



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

Standardized Procedures

Nurse Practitioner/Physician Assistants

Title: Department of Anesthesia

2021

PREAMBLE

I. Policy Statement

- A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, 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 4J Preoperative and Pain Clinic, the Pre-Op Clinic Medical Director's Office and on file in the Medical Staff Office.

II. Functions to Be Performed

The following standardized procedures are formulated as process protocols to explain the overlapping functions performed by the NP/PA in their practice. Each practice area will vary in the functions that will be performed, such as primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

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

specific conditions requiring the Nurse Practitioner to seek physician consultation.

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

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

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

1. Location of practice is in the Anesthesia Pre-operative Clinic, the Anesthesia Pain Management Clinic, and any other part of the hospital where pre-operative assessment and optimization, or acute/chronic pain assessment and management are required.

B. Supervision

1. Overall Accountability:

The NP/PA is responsible and accountable to the respective Medical Directors of the Preoperative Clinic and Pain Clinic, as well as the Anesthesia attending assigned to supervise the Anesthesia Pre-Op Clinic, Anesthesia Pain Management Clinic, or Anesthesia Acute Pain Service.

2. A consulting physician (Anesthesia attending) 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

IV. Scope of Practice

Protocol #1: Health Care Management: Primary Care/Specialty Clinics/Inpatient Units

Protocol #2: Pre-Op Screening of Adults

Protocol #3: Pre-Op Screening of Children

Protocol #4: Furnishing Medications and Drug Orders

Protocol #5: Electronic Consult (eConsult) Review

Protocol #6: Management of Neuraxial/Nerve Catheters for Pain Control

Protocol #7: Trigger Point Injections

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

1. Active California Registered Nurse/ Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
5. Possession of a National Provider Identifier or must have submitted an application.

6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA number if applicable.

B. Specialty Training

1. Degree needed for adults: Adult Nurse Practitioner (ANP), Family Nurse Practitioner (FNP) or Physician Assistant (PA)
2. Degree needed for children less than 18 years of age: FNP, PA or Pediatric Nurse Practitioner (PNP)

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 Directors and/or designated physician and other supervisors, as applicable, will assess the NP/PA's ability to practice.
 - a. Clinical Practice
 1. Length of proctoring period will be three months which can be shortened or lengthened.
 2. The evaluator will be the Medical Directors and/or designated supervising physician or peer reviewers as applicable.
 3. The method of evaluation in clinical practice will be a minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures demonstrate clinical competence or as noted in each special protocol.
2. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Directors, and/or designated physician, at appropriate intervals.
3. Ongoing Professional Performance Evaluation (OPPE): Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.
4. Biennial Reappointment: Medical Directors, and/or designated physician must evaluate the NP/PA's clinical competence. For reappointment, 5 chart reviews every 2 years or as noted in each special protocol. Charts can include reviews completed for special procedure reviews.

VII. Development and Approval of Standardized Procedure

A. Method of Development

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

B. Approval

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

C. Review Schedule

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

D. Revisions

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

Protocol #1: Health Care Management – Specialty Clinics/Inpatient Units (Core)

A. DEFINITION

This protocol covers the procedure for age appropriate health care management in specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses within outpatient clinics, Emergency Department, Inpatient units, ICU.

B. DATABASE

1. Subjective Data

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

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment

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

2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation.
 - b. Problem that is not resolved after reasonable trial of therapies.
 - c. Unexplained historical, physical or laboratory findings.
 - d. Uncommon, unfamiliar, unstable and complex patient conditions.
 - e. Upon request of patient, NP, PA, or physician
 - f. Problem requiring hospital admission or potential hospital admission.
3. Education
 - a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. smoking cessation, 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).

Protocol #2: Pre-Op Screening of Adults (Core)

A. Definition

This protocol covers the assessment and management of adults prior to the administration of anesthesia. This will include a directed history and physical.

1. Proctoring

- a. Length of proctoring period will be three months which can be shortened or lengthened.
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. The method of evaluation in clinical practice will be presentation of 5 adult cases to either the Medical Director or designated physician during the proctoring period with a chart review of the same 5 cases

2. Reappointment:

- a. The period of review will be every 2 years
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. Evaluation will be the review of ~~3~~5 adult medical record cases

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. Historical information relative to the presenting illness (past health history, family history, occupational history, personal/social history, review of systems;
- c. Status of relevant symptom(s), e.g. present or stable

2. Objective Data:

- a. Physical examination appropriate to the disease process
- b. Review of appropriate laboratory / diagnostic studies
- c. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

C. Diagnosis

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

D. Plan

1. Diagnostic Plan

- a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification
- b. Referral to specialty clinics and supportive services, as needed

2. Treatment Plan

- a. Physical and/or occupational therapy and/or speech therapy, if appropriate
- b. Diet and exercise prescription as indicated by the disease process and the patient condition
- c. Management of medications as appropriate

3. Patient conditions requiring Attending Consultation

- a. With emergent conditions requiring prompt medication attention
- b. With acute decompensation of the patient situation
- c. When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings
- d. Upon request of the patient, NP, PA, or Physician
- e. When ordering expensive and/or unusual diagnostic studies
- f. When prescribing medications not within the clinical expertise of the NP/PA
- g. Patient conditions that may require physician consultation in addition to the ones mentioned in the preamble including but not limited to:
 - Significant abnormal lab values
 - New carotid bruits
 - New cardiac murmurs or other cardiac symptoms
 - Current uncompensated heart failure
 - New ECG changes
 - Other acute or chronic conditions which will benefit from treatment and stabilization prior to surgery.

- Patients evaluated for surgery who have unusual and/or unanticipated findings.

4. Patient / Family Education

In verbal and/or written format, the Nurse Practitioner explains to the pertinent party or parties involved the disease process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up.

5. Follow-up and Referral

Performed in accordance with the standard of practice and/or with the consulting physician's recommendation.

E. Record Keeping

Patient contacts and visits are to be documented in accordance with standard practice and institutional policy. All information relevant to patient care will be recorded in the medical record.

Protocol #3: Pre-Op Screening of Children (Core)

A. Clinical Definition

This protocol covers the assessment and management of children less than 18 years of age prior to the administration of anesthesia. This will include a directed history and physical.

1. Proctoring

- a. Length of proctoring period will be three months in length which can be shortened or lengthened.
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. The method of evaluation in clinical practice will be presentation of 5 pediatric cases to either the Medical Director or designated physician during the proctoring period with a chart review of the same 5 cases.

2. Reappointment:

- a. The period of review will be every 2 years
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. Evaluation will be the review of ~~3~~5 pediatric medical record cases.

B. Database

1. Subjective Data:

- a. Screening: age appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems.
- b. Historical information relative to the presenting illness (past health history, family history, occupational history, personal/social history, review of systems
- c. Status of relevant symptom(s), e.g. present or stable

2. Objective Data:

- a. Physical examination appropriate to the disease process
- b. Review of appropriate laboratory / diagnostic studies
- c. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

C. Diagnosis

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

D. Plan

1. Diagnostic Plan

- a. Age appropriate screening tests, and/or diagnostic tests for purposes of disease identification
- b. Referral to specialty clinics and supportive services, as needed

2. Treatment Plan

- a. Physical and/or occupational therapy and/or speech therapy, if appropriate
- b. Diet and exercise prescription as indicated by the disease process and the patient condition
- c. Management of medication as appropriate.

3. Patient conditions requiring Attending Consultation

- a. With emergent conditions requiring prompt medication attention
- b. With acute decompensation of the patient situation
- c. When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings
- d. Upon request of the patient, NP/PA, or Physician
- e. When ordering expensive and/or unusual diagnostic studies;
- f. When prescribing medications not within the clinical expertise of the NP/PA
- g. Patient conditions that may require physician consultation in addition to the ones mentioned in the preamble including but not limited to:
 - Significant abnormal lab values
 - Congenital heart disorders
 - Severe neuromuscular disease
 - Cranio-facial malformations
 - Other acute or chronic conditions which will benefit from treatment and stabilization prior to surgery
 - Patients evaluated for surgery who have unusual and/or unanticipated findings

4. Patient / Family Education

- a. In verbal and/or written format, the NP/PA explains to the pertinent party or parties involved the disease process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up.
- b. The NP/PA will provide age appropriate verbal and/or written information to prepare a child and/or their family for the operative experience.

5. Follow-up and Referral

Performed in accordance with the standard of practice and/or with the consulting physician's recommendation.

E. Record Keeping

1. Patient contacts and visits are to be documented in accordance with standard practice and institutional policy.
2. All information relevant to patient care will be recorded in the medical record.

Protocol #4: Furnishing Medications/Drug Orders (Core)

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. Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, Anesthesia Services, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies to be used are: ZSFG, Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

1. Subjective Data

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

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment

- a. Initiate, adjust, discontinue, and/or renew drugs and devices.
- b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
- c. Nurse Practitioners/Physician Assistants may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the electronic health record, or in the Medication Administration Record (MAR). The protocol will include the following:
 1. location of practice
 2. diagnoses, illnesses, or conditions for which medication is ordered
 3. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
- d. To facilitate patient receiving medications from a pharmacist the following information must be provided:
 - i. name of medication
 - ii. strength
 - iii. directions for use
 - iv. name of patient
 - v. name of prescriber and title
 - vi. date of issue
 - vii. quantity to be dispensed
 - viii. license no., furnishing no.(NP only), and DEA no.
- e. Limitations
 1. A prescription for a Schedule II or III controlled substance shall be limited to the number of tablets needed until the next scheduled follow-up clinic appointment.
 2. No refills will be allowed for lost or stolen narcotic prescriptions.

2. Patient conditions requiring Attending Consultation

- a. Problem which is not resolved after reasonable trial of therapies.
- b. Unexplained historical, physical or laboratory findings.
- c. Upon request of patient, NP, PA, or physician.
- d. Failure to improve pain and symptom management.
- e. Acute, severe respiratory distress

3. Education

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

4. Follow-up

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

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the electronic medical record\MAR as appropriate.

Protocol #5: Electronic Consult (eConsult) Review

A. DEFINITION

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

1. Prerequisites:

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

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

3. Proctoring: Concurrent review of the first 20 eConsult consultation decisions will be performed by the Medical Director or designee concurrently for the first three months.

4. Reappointment: A review of five eConsults every two years.

B. DATABASE

1. Subjective Data

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

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

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

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Review of eConsult

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

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation in patient condition.
- b. Unexplained historical, physical or laboratory findings.
- c. Upon request of the referring NP, PA, or physician.
- d. Problem requiring hospital admission or potential hospital admission.
- e. When recommending complex imaging studies or procedures for the referring provider to order.

- f. Problem requiring emergent/urgent surgical intervention.
- g. As indicated per the algorithms developed by the Chief of Service.

3. Education

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

4. Scheduling of Appointments

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

5. Patient Notification

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

E. RECORD KEEPING

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

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

Protocol #6: Management of Neuraxial and Peripheral Nerve Catheters

A. Definition

Management of in situ neuraxial and peripheral nerve catheters for the purpose of optimizing pain control including assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter after use is no longer indicated.

1. Location of procedure may include Emergency Department, Inpatient Units, Perioperative Area, and Intensive Care Units
 - a. Indications - Patients with in situ neuraxial or peripheral nerve catheters who require catheter management.
 - b. Precautions/Contraindications that require physician consultation:
 - Patients who are acutely hypotensive or predisposed to hypotension such as elderly patients, patients with heart failure, or hypovolemic patients.
 - New focal neurologic findings or severe back pain.
 - Patients with signs of neuraxial or peripheral nerve catheter infection or risk factors for contamination of such catheters including fever or elevated white blood cell count; catheter site tenderness, erythema, swelling, discharge, or bleeding; non-intact catheter dressing or catheter disconnection.
 - Patients with documented allergy to medication or medication in same class as catheter infusion medication.
 - Patients with coagulopathy or taking antithrombotic medications not consistent with joint UCSF/ZSFG “Guidelines For The Use of Antithrombotic Agents In The Setting Of Neuraxial Procedures”¹.

B. Data Base

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint, pain presentation, and catheter placement procedure

¹ <https://anesthesia.ucsf.edu/clinical-resources/guidelines-use-antithrombotic-agents-setting-neuraxial-procedures-0>

- 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 and opioids.

2. Objective Data

- a. Physical exam to include vital signs review, inspection and palpation of the catheter site, sensory level of the neuraxial or nerve block, extremity motor and sensory function as appropriate
- 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 gauge effectiveness of pain control and determine the presence of complications related to pain management therapies

D. Plan

1. Therapeutic Treatment Plan

- a. Explain to the patient, if possible, the availability, risks, and benefits of relevant pain treatment modalities.
- b. Determine, in consultation with the attending physician, the consulting team, and the patient, which pain treatment modalities will be initiated, adjusted or discontinued
- c. Set up catheter medication infusion pump, initiate/adjust infusion medication, or remove catheter as appropriate
- d. Initiate, adjust, or discontinue other pharmacologic and non-pharmacologic pain modalities as indicated

2. Patient conditions requiring attending physician consultation

- a. Acute hypotension, allergic reaction, and any decompensation of patient.
- b. New neurologic findings or severe back pain

- b. Unexplained physical or laboratory findings
- c. Catheter requires removal/replacement due to inadequate function, loss of sterility, or signs of infection
- d. Upon request of patient, NP, PA or physician

3. Education

Provide patient and provider education related to catheter purpose, signs of malfunction/complication, and the patient controlled analgesia function

4. Follow-up

While on service, NP/PA will perform daily subjective/objective evaluation as described in section B) Data Base while catheter is in situ.

E. Record Keeping

- 1. Patient contacts are to be documented in the medical record in accordance with standard practice and institutional policy.
- 2. All information relevant to patient care will be recorded in the medical record

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
a. Completion of onsite training by a qualified anesthesia provider.
Proctoring
a. A minimum of 2 observations by a qualified anesthesia attending of each of the following: clinical assessment of patient in relation to pain management, assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter

Reappointment

- | |
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| <ul style="list-style-type: none">a. The evaluator will be the Medical Director of the Anesthesia Acute Pain Serviceb. Management of 2 cases and 1 chart review every 2 years. |
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Protocol #7: Procedure: Trigger Point Injection

A. DEFINITION:

A trigger point is defined as a focal area of soft tissue hyperirritability that is painful on palpation and/or elicits a twitch response. Trigger point injection is the insertion of a needle into a trigger point, with or without injection of solution (e.g. saline, steroids, and anesthetics) into the region of the trigger point.

1. Indications:

- Pain attributed to a trigger point or a taut area of skeletal muscle

2. Precautions/contradictions:

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

B. DATA BASE

1. Subjective Data

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

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Therapeutic Treatment Plan

- a. Explain the procedure to the patient.
- b. Patient consent obtained per hospital policy before procedure is performed.
- c. Time Out performed per hospital policy.
- d. The procedure is performed following standard medical technique according to the departmental guidelines.

- e. Diagnostic tests for purposes of disease identification.
 - f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - g. Referral to physician, specialty clinics, and supportive services, as needed.
- 2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation.
 - b. Allergic reaction
 - c. Unexplained historical, physical or laboratory findings
 - d. Upon request of patient, NP/PA, or physician
 - e. Problem requiring hospital admission or potential hospital admission.
 - 3. Education

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

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

E. RECORD KEEPING

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

F. Summary of Proctoring and Reappointment Competency

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

Training by 3 direct observations of a qualified anesthesia attending performing trigger point injections will occur.

Standardized Training will include NP/PA being able to demonstrate knowledge of the following for all noted injection sites:

- 1. Indications for procedure and treatment
- 2. Risks and benefits of procedure and medication
- 3. Related anatomy and physiology
- 4. Consent process
- 5. Wound infection and wound healing mechanisms

6.	Use of required equipment
7.	Steps in performing procedures
8.	Ability to interpret results and formulate follow-up plans
9.	Documentation and CPT and ICD-10 coding
10.	Ability to recognize complication
Proctoring:	
a.	New practitioners to procedure will have a minimum of 2 successful observed demonstrations of the procedure
b.	Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstrations of the procedure.
c.	Chart review of all observed cases.
Reappointment Competency	
a.	Performance of at least 2 injections every 2 years.
b.	1 chart review every 2 years.

ZSFG 202~~10~~ Anesthesia Service NP/PA Standardized Procedures

Medical Director or Division Chief Approval or Service Chief Approval

Marc Steurer, MD

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