Ommaya Reservoir into cerebrospinal fluid (CSF) for treatment of previously diagnosed central nervous system (CNS) involvement by leukemia and lymphoma or other malignancies. The procedure is also used for withdrawal of CSF for laboratory analysis in patients with known CNS malignancy.

1. May be performed in the 4C Infusion Center Or Inpatient Units

i. Indications

a. Patients with surgically implanted Ommaya reservoir and recent diagnosis or history of leptomeningeal malignancy

b. Patients with Ommaya reservoir and meningeal signs or symptoms such as nuchal rigidity and headaches, without evidence of increased intracranial pressure.

c. Withdrawal of CSF may be done as part of evaluation of fever (as indicated) in patients with Ommaya reservoir.

ii. Precautions

a. Precautions: Evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, papilledema, bulging Ommaya or significant decrease in the level of consciousness; evidence of focal neurological findings.

iii. Contraindication: Cutaneous infection at the site of puncture.

B. Data Base:

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

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis

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

D. Plan

1. Therapeutic Treatment Plan
   a. Obtain informed consent prior to procedure and according to hospital policy.
   b. Time out performed according to hospital policy.
   c. CSF may be sent for evaluation for infection or malignancy.

2. Patient conditions requiring attending consultation:
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings.
   c. Initiation or adjustment of medication other than those in the formularies.

3. Education
   a. Appropriate and relevant patient and family education/counseling in written and/or verbal format.

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

E. Documentation

Post-procedure note recorded in the medical record in addition to consent forms and other procedure specific documents as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the PA within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisite<br><br>Training will consist of instruction by clinical directors or physician/NP designee. |
| Proctoring Period<br><br>a. Proctoring period for practitioners will be a minimum of 3 successful observed demonstrations within the proctoring period, if there are insufficient opportunities within the proctoring period, and then procedure will be supervised until the minimum requirement is met. |

Reappointment

a. A minimum of 2 procedures within a 2 year period. If no opportunities occur within a 2 year period, provider will be supervised for 1 additional procedure when the opportunity occurs.

b. 2 chart reviews every 2 years.

Protocol # 17: Procedure: Lumbar Puncture

A. DEFINITION

A diagnostic procedure used to identify infectious, neoplastic, and autoimmune processes of the central nervous system. Lumbar puncture may also be performed to determine the intracranial pressure.

1. Location to be performed**:** Inpatient Units and the 4C Outpatient Infusion Center
2. Performance of Lumbar Puncture
   a. Indications
      1. To obtain Cerebral Spinal Fluid (CSF) for diagnosis of infectious, inflammatory or neoplastic diseases
   b. Precautions

      Indications for brain CT scan prior to LP include the following
      1. Age >60 years
      2. Immunocompromised patients
      3. Known CNS lesions
      4. Recent seizure activity
      5. Abnormal level of consciousness
      6. Focal findings on neurological examination
   c. Contraindications
      1. Increased Intracranial Pressure
      2. Soft tissue infection at the entry site
      3. Coagulopathy
      4. Known spinal cord arteriovenous malformations
      5. Patient refusal

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination, assessment of papilledema, and integrity of the lumbar skin site.

b. The procedure is performed following standard medical technique according to The Handbook of Neurosurgery by Mark Greenberg, Section 23.7.3. Lumbar Puncture.
c. Laboratory evaluation to include CBC with platelets, PT, PTT, and INR. Imaging evaluation, including CT head to rule out a mass lesion, a posterior fossa lesion, or subarachnoid hemorrhage, as indicated by history and physical exam.
d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
a. Patient consent, consistent with hospital policy, obtained before procedure is performed.
b. Timeout conducted consistent with hospital policy.
c. Diagnostic tests on the CSF for purposes of disease identification may include chemistry, gram stain, culture and sensitivity, blood cell count and differential, and measurement of CSF pressure. Additional diagnostic tests may be sent, as indicated
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
a. Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print-outs titled “Lumbar Puncture” and “Having a Lumbar Puncture” can be provided to patients to assist with pre- and post-procedural education.

4. Follow-up
As appropriate for lumbar puncture.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review

those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisite<br>a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this procedure.<br>b. Completion of onsite training by qualified provider if no prior experience. |
| Proctoring<br>a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations and 3 chart reviews<br>b. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations and 2 chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.<br>c. Proctoring for 1 of the procedures may be performed on a simulated model |
| Reappointment<br>a. The evaluator will be an attending physician or another designated clinician that has unrestricted privileges to perform lumbar punctures<br>b. Ongoing Competency Evaluation<br>1. Three Lumbar Punctures will be needed to maintain proficiency every 2 years.<br>2. Three chart reviews will be needed every 2 years.<br>c. Proctoring for 1 of the procedures may be performed on a simulated model |

Protocol #18 Procedure: - Lumbar puncture with the Administration of Intrathecal Chemotherapy

A. Definition – The lumbar puncture (LP) may assist in diagnosis of central nervous system (CNS) infections, malignancies and subarachnoid hemorrhage. The LP also facilitates the intrathecal administration of chemotherapy into CSF in previously diagnosed lymphoma and leukemia patients with leptomeningeal involvement or high risk for leptomeningeal involvement.

1. Location of procedure may include 4C Infusion Center, Inpatient rooms and fluoroscopy room in Radiology.

   a. Indications - Patients with recent diagnosis of CNS malignancy, history of CNS malignancy, therapy related complications of the CNS, or signs and symptoms of infections of the CNS, acute leukemia or lymphoma (as staging or CNS prophylaxis).

   b. Precautions/Contraindications:

   - Patients with evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, altered mental status, or focal neurological deficits should undergo a neuroimaging study before a LP is performed and requires physician consultation.
   - New focal neurologic findings and/or lesions, or imaging studies revealing significant mass effect. Requires physician consultation.
   - Use caution with patients with a history of low back pain, sciatica pain, or lower extremity neuralgia. Any patients with prior back surgery shall be evaluated by the attending physician prior to the procedure.
   - Patients with meningeal signs or symptoms, such as nuchal rigidity and headache with or without evidence of increased intracranial pressure, fever or altered mental status should be done in the hospital after appropriate CT scanning and prior physician consultation.
   - Patients with either thrombocytopenia (platelet count less than 30,000), INR > 1.4, PTT >40 Consult with physician before performing the procedure. Patients may require additional studies or blood products to correct the platelet count and/or coagulation factor deficiencies.

B. Data Base

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-

containing products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

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

D. Plan
1. Therapeutic Treatment Plan
   a. Obtain informed consent prior to procedure and according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for clarification of disease state or infection.
   d. Initiation or adjustment of medication per chemotherapy order writing protocol.
2. Patient conditions requiring attending physician consultation
   a. Acute decompensation of patient.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA or physician
   d. Any precautions listed under A1b
3. Education
   Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print outs titled "Lumbar Puncture" and "Having a Lumbar Puncture" can be provided to patients to assist with pre and post-procedural education.
4. Follow-up
   As indicated and appropriate to client health status and diagnosis.

E. Documentation

Post-procedure note recorded in the medical record and LCR as appropriate and will include all necessary documentation. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the PA within thirty (30) days of the procedure. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites

a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this minor procedure.
b. Completion of onsite training by a qualified provider if no prior experience.

Proctoring

a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations and chart reviews.
b. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations and chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.

Reappointment

a. The evaluator will be the Clinical Service Chief or another designated physician that has unrestricted privileges to perform lumbar punctures.
b. Ongoing Competency Evaluation
    1. 2 Lumbar Punctures will be needed every 2 years.
    2. 2 chart review will be needed every 2 years.

Protocol #19: Procedure: Procedural Moderate Sedation

A. DEFINITION

Procedural/Moderate Sedation/Analgesia: is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light or tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation (SFGH policy number 19.08 titled, "Procedural Sedation: Moderate and Deep") by the Nurse Practitioner/Physician Assistant during procedures in adults within a monitored setting. For the purpose of this protocol, the setting is specifically in the Gastroenterology Department. The Nurse Practitioner/Physician Assistant practices under the supervision of the Chief of Gastroenterology or designee. Practitioners producing a level of sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes, and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedure may only be done in 3D GI Service or in the 5B Research Unit.

Materials necessary for procedural sedation and rescue include:

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

Indications:

a. Procedural sedation may be indicated, but not limited to colonoscopy and esophagogastroduodenoscopy (EGD).

Precautions/Contraindications:

a. Inability to obtain informed patient consent.
b. Anticipated difficult intubation.
c. The patient's American Society of Anesthesiologists (ASA) physical status; consultation with Anesthesia Service should be considered for patients who have an ASA score of 3 or above. A procedure requiring sedation would not be done on a patient with an ASA score above a three (3) without anesthesia assistance.
d. When the patient's cardiovascular status will not permit positioning in a recumbent position.
e. Undiagnosed potential trauma to the gastrointestinal tract.

B. DATA BASE
   1. Subjective Data
      a. Obtain a history within 24 hours of the procedure and sedation. If completed prior to 24 hours, an interim history must be obtained.
      b. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
      c. Pertinent past medical history, surgical history, hospitalizations, habits, anesthetic, allergy and drug history.

   2. Objective Data
      a. Physical exam within 24 hours of procedure and sedation. If completed prior to 24 hours, an interim physical must be obtained.
      The exam is to include airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight), and IV access.
      b. Diagnostic data, as appropriate.
      c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.
      d. Laboratory and imaging results, as indicated, relevant to the history and physical exam.

C. DIAGNOSIS/ASSESSMENT
   1. A judgment as to the appropriateness of the procedure and safety of sedation for the particular patient, that includes consideration of the patient's age, medical condition, and the procedure and sedation side effects and risks.
   2. Assignment of an ASA physical status. Patients with a Physical ASA class of IV or V will not undergo moderate sedation by the Nurse Practitioner/Physician Assistant in the Gastroenterology Department.
   3. Assignment of the pre-procedure Modified Aldrete Score.
   4. Evidence of verification of compliance with the NPO status (adult: minimum 8 hours (solids) and 2 hours (clear liquids) before procedure to decrease risk of aspiration).
   5. Assess and document the benefits of sedation against the risk of possible aspiration.
   6. A responsible adult is available to take the patient home after the procedure.

D. PLAN
   1. Therapeutic Treatment Plan shall follow SFGH policy number 19.08 titled "Procedural Sedation: Moderate and Deep"
      a. Informed consent for the procedure and sedation must be obtained and documented by the nurse practitioner/physician assistant prior to the delivery of sedation. The consent form must list the procedure to be performed as well as the sedation planned.
      b. Pre-Procedure patient education shall be given and documented, to include, but not be limited to:

1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
2. Risks, benefits, and alternatives.
3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
4. Date/time of procedure.
5. Necessity of an escort for discharge to home and/or an appropriate mode of transportation home.

c. Re-assessment immediately prior to the procedure to include:
1. Indication for procedure.
2. Two patient identifiers.
3. A “time out” documented.
4. Immediate pre-procedure vital signs (blood pressure, heart rate and oxygen saturation).
5. An assessment of level of movement and consciousness, and responsiveness.

d. The Procedure:
1. Verify pre-procedure assessment and monitoring guidelines.
2. Administer appropriate medications as indicated.
3. Continuously assess the patient’s response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, ETCO2, EKG rhythm, and pain level).
5. Reversal agents, if indicated.

e. Post-procedure
1. Monitor level of consciousness, respiratory (RR, SaO2) and cardiovascular parameters, and pain level.

f. Termination of Treatment
1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.

2. Patient conditions requiring Attending Consultation
a. Physical ASA status 3 or above.
b. Aspiration.
c. Acute decompensation of patient situation.
d. Unexplained historical, physical or laboratory findings.
e. Upon request of patient, NP, PA, or physician.
f. Problem requiring hospital admission or potential hospital admission.

3. Education

Patient will be instructed on signs and symptoms of complications. A 24 hour emergency advice number will be given to the patient for any post-procedural problems. Examination findings/pathology results will be provided to the patient by the primary care provider, telephone, or during an appointment in the GI Clinic.

4. Follow-up
   A. If the patient is transferred to the recovering unit:
      1. The patient must be accompanied by trained and/or licensed personnel.
      2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:
         a. Pertinent medical history
         b. The procedure performed.
         c. The condition of the patient; including pain score.
         d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
         e. Any significant clinical events occurring during and post-procedure.
         f. Any additional physician orders relating to the post-procedural/moderate sedation care.
   B. Any patient receiving a reversal agent (narcan or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re- sedation. In addition an Unusual Occurrence Report must be completed. See Hospital Policy 19.08 for other criteria requiring submission of an unusual occurrence report.
   C. The outpatient is discharged “to home”:
      1. By a specific discharge order from a physician or nurse practitioner/physician assistant; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.
      2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
      3. Outpatients who are discharged to home must be accompanied by a responsible adult and have an appropriate mode of transportation.

E. RECORD KEEPING

Patient visit, consent forms, other procedure specific documents, and a post procedure note will be recorded in the Medical record as appropriate. The patient status and compliance with discharge criteria must be documented in the patient’s medical record by the physician, nurse practitioner, physician assistant, or registered nurse discharging the patient. Document all findings in the computerized procedure database. Procedure documentation is automatically exported to the Lifetime Clinical Record (LCR).

F. Summary of prerequisites, proctoring & reappointment of competency

| Prerequisites |
| --- |
| A. Specialty Training<br>The NP/PA will be able to demonstrate knowledge of the following:<br>1. Indications for procedures. |

2. Risks and benefits of procedures.
3. Related anatomy and physiology.
4. Bowel preparation procedures.
5. Informed consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.

B. Training Program
1. Completion of the SFGH Procedural Sedation Test with a passing score of 90%. 2. Completion of (BLS) training.
3. Completion of the Registered Nursing Moderate Sedation Education Module.
4. Furnishing License and/or DEA number.

Proctoring

A. Direct observation by GI attending staff credentialed in moderate sedation for a minimum of 30 procedures with moderate sedation, while an experienced practitioner to moderate sedation requires a minimum of 10 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
B. Successful completion of Education Module post test.
C. Review of 30 procedure notes by the Chief of Gastroenterology.

Reappointment

A. Ongoing competency will include the successful observed completion of three procedures every 2 years.
B. Direct observation of one patient clinic encounter will be conducted by the Medical Director or other designated attending physicians every 2 years.
C. Maintenance of BLS Certification.
D. Passing of Procedural Sedation test with a passing score of 90%

Protocol #20: Procedure: Ordering Blood Transfusions

A. DEFINITION
Ordering the administration of whole blood or blood components i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate. Exchange transfusion is the withdrawal of blood prior to a transfusion to keep hemoglobin unchanged.

1. Location to be performed: Inpatient hospital units, Hematology/Oncology Clinic, 4C Infusion Center and the Positive Health Clinic. Exchange transfusions will only be done in the 4C Infusion Center.

2. Performance of procedure:
   a. Indications
      1. Anemia
      2. Thrombocytopenia or platelet dysfunction
      3. Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means.
      4. Exchange transfusions for sickle cell patients with the following, but not limited to: acute chest syndrome, stroke, severe infection, severe anemia, preoperatively, during pregnancy and to prevent recurrent acute chest pain.
   b. Precautions
      1. Blood and blood components must be given according to SFGH guidelines.
      2. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.
   c. Contraindications
      Absolute: none
      Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenia purpura (TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.

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

2. Objective Data
    a. Physical exam relevant to the decision to transfuse.
    b. Laboratory evaluation.
    c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

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

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

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

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

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

E. RECORD KEEPING
Patient visit, consent forms, and other transfusion-specific documents(completed transfusion report and “blood sticker” will be included in the medical record, ICIP, LCR and other patient data bases, as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisite:<br>a. Successful completion of the San Francisco General Hospital and Trauma Center Transfusion Training course.<br>b. Successful completion of Transfusion Training course test on blood ordering and informed consent.<br>c. Must have an 80% test score on both examinations. |
| Proctoring:<br>a. Read and Sign the SFGH Administrative Policy and Procedure 2.3 “Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options”.<br>b. Review of SFGH Transfusion Guidelines in Laboratory manual.<br>c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record. |
| Reappointment:<br>a. Completion of the two education modules and completion of the two examinations with a passing score of 80%.<br>b. Performance of 2 transfusion orders every 2 years and 2 medical record reviews every 2 years.<br>c. Review of any report from the Transfusion Committee. |

Protocol #21: Procedure: Ordering Chemotherapy

A. Definition: Chemotherapy is the use of anti-cancer, immunotherapy and growth factor drugs to treat malignancies. Selection of specific drugs or protocols is based on results of prior and on-going clinical trials.

1. Location for ordering chemotherapy: Hematology/Oncology Clinic and the 4C Infusion Center.
2. Policy – The standardized procedures enables the NP/PA to initiate or change, in consultation with the attending physician(s) as appropriate, chemotherapy regimens. The NP/PA shall also write chemotherapy orders

B. Data Base:

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

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis
Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (ie. Stage of cancer)

D. Plan

1. Chemotherapy orders procedure
   - Verify patient height and weight and calculate BSA, CrCl and other needed parameters according to protocol guidelines
   - Confirm doses and dose parameters specific to chemotherapy protocols.
   - Order pre-chemotherapy checklist labs as per hospital protocol
   - Write anti-emetics and pre-medication orders appropriate to chemotherapy protocol.
   - Write chemotherapy orders in consultation with the Attending Physician as appropriate.

2. Client conditions requiring consultation
   a. Acute decompensation of patient situation

b. Unexplained physical or laboratory findings
c. Upon request of patient, NP, PA or physician
d. Problem requiring hospital or potential hospital admission

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

4. Follow-up
   Patients shall be closely monitored, as indicated, for excessive toxicities appropriate to the drug and/or regimen, progression of disease, or development of new or exacerbation of concurrent medical problem that would contraindicate receiving treatment or necessitate an appropriate change in the regimen.

E. Record Keeping
Chemotherapy orders are written on the standard SFGHMC Chemotherapy Order Sheet and will include all necessary documentation according to hospital policy. Patient visit, consent forms and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistant, using protocols for supervision the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within 30 days after completion of proctoring period. The physician shall select for review those cases that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisite, Proctoring, and Reappointment Competency

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|---|
| Prerequisites<br><br>Training will include a weekly didactic meeting with the clinical director during the three month proctoring period and may be extended depending upon the evaluation of the clinical director or Heme Onc attending at the completion of proctoring. |
| Proctoring<br><br>a. All NPs/PAs who are recently hired will have their chemotherapy orders cosigned for the duration of their proctoring period, 3 months for full time employees and 6 months for part time employees.<br>b. Experienced practitioner will have 2 chemotherapy orders reviewed by clinical director. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. |
| Reappointment |

a. Evaluation will be done by the Medical Director or designated Physician.
b. Ongoing competency evaluation.
    1. Three chemotherapy orders reviewed every 2 years.
    2. Three chart reviews needed every 2 years.

Protocol #22: Procedure: Skin Biopsies

A. DEFINITION

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

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

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

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
b. Time out performed per hospital policy.
c. Diagnostic tests for purposes of disease identification.
d. Biopsy tissue is sent to pathology if indicated.
e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
f. Referral to physician and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.

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

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisites<br>a. Onsite training of procedures by a qualified provider.<br>b. Review of aseptic technique<br>c. Review of departmental policy and procedure |
| Proctoring Period<br>a. New practitioner to procedure, a minimum of 2successful observed demonstrations and chart reviews of each procedure<br>b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstration and chart review of each procedure. |

| |
|---|
| Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. |
| Reappointment Competency<br>a. Evaluator will be the Medical Director or other qualified provider<br>b. Competency<br>1. Perform 1 procedures of each type every 2 years.<br>2. 1 chart review of each type every 2 years. |

Protocol #23: Procedure: Thoracentesis

A. DEFINITION: Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid. This procedure can be done in the Inpatient hospital units.

1. Performance of procedure
   Indications
   a. For the purposes of this protocol, thoracentesis may be used to determine the cause of a pleural effusion or
   b. To relieve the symptoms of non-acute respiratory distress

   Contraindications
   a. Infection in the tissues near the puncture site.
   b. Acute respiratory compromise
   c. Coagulopathy
   d. Significant pulmonary parenchymal disease

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

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

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.

d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
All patients needing procedure

3. Education
Discharge information and instructions.

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisite<br>a. Onsite training by a qualified provider. |
| Proctoring Period<br>a. New provider to procedure, a minimum of 3 successful observed demonstrations and 3 chart reviews<br>b. Experienced provider to procedure, a minimum of 2 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.<br>c. Proctoring for 1 of the procedures may be performed on a simulated model |
| Reappointment Competency<br>a. The evaluator will be an Attending Physician or another clinician that has unrestricted privileges to perform thoracentesis<br>b. Ongoing competency evaluation.<br>1. Perform a minimum of 3 procedures every 2 years. |

2. Three chart reviews every 2 years.

c. Proctoring for 1 of the procedures may be performed on a simulated model

Procedure #24: Procedure: Waived Testing

A. DEFINITION

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

1. Location where waived testing is to be performed: Adult Medical Clinic, Specialty Clinics on Ward 92, 4C Infusion Center, 5B Research Unit, Occupational Health Services, Positive Health Clinic, Ward 17 Renal Dialysis Center and Inpatient Units.

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

B. DATA BASE

1. Subjective Data
   Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed

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

C. DIAGNOSIS

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

D. PLAN

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

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

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

2. Test Results requiring Attending Consultation
    a. Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

3. Education
    a. Inform patient of test results and need of additional tests, as necessary
4. Follow-up
    a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Prerequisites:<br><br>Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics, |
| Proctoring:<br><br>Successful completion of Health stream quizzes for each of the waived tests the practitioner is performing at SFGH, achievement of passing scores of at least 80% on each module. |
| Reappointment Competency Documentation:<br><br>Renewal required every two years with documentation of successful completion of the required Health stream quizzes. Provider must have passed each required module with a score of 80%. |

## Protocol #26: Procedure: Contraceptive Implant Insertion

### A. DEFINITION

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

1. Location to be performed will be all appropriate sites within the DGIM department.

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

### B. DATA BASE

1. Subjective Data
   - a. History and review of symptoms relevant to presenting complaint or procedure/surgery to be performed, including sexual history to rule out preexisting pregnancy.
   - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, including over-the-counter and herbal remedies, allergies.

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

### C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Timing of insertion: see prescribing information.
   c. Implant insertion as described in prescribing information.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Difficult insertions.
   b. Acute decompensation of patient situation.
   c. Upon request of NP, PA or physician

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

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring, and Reappointment Competency

| |
|---|
| Requirements to be completed prior to initiation of proctoring and provision of direct patient care:<br><br>a. Completion of a company sponsored training program |
| Proctoring:<br>a. Direct observation of 2 insertions by a qualified provider for providers new to this procedure.<br>b. Direct observation by a qualified provider of 1 insertion for an experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years).<br>c. Chart review of all observed cases. |
| Reappointment Competency Documentation: |

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

## Protocol #27: Procedure: Contraceptive Implant Removal

### A. DEFINITION

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

1. Location to be performed: All appropriate sites within the FCM department.

2. Performance of procedure:
   a. Indications
      Woman desires removal of implant or implant is expired.
   b. Precautions: See prescribing information.
   c. Contraindications: See prescribing information.

### B. DATA BASE

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

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

### C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

### D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Diagnostic tests for purposes of disease identification.
   c. Timing of removal: See prescribing information
   d. Removal: as described in prescribing information
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Difficult Implant removal.
   c. Upon request of patient, affiliated staff or physician
   d. If patient desires removal and rod is not readily palpable.

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

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| |
|---|
| Requirements to be completed prior to initiation of proctoring and provision of direct patient care:<br>a. Completion of a company sponsored training class |
| Proctoring Period:<br>a. Performance of a minimum of 6 removals for a new provider and 2 removals for a provider who has prior experience with independent removal.<br>b. Proctor must be a qualified provider.<br>c. Chart review of all observed cases. |
| Reappointment Competency Documentation:<br>a. Performance of 8 removals every 2 years.<br>b. 2 chart review needed every two years. |