

City and County of San Francisco

Department of Public Health



Daniel Lurie
Mayor

**Zuckerberg San Francisco General
Hospital and Trauma Center**

Mary Mercer, MD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	<i>ZSFG Clinical Service Rules and Regulations Updates 2026</i>
Clinical Service :	<i>Laboratory Medicine Service</i>
Date of last approval:	<i>2024</i>
Summary of R&R updates:	Update Lab Information System, Resident Education changes, addition of Lab Utilization Committee, and appointed Designees for guiding resident training and review of SAFE reports. Update Org Chart.
Update #1:	Remove Clinisys Inc, Tucson, AZ as Lab Information system. Replaced by EPIC Beaker and SoftBank software for Blood Bank.
Update #2:	Change three Core resident rotations to each lasting one to two 4-week blocks.
Update #3:	Add The Laboratory Director or Faculty Designee serves as Resident Training Coordinator.
Update #4:	For Laboratory Medicine PIPS and Utilization Management, add statement describing the new MEC Lab Utilization Committee.
Update #5:	Monitoring SAFE Reports, the Lab Director or Lab Leadership Designee reviews each incident.
Update #6:	Update Appendix II. Laboratory Medicine Service Organization Chart.

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LABORATORY MEDICINE SERVICE RULES AND REGULATIONS 20264

LABORATORY MEDICINE SERVICE RULES AND REGULATIONS

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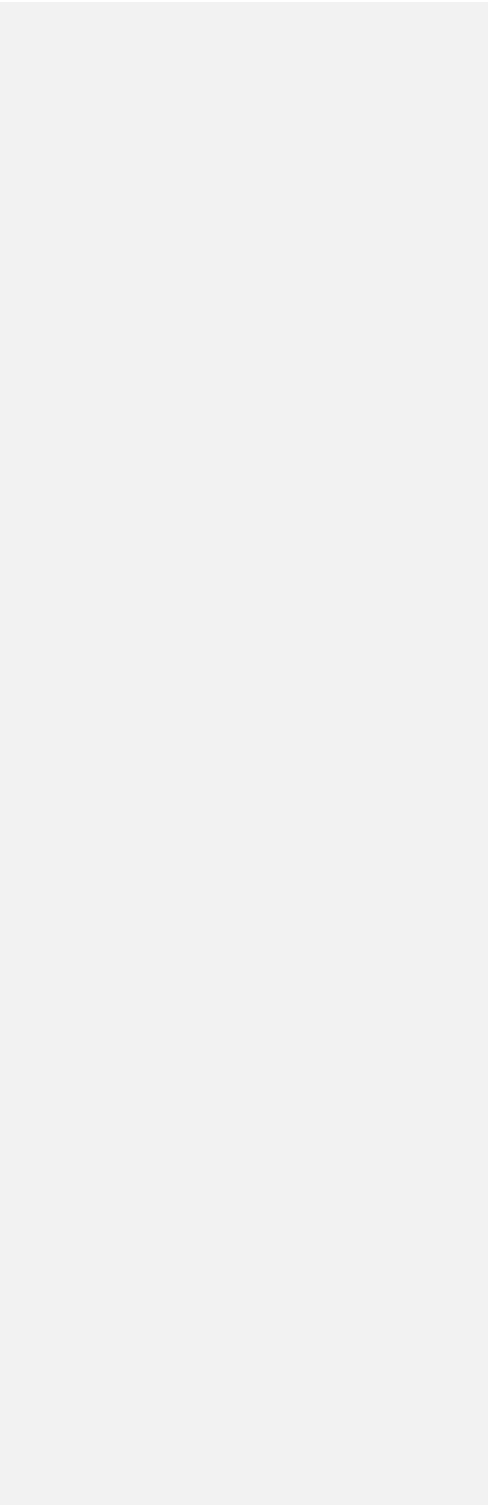
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I. LABORATORY MEDICINE SERVICE ORGANIZATION

A. Scope of Services

The University of California Clinical Laboratory at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) (“Clinical Laboratory” or “Laboratory Medicine Service”) performs more than five hundred varieties of diagnostic laboratory procedures on blood body fluids and tissues, providing routine and emergency (stat) services 24 hours daily, including weekends and holidays. The department has over 150 full- and part-time employees, including physicians, Clinical Laboratory Scientists, specialists and other professional support personnel. Provided services include, but are not limited to the following:

1. Limited phlebotomy services for ZSFG outpatients.
2. Chemical analysis of clinical specimens (routine and special) and clinical consultation.
3. Toxicology testing and clinical consultation.
4. Hematology (routine and special), coagulation studies, urinalysis and clinical consultation.
5. Microbiology studies – including bacteriology, mycobacteriology, mycology, virology, parasitology and molecular diagnostics - and clinical consultation.
6. Immunology and serology testing and clinical consultation.
7. Transfusion services, blood product utilization monitoring and clinical consultation.
8. Point-of-care testing (POCT): training of lead POCT personnel, coordination, oversight and maintenance of interdepartmental programs for POCT at ZSFG, including inpatient wards, designated outpatient clinics, Operating Room, Cardiac Catheterization Laboratory, Interventional Radiology Suite, Nursery and Intensive Care Units. Services include consultation, method development, assay validation and verification, coordination of quality control, performance improvement and patient safety, utilization management programs, and related activities. The Laboratory does not oversee POCT programs at off-campus sites, i.e., San Francisco Department of Public Health (SFDPH) health centers and affiliated clinics but offers consultative services on POCT issues to these facilities if requested.
9. Laboratory reports: electronic reports generated by the Laboratory Information Systems (~~EPIC Beaker and SoftBank Software for Blood Bank~~) (~~Clinisys Inc., Tucson, AZ~~) are transmitted to the electronic medical record (EMR) maintained by the San Francisco Department of Public Health. Limited printed cumulative and interim reports for laboratory clients without reliable access to the electronic medical record system are available.
10. Support services, including maintenance of phlebotomy supplies for designated inpatient and outpatient sites, special supplies, sterilization of medical supplies and disinfection of biohazardous waste.
11. Maintenance of an online Laboratory Manual, accessible at <https://www.testmenu.com/zsfglab/>, that provides in-depth information on tests and services provided, specimen requirements, laboratory contacts and other helpful information for Laboratory clients.

Age-Specific Specimen and Collection Techniques

Laboratory tests are performed and interpreted for patients of all ages, as requested by the clinical care provider or other authorized personnel. Phlebotomy is performed only in the outpatient setting and is generally limited to adults and some pediatric patients in their teens. Blood collection techniques may vary according to the age of the patient and/or the ease of obtaining the specimen, as assessed by the phlebotomist.

Patient/Client Needs Assessment

Our clients include patients and health care providers at ZSFG, LHH, city jails and outpatient health centers and clinics operated by or affiliated with the SFDPH. Modification of existing services or provision of new services is based on suggestions or requests from clinical services, results from periodic client satisfaction surveys, new availability of tests, in response to problems uncovered by SAFE reports or informal complaints, and the availability of funding and other required resources.

Staffing Plan

Each Division within the Clinical Laboratory maintains a standard staffing level based on the type and volume of tests requested. Staffing is flexible in order to accommodate changes in the test workload, clinical practice patterns, patient mix, or other factors.

Standards of Practice

The Clinical Laboratory at ZSFG strives to serve as a model of excellence for clinical laboratories in urban teaching hospitals, by providing accurate, timely, appropriate and cost-effective laboratory services of the highest quality, in support of the mission of SFDPH and ZSFG.

The Laboratory follows the guidelines and standards established by state and federal law and by recognized agencies such as The Joint Commission (TJC), Clinical and Laboratory Standards Institute (CLSI, formerly known as the National Committee for Clinical Laboratory Standards, or NCCLS), and other professional organizations. ZSFG, through the Laboratory Medicine Service, maintains Associate Active Membership in the Clinical and Laboratory Standards Institute (CLSI). This allows the laboratory director and other members of this department to participate directly in the standards-setting processes of this internationally recognized organization.

Reference Laboratories

Reference laboratories used by the Laboratory Medicine Service at ZSFG include the following:

- a. ARUP (Salt Lake City, Utah), one of the nation's leading reference laboratories under contract to perform the bulk of reference laboratory work for ZSFG
- b. UCSF Clinical Laboratories at Moffitt-Long Hospital, Mission Bay, and China Basin

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- c. Laboratories of the San Francisco Department of Public Health and other governmental (City and county, state and federal) laboratories
- d. Other reference laboratories as required for special tests and procedures

ZSFG Clinical Laboratory is responsible for assuring the quality of work provided by the laboratories to which it refers specimens for testing. Clinical Staff can recommend to the Laboratory Director alternative reference laboratories based on clinical need. The Laboratory Director will evaluate and approve Clinical Staff recommendation if indicated.

- B. Organization of the Laboratory Medicine Service
See Appendix II – Laboratory Medicine Service Organization Chart

II. APPOINTMENTS AND REAPPOINTMENTS

A. Medical Staff Membership Requirements

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

B. Staff Categories

Medical staff members on the Laboratory Medicine Service fall into the same two categories, i.e., active and courtesy as described in Article III – Categories of the Medical Staff of the ZSFG Bylaws, Rules and Regulations

C. Process for Appointments and Reappointments

The application process for new appointments and reappointments of Laboratory Medicine practitioners to the ZSFG Medical Staff follows ZSFG Bylaws, Rules and Regulations, and these Clinical Service Rules and Regulations.

Reappointment is dependent on continuing demonstration of professional conduct and competence. Laboratory Medicine will assist the hospital in this responsibility through ongoing professional performance evaluation of its practitioners (OPPE, see below) and summary evaluations by the Chief and Acting Chief of Service.

D. Affiliated Professionals

The process of appointment and reappointment to the Affiliated Professionals of ZSFG through the Laboratory Medicine Service is in accordance with ZSFG Bylaws and Rules and Regulations, as well as these Clinical Service Rules and Regulations.

III. CLINICAL PRIVILEGES

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A. Development of Privilege Criteria

Laboratory Medicine Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V: Clinical Privileges. All requests for clinical privileges will be evaluated and approved by the Chief of Laboratory Medicine. Refer to Appendix I.

B. Review of Privilege Request Form

The Laboratory Medicine Services Privilege Request Form shall be reviewed at least every other year..

C. Change, Addition or Removal of Clinical Privileges

Laboratory Medicine Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V: Clinical Privileges. All requests for clinical privileges will be evaluated and approved by the Chief of the Laboratory Medicine Service (synonymous with "Director of the Clinical Laboratory").

D. Temporary, Visiting, Emergency or Disaster Privileges

Privileges in these categories shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

IV. PROCTORING AND MONITORING

A. Requirements and Responsibility

Proctoring of newly appointed practitioners and practitioners who acquired new privileges, as well as ongoing monitoring of professional performance of practitioners on the Laboratory Medicine Service shall be in accordance with ZSFG Bylaws, and these service rules and regulations. The Laboratory Medicine Service will assist the medical staff office and credentials committee by proposing relevant indicators, evaluate practitioners and provide evaluations and summary reports, including engaging appropriate evaluators from outside the service, as necessary and required. It is the responsibility of the Chief of Service that proctoring and monitoring requirements are met.

B. Ongoing Professional Performance Evaluation (OPPE)

The Laboratory Medicine Service monitors the professional performance of its practitioners on an ongoing basis using a set of indicators that are developed by the service and approved by the Credentials Committee.

The Chief or Acting Chief of Service will evaluate performance profiles of Lab Medicine practitioners at least once per year and at the time of reappointment.

V. EDUCATION AND RESEARCH

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The Laboratory Medicine Service at ZSFG actively participates in and promotes UCSF's academic mission in medical education and research. Graduate and undergraduate medical education and research is conducted in accordance with applicable UCSF and ZSFG administrative policies and procedures and ZSFG Medical Staff Bylaws. The Laboratory Director is accountable to the UCSF's Vice Dean at ZSFG and the Chair of Laboratory Medicine for establishment, supervision, periodic review, and, if necessary, corrective actions of educational and research programs within the Clinical Laboratory.

The Laboratory Medicine Service also actively supports professional staff training and education through offering a Clinical Laboratory Scientist (CLS) student internship program in partnership with San Francisco State University, and by maintaining a Continuing Education Program, administered by the Department's Continuing Education Committee under the general direction of the Laboratory Director. This program is approved for State of California Continuing Education credits as authorized by the Continuing Education Accreditation Agency of the UCSF Clinical Laboratory at Zuckerberg San Francisco General, for which the Laboratory Director serves as Administrator.

All faculty and staff are encouraged to maintain and enhance their professional skills by attendance at professional meetings and participation in appropriate educational conferences, seminars and courses.

VI. LABORATORY MEDICINE SERVICE RESIDENT TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that Housestaff assume progressively increasing responsibility for patient care according to their level of training, ability and experience (Refer to CHN Website for Housestaff Competencies). Before starting their rotation residents will be oriented to the Laboratory Medicine Service, provided with a packet of relevant documents including Laboratory Safety Guidelines, and will attest to receipt of these materials (Attachment B: Lab Med Service Resident's Packet)

A. Description

There are 2-3 Laboratory Medicine Residents assigned at all times to individual rotations within the Laboratory Medicine Services at ZSFG. These rotations are in the Microbiology, Clinical Chemistry/Toxicology, and Hematology/Blood Bank Divisions of the Clinical Laboratory.

B. Resident Duties

Resident duties differ on each of the rotations but fall into 3 major categories: test approval, test interpretation, and clinical consultation. Detailed information on resident duties for each of the rotations, guidelines for prospective and retrospective review of blood product usage, the recommended management of issues commonly encountered outside of routine working hours, including when to notify attending faculty, are maintained by the Laboratory Medicine Service, reviewed annually and updated as necessary. Orientation and Learning material for Laboratory Medicine Residents is maintained within each laboratory division and reviewed by Division Directors and Leadership staff as needed.

C. Resident Supervision

Laboratory Medicine (also referred to as Clinical Pathology) residency training is a three year postgraduate program (for Laboratory Medicine only) or two years of a four year combined residency training program in Anatomic Pathology/Clinical Pathology (AP/CP). The UCSF combined AP/CP residency training program or the straight Laboratory Medicine residency training program has flexibility, such that resident competencies and skills are not correlative with year of training. Resident competencies and skills are instead related to type of clinical rotation completed. For example, a resident in his/her final year (4th) year of training may be taking a Clinical Microbiology rotation for the very first time in his/her training. In contrast, another resident may have already completed such a rotation in his/her first year of training.

Laboratory Medicine residency training at ZSFG consists of three core rotations – Microbiology, Chemistry/Toxicology, and Hematology/Blood Bank/Cell Therapy. Microbiology and Chemistry/Toxicology rotations each ~~last one to two week blocks, last two months~~, the Hematology/Blood Bank rotation lasts one month. Elective rotations are offered in Toxicology and Consultative Hematology / Transfusion Medicine. Each rotation is supervised by the Director of the respective Clinical Laboratory Division. The Laboratory Director ~~or Faculty Designee~~ serves as Training Site Coordinator, ensuring orientation of residents at the beginning of the rotation, appropriate handling and resolution of residency-related issues and maintenance of materials and environment for effective education and learning.

Each resident assigned to a rotation in the Clinical Laboratory is closely supervised by the responsible Division Director during the regular work day. Clinical responsibilities typically consist of test approvals, test interpretations, and clinical consultations. All of these resident functions have direct impact on patient care, as residents make decisions about requests for esoteric testing, interpret laboratory results for diagnostic or therapeutic decisions, and recommend testing strategies for optimum patient management. Initially, all issues and concerns are discussed with and supervised by the respective Division Director at least daily. The resident assumes more responsibility and independence later in the rotation when s/he has become familiar with the issues unique to each division, is knowledgeable about the policies governing these issues, and the Division Director has developed confidence in his/her clinical judgment.

Laboratory Medicine residents also participate in a variety of clinical conferences (e.g., Medicine's Morbidity and Mortality report, Infectious Diseases conference, Cardiology conference, Endocrinology Conference, Poison Control rounds, etc.). These conferences provide a feedback mechanism by which the residents (and respective Division Director) can witness the impact of their decisions. These conferences also provide a feedback mechanism for the Clinical Service in general, in which existing Laboratory Medicine policies can be discussed and modified, if necessary.

In addition to their daily duties, each Laboratory Medicine Service Resident takes call for all Clinical Laboratory Services at the 5 UCSF teaching hospitals (UCSFMC, Mission Bay, Mt. Zion, ZSFG, VAMC) on a rotating basis to provide consultation on laboratory-related issues, approve unusual laboratory tests requests and handle transfusion-related problems arriving outside of routine hours (Mon-Fri 5PM – 8AM, Weekends and Holidays). Faculty members provide backup at all times by long range beepers and/or telephone. Disagreements between a clinical service and the Laboratory Medicine

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Resident are resolved by the faculty member responsible for the service. All situations handled by residents while on-call are logged and reviewed and critiqued weekly via internet video conferencing by Clinical Laboratory faculty from all UCSF teaching sites.

Laboratory Medicine residents do not perform invasive procedures, with the exception of bone marrow aspirates / biopsies which would be performed under direct supervision of a Clinical Hematology Fellow or Attending. Some of their duties regarding test utilization or clinical consultation, however, can have serious impact on the acute clinical management and course of the patient (i.e., blood product use, antimicrobial susceptibility test interpretation, etc.). All major decisions having clinical impact are either discussed immediately or reviewed regularly by the responsible Division Director.

D. Resident Evaluation

ZSFG Laboratory Medicine residents are evaluated daily by the responsible Division Director and by all faculty and the Chief of the Service weekly as to their performance while “on-call” (Friday morning conference). Residents are given constant informal feedback on their performance as well as recommendations for improvement, if necessary.

Residents are given a formal in-person evaluation halfway through their rotation, with concrete recommendations for improving their performance if necessary. Residents are formally evaluated at the end of their rotation by the responsible Division Director. The evaluation is discussed and the discussion documented by checking the appropriate box on the online evaluation form (MedHub).

The UCSF Laboratory Medicine Residency Program Director reviews all final evaluations. Copies of all evaluations are available through the Laboratory Medicine Residency Program Director or the Residency Program Coordinator (contact information: phone: 415-353-7359, 185 Berry Street 1036, Suite 100, University of California, San Francisco, San Francisco, CA. 94143 – 0506).

The Director of the Laboratory Medicine Residency Training Program meets with each resident twice annually to review performance, discuss evaluations, and address concerns.

E. Ability to Write Patient Orders

ZSFG Laboratory Medicine residents do not independently write patient orders.

VII. CLINICAL LABORATORY FELLOWSHIP PROGRAMS

In addition to training Laboratory Medicine Residents, the Clinical Laboratory offers accredited postdoctorate fellowship education in Clinical Chemistry/Toxicology. Curriculum development, orientation, supervision and evaluation of fellows is the responsibility of the faculty member overseeing the respective programs, observing UCSF and ZSFG administrative policies and ZSFG Medical Staff Bylaws Rules and Regulations.

VIII. LABORATORY MEDICINE SERVICE CONSULTATION CRITERIA

Formal or informal professional consultation will be provided upon request for a member of the Medical Staff, professional or administrative personnel of the SFDPH, or other clients of the Laboratory Medicine Service. Such consultations will be provided by Laboratory Medicine residents, fellows, faculty or Clinical Laboratory Scientists, as appropriate. A consultation may also be initiated by the Laboratory Medicine Service if a potential problem is discovered that may adversely affect patient care.

IX. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the ZSFG Laboratory Medicine Service.

X. LABORATORY MEDICINE PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT

A. Goals, Objectives

It is the mission of Zuckerberg San Francisco General Clinical Laboratory to:

- Provide accurate, timely, efficient, cost-effective and high quality laboratory services in a safe and supportive work environment.
- Further the UCSF/ZSFG academic missions of research, education, patient care and public service.

The department conducts periodic surveys to assess staff and client satisfaction and to identify new or changed needs for tests or services. The term “client” is used broadly and includes health care providers, patients (inpatients, outpatients, and those within the primary care network), hospital employees and others who interact with the Clinical Laboratory. The department also provides continuing education to housestaff on a regular basis regarding testing procedures, interpretation and optimal utilization of clinical laboratory services.

An MEC Committee, The Laboratory Utilization Committee, has been established, chaired by the ZSFG Director of the Clinical Laboratory. This committee of providers and Lab Leaders from all Hospital and DPH Labs will address issues of medical necessity for new test requests, requests for changes in current laboratory testing, or in send-out testing requests with the goal to provide appropriate testing needed for quality patient care in a responsible, cost-effective manner. Lab testing issues and recommendations for changes in testing will be presented quarterly to the Leadership MEC.

B. Responsibility

The Director of the Clinical Laboratory has overall responsibility for the departmental quality management program which includes performance improvement and patient safety activities.

The Director and/or designated representative of the Department of Laboratory Medicine attends meetings of the ZSFG Performance Improvement/Patient Safety Committee and participates in the activities of other ZSFG committees as appropriate, in order to promote the performance improvement and patient safety goals of the department and of the hospital.

The Laboratory Administrator maintains, coordinates, and distributes documents relating to performance improvement and patient safety activities, assures compliance with all laws, rules and regulations, and is responsible for related administrative functions. The Laboratory Administrator maintains an index of all policies and procedures pertinent to the Performance Improvement and Patient Safety process, as well as minutes of relevant staff meetings and committee meetings.

Division Directors and Clinical Laboratory Scientist Managers within each division, as well as other personnel designated, are responsible for the identification of performance improvement and patient safety issues and the implementation and maintenance of performance improvement and patient safety activities within their areas of expertise and supervision, including the biennial review and update of policies and procedures.

C. Reporting

The Director of the Clinical Laboratory or designated representative provides an annual report to the ZSFG Performance Improvement/Patient Safety and a biennial report to the Medical Executive Committees.

D. Clinical Indicators and Components of the Laboratory Medicine Quality Management Plan

The following procedures will be utilized for the evaluation and review of quality and appropriateness of the activities of this department.

1. Quality control results for each test method.
2. Periodic review and update of procedures and policies for special handling, test methods and reports.
3. Quarterly review of reference lab testing for quality and client services at the monthly Clinical Lab leadership meeting.
4. Participation in:
 - a. Proficiency testing programs of the College of American Pathologists and/or other providers as appropriate, e.g., the Centers for Disease Control and Prevention, the State of California, and commercial suppliers.
 - b. Other quality improvement programs as appropriate, for example Q-Tracks/Q-Probes programs of the College of American Pathologists.
 - c. Biennial accreditation surveys by The Joint Commission.

5. Case reviews by faculty and house staff of the Laboratory Medicine Service.
6. A variety of pre-analytical and post-analytical test variables specific to each testing discipline that have major impact on patient care (e.g., turnaround testing times for key 'stat' tests, relay of critical test results to clinical care providers, specimen rejection rate, readiness and transport time for blood products, etc.)
7. Regular performance evaluations will be conducted for employees, house staff and faculty according to UCSF and ZSFG policies and procedures, as applicable.

E. Monitoring & Evaluation of Appropriateness of Patient Care Services and Response to SAFE Reports

The Director of the Clinical Laboratory will conduct an annual review and approval of the Quality Management (Performance Improvement / Patient Safety) Plan and of the professional practices of the department to assure that they are appropriate and consistent with the plan.

SAFE Reports, complaints, or issues are investigated and reported in writing as soon as possible. The Director or Leadership Designee, reviews each such incident and a response is forwarded, when appropriate, to the ZSFG Quality Management Office, other appropriate hospital committee, authority, and/or the complaining party.

Summaries of SAFE reports shall be reviewed at regular meetings of the Clinical Laboratory Leadership to identify events that require focused additional review. As issues, patterns and trends are identified, further assessment will be performed to determine the cause and extent of specific problems. The procedures to be followed may include audits of patient charts, pilot studies, research protocols, and interviews with clinical staff.

Corrective action may include any of the following, as appropriate:

1. In-service education and training programs for staff, house staff and faculty members.
2. Counseling and proctoring.
3. Staffing changes.
4. Changes in procedures or policies.
5. Changes of reagents and/or equipment.

Appropriate utilization of Clinical Laboratory services by the clinical staff will be promoted by formal and informal interaction between Laboratory Medicine faculty and house staff and members of the clinical departments at departmental rounds, house staff conferences, student lectures and seminars, and individual consultations.

XI. MEETING REQUIREMENTS

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In accordance with ZSFG Medical Staff Bylaws, all Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, including weekly call conferences and the annual Medical Staff Meeting. ZSFG Clinical Laboratory faculty who are not physicians are expected to meet the same attendance requirements as medical staff members, with the exception of attendance at the Annual Medical Staff Meeting. For faculty members with part time clinical appointments the expectation for attendance at meetings is reduced in proportion to their appointment.

The leadership of the Laboratory Medicine Service shall meet as frequently as necessary, usually monthly, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

As defined in the ZSFG Medical Staff Bylaws, a quorum is constituted by at least three (3) voting members of the Active Staff for the purpose of conducting business. In accordance with the Bylaws, the Laboratory Medicine Service Chief may extend voting rights to non-medical staff members. This will be documented in committee minutes at the beginning of the Medical Staff year and shall remain in effect for one year.

XII. ADOPTION, REVIEW AND AMENDMENT

Adoption of these Laboratory Medicine Service Rules and Regulations, as well as any revisions or amendments require a majority vote of all active medical staff members and faculty of the Laboratory Medicine Service Department at ZSFG. The Service Chief will conduct a review of these Rules and Regulations at least every other year and propose revisions and amendments to the voting members of the Department.

XIII. REVISION HISTORY

Description:	Supervisor Signoff By:	Signoff Date:
Changed review cycle from “annual” to “at least biannual” in sections III B. (Review of Privilege Request Form) and XII (Adoption, Review and Amendment). Clarified the review and voting process on revisions and amendments of these service rules and regulations in section XII.	E. Fiebig	9/25/2012
Placed in new format. Updated Lab Medicine Service Org Chart. Update references to SFGH LMR Rotation Guidelines (attachments)	E. Fiebig	6/21/2013
Updated Lab Medicine Service Org Chart (Core Lab) Deleted reference to “Community Health Network, CHN” in Clin Lab Director’s Job Description Update Attachment B, Resident’s Packet Omit reference to Fellowship education in Public Health Microbiology, section VII.	B. Haller	9/1/2016

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Changed all SFGH to ZSFG Updated Org Chart	B. Haller	9/11/2018
Changed all references to LCR to electronic medical record (EMR) Changed eval to MedHub (for resident and student evaluations) Changed annual report to MEC to biannual report	B. Haller	5/14/2019
Laboratory Director will recommend annually reference laboratories to the Medical Executive Committee – Changed to the following statement which meets Joint Commission Standards: Clinical Staff can recommend to the Laboratory Director alternative reference laboratories based on clinical need. The Laboratory Director will evaluate and approve Clinical Staff recommendation if indicated.	B. Haller	9/10/2020
Change biannual to “biennial” or “every other year”. Minor formatting and grammar changes.	B. Haller	9/10/2020
Updated location of Laboratory On-Line Manual - https://www.testmenu.com/zsfglab/ Updated Org Chart	B. Haller	9/10/2020
Removed Attachment D. ZSFG Laboratory Resident Survival Manual. To be updated and rewritten to include new test methodologies and testing strategies at ZSFG Clinical Laboratory.	B. Haller	9/10/2020
Updated Company name for Lab Information System	B. Haller	9/12/2022
Updated Appendix II, Laboratory Medicine service Organization Chart	B. Haller	9/12/2022
Changed Chief of Service evaluation of Medical Staff will be once per year instead of every 6 months	B. Haller	9/12/2022
Updated Resident Packet received at Orientation to Rotations	B. Haller	9/12/2022
Omit Attachment C. Add text to R+R stating that Orientation and Learning Material is maintained in each Resident rotation site in the Lab.	B. Haller	9/12/2022
Edit Table of Contents	B. Haller	9/1/2024
Replace “unusual occurrence” reports with “SAFE” reports	B. Haller	9/1/2024

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Update Appendix II. Organization Chart and Attachment B. Laboratory Medicine Resident's Packet	B. Haller	9/1/2024
Change UCSF's "Associate" Dean to UCSF's "Vice" Dean	B. Haller	9/1/2024
Change Division "Chief" to Division "Director"	B. Haller	9/1/2024
Change "Senior Supervising" Clinical Laboratory Scientists to Clinical Laboratory Scientist "Managers"	B. Haller	9/1/2024
Formatting of Laboratory Medicine Privileges (no change in content)	B. Haller	9/1/2024
<u>Section I. A. Remove Clinisys Inc, Tucson, AZ as Lab Information System. Replaced by EPIC Beaker and SoftBank software for Blood Bank.</u>	<u>B. Haller</u>	<u>9/9/2026</u>
<u>Section V. C. paragraph 2: Change Three Core resident rotations each last two months to each lasting one to two 4-week blocks.</u>	<u>B. Haller</u>	<u>9/9/2026</u>
<u>Section V. C. paragraph 2: Add The Laboratory Director or Faculty Designee serves as Training Site Coordinator.</u>	<u>B. Haller</u>	<u>9/9/2026</u>
<u>Section X. A. Laboratory Medicine PIPS and Utilization Management: Add statement about the MEC Lab Utilization Committee.</u>	<u>B. Haller</u>	<u>9/9/2026</u>
<u>Section X. E. paragraph 2: Monitoring SAFE Reports, The Director or Lab Leadership Designee reviews each such incident.</u>	<u>B. Haller</u>	<u>9/9/2026</u>
<u>Update Appendix II. Laboratory Medicine Service Organization Chart</u>	<u>B. Haller</u>	<u>9/9/2026</u>

XIV. APPENDIX I – LABORATORY MEDICINE PRIVILEGES

Privileges for Zuckerberg San Francisco General

Applicant: Please initial the privileges you are requesting in the Requested column.

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

FOR ALL PRIVILEGES: All complication rates, problem transfusions, deaths, unusual occurrence reports, patient complaints and sentinel events, as well as any specific Department quality indicators, are monitored semiannually.

Requested

Approved

16 LABORATORY MEDICINE

_____	_____	16.10	CATEGORY I – CORE PRIVILEGES PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pathology in Clinical Pathology or Anatomic & Clinical Pathology. Patient care responsibilities encompass supervision and direction of the specimen collection, selection of laboratory procedures appropriate for patient care, analysis, reporting and interpretation of results of diagnostic tests, including recommendations for patient management based on these results in Blood Banking /Transfusion Medicine/Immunohematology, Clinical Chemistry, Toxicology, Hematology, Immunology, Microbiology/Virology, Molecular Diagnostics, Medical Informatics and Laboratory Management. PROCTORING: 1) 6 months by the Chief of the Laboratory Medicine Service or Designee. 2) Review of 10 Case Discussions at weekly Lab Med Service Conferences. 3) 6-month review of QC oversight documentation (incl. proficiency testing and quality test management) REAPPOINTMENT: Renewal of privileges requires every 2 years: 1) review of a minimum of 5 Case Discussions at weekly Lab Med Service Conferences 2) review of QC oversight documentation during the evaluation period
_____	_____	16.11	BONE MARROW INTERPRETATION Review and analysis of bone marrow aspirate and biopsy material for diagnosis or monitoring of conditions affecting the hematopoietic system. PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pathology in Clinical and/or Anatomic Pathology and Hematopathology.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Cases by the Anatomic Pathology Service

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 3 cases by the Anatomic Pathology Service every 2 years.

16.20

CATEGORY II – SPECIFIC PRIVILEGES

Individuals who do not qualify for core privileges covering all aspects of laboratory medicine may indicate their specific areas of privileging from the list of subspecialties below. Patient care responsibilities within the specific area for which privileges are requested are the same as outlined above for core privileges in Laboratory Medicine.

16.21
IMMUNOHEMATOLOGY

BLOOD BANKING, TRANSFUSION MEDICINE,

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Medicine, Pediatrics, Obstetrics/Gynecology, General Surgery, or Anesthesia **and** Blood Banking/Transfusion Medicine.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Transfusion Reaction Reports
- 3) Review of 10 Case Discussions at weekly Lab Med Service Conferences

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Transfusion Reaction Reports
- 2) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 3) review of QC oversight documentation during the evaluation period

16.22

CLINICAL CHEMISTRY, TOXICOLOGY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Chemical Pathology or Clinical Chemistry, Toxicology

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Serum/Urine Protein Electrophoresis Reports
- 3) Review of 10 Case Discussions at weekly Lab Med Service Conferences
- 4) review of QC oversight documentation during the evaluation period

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Serum/Urine Protein Electrophoresis Reports

- 2) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 3) review of QC oversight documentation during the evaluation period

16.24 **HEMATOLOGY** (excluding Bone Marrow Interpretation)

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Clinical Hematology or Hematopathology.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Blood Smear/Body Fluid Interpretations
- 3) Review of 10 Hemoglobinopathy Interpretations
- 4) Review of 10 Case Discussions at weekly Lab Med Service Conferences

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Blood Smear/Body Fluid Interpretations
- 2) Review of 5 Hemoglobinopathy Interpretations
- 3) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 4) review of QC oversight documentation during the evaluation period

16.25 **MICROBIOLOGY / VIROLOGY**

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Medical Microbiology.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Broncho-Alveolar Lavage Interpretations
- 3) Review of 10 Case Discussions at weekly Lab Med Service Conferences

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Broncho-Alveolar Lavage Interpretations
- 2) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 3) review of QC oversight documentation during the evaluation period

Privileges for Zuckerberg San Francisco General

I hereby request clinical privileges as indicated above.

Applicant

Date

FOR DEPARTMENTAL USE:

____ Proctor has been assigned for newly granted privileges.

____ Proctoring requirements have been satisfied.

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

____ Medications requiring DEA certification will not be provided by this provider.

____ CPR Certification is required.

____ CPR Certification is not required.

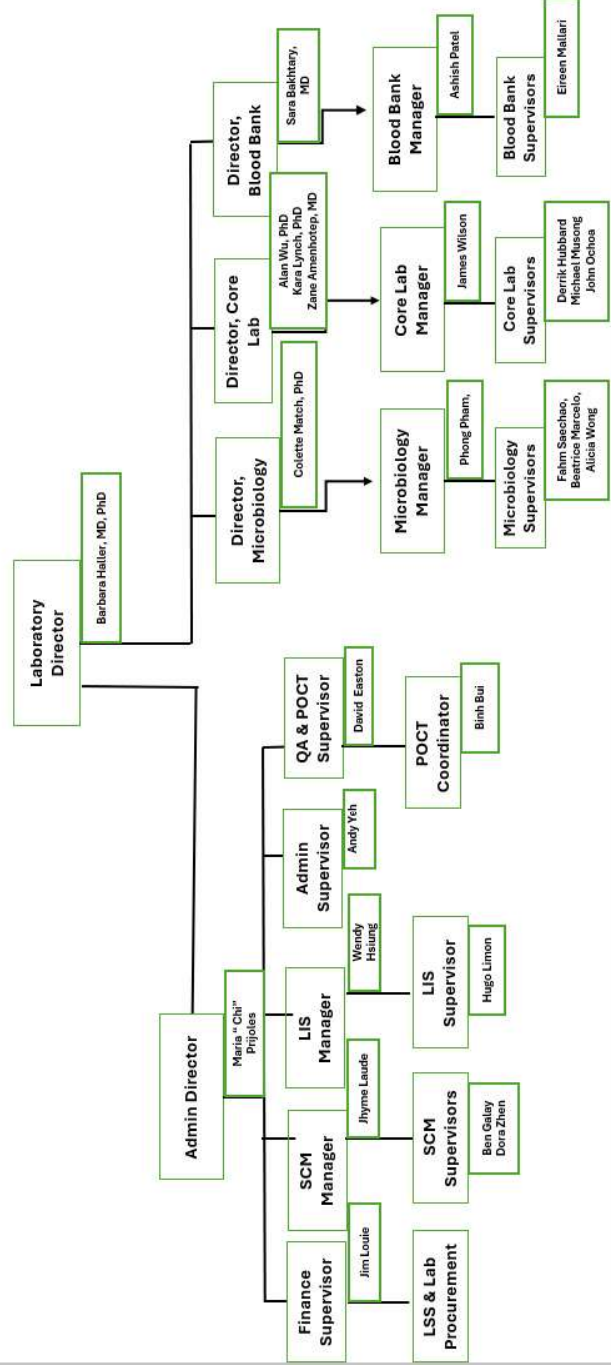
APPROVED BY:

Division Chief

Date

Service Chief

Date



XVI. ATTACHMENT A – CLINICAL SERVICE CHIEF’S JOB DESCRIPTION

University of California, San Francisco – Department of Laboratory Medicine
Zuckerberg San Francisco General
1001 Potrero Avenue, San Francisco CA 94110
Clinical Laboratory

DIRECTOR OF CLINICAL LABORATORY, ZUCKERBERG SAN FRANCISCO GENERAL

JOB DESCRIPTION:

General:

The Director of the Clinical Laboratory at Zuckerberg San Francisco General is accountable to the Chairman of the UCSF Department of Laboratory Medicine and the Associate Dean of the UCSF School of Medicine at ZSFG. This individual also serves as Chief of the Laboratory Medicine Service at ZSFG and as Vice Chair for the UCSF Department of Laboratory Medicine at ZSFG.

The Director of Clinical Laboratory has overall responsibility for the ZSFG Clinical Laboratory, including direction, planning, implementation and maintenance of all professional and administrative activities, training and educational programs conducted by the Department at ZSFG, as well as any other duties that may be assigned or delegated.

Specific responsibilities include, but are not limited to the following:

Administrative Responsibilities:

- Enforces the Medical Staff Bylaws, Rules and Regulations within the Laboratory Medicine Service.
- Assures compliance with the standards and regulations of the Joint Commission on the Accreditation of Healthcare Organizations, and federal, state and local regulatory agencies.
- Participates in departmental, hospital-wide, and university-wide activities, including staff meetings, committees, and related functions.
- Supervises the development, implementation and maintenance of procedures and policies relevant to departmental responsibilities and activities.
- Assures financial integrity of the department. Directs preparation and justification of annual budgets and assures operation within established budgets.

Laboratory Medicine Service Rules and Regulations 2026

Clinical Responsibilities:

- Assures that the Clinical Laboratory provide accurate, timely and appropriate laboratory testing, efficiently and cost-effectively.
- Coordinates and integrates intradepartmental and interdepartmental services with the primary functions of the San Francisco Health Network.
- Develops effective procedures to promote professional interaction between the Laboratory Medicine Service and patient-care services for improved patient care.
- Assures the development, implementation and maintenance of departmental continuing quality improvement programs.
- Assures that all personnel performing work in or for the ZSFG Clinical Laboratories have the necessary qualifications and competence.
- Keeps current with and implements emerging technologies as necessary.

Academic Responsibilities:

- As Vice Chair of the UCSF Department of Laboratory Medicine, supervises academic activities at ZSFG, as authorized or delegated by the Department Chair at UCSF and/or the Associate Dean for ZSFG.
- Assures and provides general supervision for training programs, elective courses and continuing education programs, as appropriate, for house staff assigned to ZSFG, UCSF medical students and technical staff of the ZSFG Clinical Laboratory.
- Promotes opportunities for continuing education and academic activities, where appropriate, for faculty and staff of the Department of Laboratory Medicine at ZSFG.
- Maintains competence and leadership in the field of Laboratory Medicine by participation in programs for continuing medical education, professional organizations and public service activities, as appropriate.

Approved:

Barbara Haller, MD, PhD
Laboratory Director, UCSF Clinical Laboratory at ZSFG

Date

[Division Chiefs' Job Descriptions are held at Laboratory Medicine Service Office]

XVII. ATTACHMENT B – RESIDENT’S PACKET

**Laboratory Medicine Service
Resident’s Packet**

STATEMENT OF RECEIPT:

I certify that I have received the Laboratory Medicine Resident’s Packet with the following documents enclosed:

Please check off:

- _____ ZSFG Laboratory Safety Guidelines
- _____ ZSFG Confidentiality Agreement (Use of DPH Records & Information Systems)
- _____ Code of Professional Conduct Policy
- _____ On-Call Schedule
- _____ Resident’s Weekly Calendar of Conferences

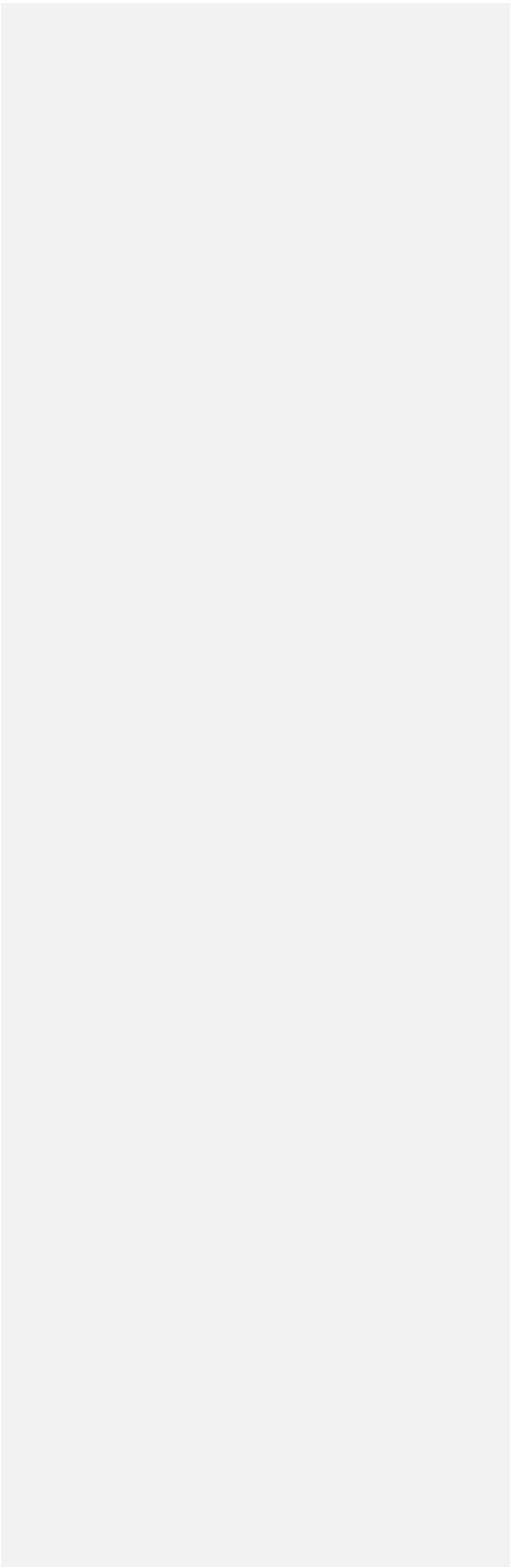
** ZSFG Clinical Laboratory Test Directory is available @ <https://www.testmenu.com/zsfglab>

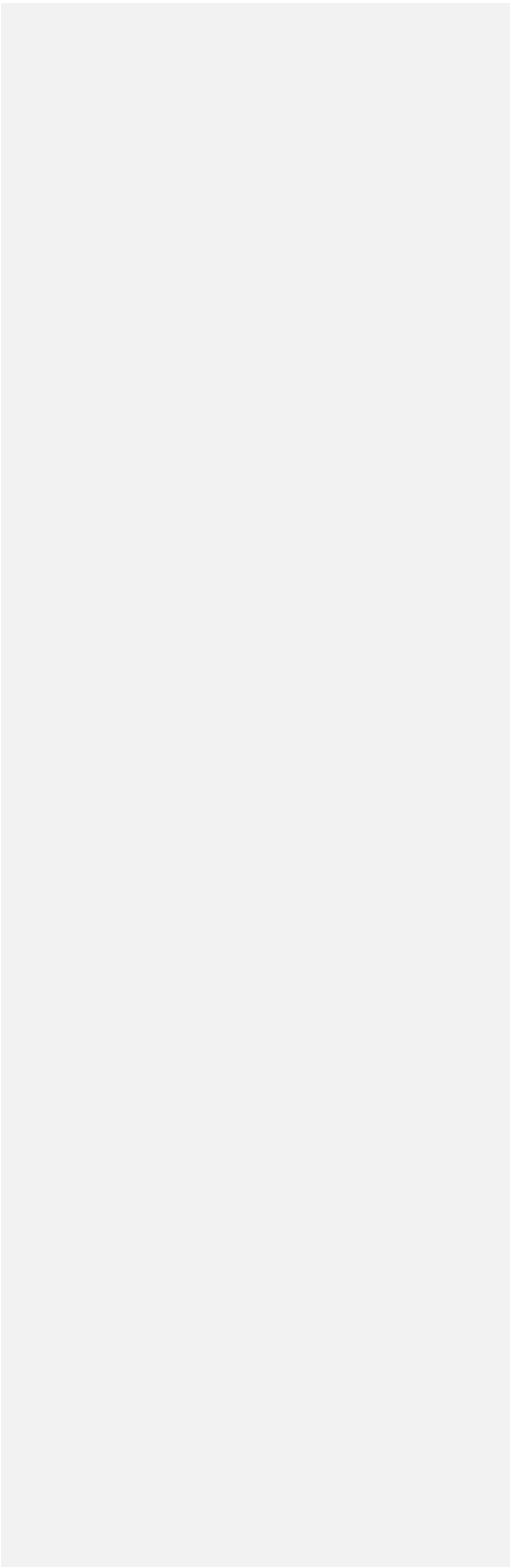
Signature: _____

Date: _____

Please complete this form and return it to Andy Yeh in the Administration Office after review.

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University of California, San Francisco – Department of Laboratory Medicine
Zuckerberg San Francisco General
1001 Potrero Avenue, San Francisco, CA 94110

Clinical Laboratory – Barbara Haller, MD, PhD, Director

**LABORATORY MEDICINE
SERVICE RULES AND REGULATIONS
2026**

**LABORATORY MEDICINE SERVICE
RULES AND REGULATIONS**

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I. LABORATORY MEDICINE SERVICE ORGANIZATION

A. Scope of Services

The University of California Clinical Laboratory at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) (“Clinical Laboratory” or “Laboratory Medicine Service”) performs more than five hundred varieties of diagnostic laboratory procedures on blood body fluids and tissues, providing routine and emergency (stat) services 24 hours daily, including weekends and holidays. The department has over 150 full- and part-time employees, including physicians, Clinical Laboratory Scientists, specialists and other professional support personnel. Provided services include, but are not limited to the following:

1. Limited phlebotomy services for ZSFG outpatients.
2. Chemical analysis of clinical specimens (routine and special) and clinical consultation.
3. Toxicology testing and clinical consultation.
4. Hematology (routine and special), coagulation studies, urinalysis and clinical consultation.
5. Microbiology studies – including bacteriology, mycobacteriology, mycology, virology, parasitology and molecular diagnostics - and clinical consultation.
6. Immunology and serology testing and clinical consultation.
7. Transfusion services, blood product utilization monitoring and clinical consultation.
8. Point-of-care testing (POCT): training of lead POCT personnel, coordination, oversight and maintenance of interdepartmental programs for POCT at ZSFG, including inpatient wards, designated outpatient clinics, Operating Room, Cardiac Catheterization Laboratory, Interventional Radiology Suite, Nursery and Intensive Care Units. Services include consultation, method development, assay validation and verification, coordination of quality control, performance improvement and patient safety, utilization management programs, and related activities. The Laboratory does not oversee POCT programs at off-campus sites, i.e., San Francisco Department of Public Health (SFDPH) health centers and affiliated clinics but offers consultative services on POCT issues to these facilities if requested.
9. Laboratory reports: electronic reports generated by the Laboratory Information Systems (EPIC Beaker and SoftBank Software for Blood Bank) are transmitted to the electronic medical record (EMR) maintained by the San Francisco Department of Public Health. Limited printed cumulative and interim reports for laboratory clients without reliable access to the electronic medical record system are available.
10. Support services, including maintenance of phlebotomy supplies for designated inpatient and outpatient sites, special supplies, sterilization of medical supplies and disinfection of biohazardous waste.
11. Maintenance of an online Laboratory Manual, accessible at <https://www.testmenu.com/zsfglab/>, that provides in-depth information on tests and services provided, specimen requirements, laboratory contacts and other helpful information for Laboratory clients.

Age-Specific Specimen and Collection Techniques

Laboratory tests are performed and interpreted for patients of all ages, as requested by the clinical care provider or other authorized personnel. Phlebotomy is performed only in the outpatient setting and is generally limited to adults and some pediatric patients in their teens. Blood collection techniques may vary according to the age of the patient and/or the ease of obtaining the specimen, as assessed by the phlebotomist.

Patient/Client Needs Assessment

Our clients include patients and health care providers at ZSFG, LHH, city jails and outpatient health centers and clinics operated by or affiliated with the SFDPH. Modification of existing services or provision of new services is based on suggestions or requests from clinical services, results from periodic client satisfaction surveys, new availability of tests, in response to problems uncovered by SAFE reports or informal complaints, and the availability of funding and other required resources.

Staffing Plan

Each Division within the Clinical Laboratory maintains a standard staffing level based on the type and volume of tests requested. Staffing is flexible in order to accommodate changes in the test workload, clinical practice patterns, patient mix, or other factors.

Standards of Practice

The Clinical Laboratory at ZSFG strives to serve as a model of excellence for clinical laboratories in urban teaching hospitals, by providing accurate, timely, appropriate and cost-effective laboratory services of the highest quality, in support of the mission of SFDPH and ZSFG.

The Laboratory follows the guidelines and standards established by state and federal law and by recognized agencies such as The Joint Commission (TJC), Clinical and Laboratory Standards Institute (CLSI, formerly known as the National Committee for Clinical Laboratory Standards, or NCCLS), and other professional organizations. ZSFG, through the Laboratory Medicine Service, maintains Associate Active Membership in the Clinical and Laboratory Standards Institute (CLSI). This allows the laboratory director and other members of this department to participate directly in the standards-setting processes of this internationally recognized organization.

Reference Laboratories

Reference laboratories used by the Laboratory Medicine Service at ZSFG include the following:

- a. ARUP (Salt Lake City, Utah), one of the nation's leading reference laboratories under contract to perform the bulk of reference laboratory work for ZSFG
- b. UCSF Clinical Laboratories at Moffitt-Long Hospital, Mission Bay, and China Basin

- c. Laboratories of the San Francisco Department of Public Health and other governmental (City and county, state and federal) laboratories
- d. Other reference laboratories as required for special tests and procedures

ZSFG Clinical Laboratory is responsible for assuring the quality of work provided by the laboratories to which it refers specimens for testing. Clinical Staff can recommend to the Laboratory Director alternative reference laboratories based on clinical need. The Laboratory Director will evaluate and approve Clinical Staff recommendation if indicated.

- B. Organization of the Laboratory Medicine Service
See Appendix II – Laboratory Medicine Service Organization Chart

II. APPOINTMENTS AND REAPPOINTMENTS

A. Medical Staff Membership Requirements

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

B. Staff Categories

Medical staff members on the Laboratory Medicine Service fall into the same two categories, i.e., active and courtesy as described in Article III – Categories of the Medical Staff of the ZSFG Bylaws, Rules and Regulations

C. Process for Appointments and Reappointments

The application process for new appointments and reappointments of Laboratory Medicine practitioners to the ZSFG Medical Staff follows ZSFG Bylaws, Rules and Regulations, and these Clinical Service Rules and Regulations.

Reappointment is dependent on continuing demonstration of professional conduct and competence. Laboratory Medicine will assist the hospital in this responsibility through ongoing professional performance evaluation of its practitioners (OPPE, see below) and summary evaluations by the Chief and Acting Chief of Service.

D. Affiliated Professionals

The process of appointment and reappointment to the Affiliated Professionals of ZSFG through the Laboratory Medicine Service is in accordance with ZSFG Bylaws and Rules and Regulations, as well as these Clinical Service Rules and Regulations.

III. CLINICAL PRIVILEGES

A. Development of Privilege Criteria

Laboratory Medicine Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V: Clinical Privileges. All requests for clinical privileges will be evaluated and approved by the Chief of Laboratory Medicine. Refer to Appendix I.

B. Review of Privilege Request Form

The Laboratory Medicine Services Privilege Request Form shall be reviewed at least every other year..

C. Change, Addition or Removal of Clinical Privileges

Laboratory Medicine Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V: Clinical Privileges. All requests for clinical privileges will be evaluated and approved by the Chief of the Laboratory Medicine Service (synonymous with “Director of the Clinical Laboratory”).

D. Temporary, Visiting, Emergency or Disaster Privileges

Privileges in these categories shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

IV. PROCTORING AND MONITORING

A. Requirements and Responsibility

Proctoring of newly appointed practitioners and practitioners who acquired new privileges, as well as ongoing monitoring of professional performance of practitioners on the Laboratory Medicine Service shall be in accordance with ZSFG Bylaws, and these service rules and regulations. The Laboratory Medicine Service will assist the medical staff office and credentials committee by proposing relevant indicators, evaluate practitioners and provide evaluations and summary reports, including engaging appropriate evaluators from outside the service, as necessary and required. It is the responsibility of the Chief of Service that proctoring and monitoring requirements are met.

B. Ongoing Professional Performance Evaluation (OPPE)

The Laboratory Medicine Service monitors the professional performance of its practitioners on an ongoing basis using a set of indicators that are developed by the service and approved by the Credentials Committee.

The Chief or Acting Chief of Service will evaluate performance profiles of Lab Medicine practitioners at least once per year and at the time of reappointment.

V. EDUCATION AND RESEARCH

The Laboratory Medicine Service at ZSFG actively participates in and promotes UCSF's academic mission in medical education and research. Graduate and undergraduate medical education and research is conducted in accordance with applicable UCSF and ZSFG administrative policies and procedures and ZSFG Medical Staff Bylaws. The Laboratory Director is accountable to the UCSF's Vice Dean at ZSFG and the Chair of Laboratory Medicine for establishment, supervision, periodic review, and, if necessary, corrective actions of educational and research programs within the Clinical Laboratory.

The Laboratory Medicine Service also actively supports professional staff training and education through offering a Clinical Laboratory Scientist (CLS) student internship program in partnership with San Francisco State University, and by maintaining a Continuing Education Program, administered by the Department's Continuing Education Committee under the general direction of the Laboratory Director. This program is approved for State of California Continuing Education credits as authorized by the Continuing Education Accreditation Agency of the UCSF Clinical Laboratory at Zuckerberg San Francisco General, for which the Laboratory Director serves as Administrator.

All faculty and staff are encouraged to maintain and enhance their professional skills by attendance at professional meetings and participation in appropriate educational conferences, seminars and courses.

VI. LABORATORY MEDICINE SERVICE RESIDENT TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that Housestaff assume progressively increasing responsibility for patient care according to their level of training, ability and experience (Refer to CHN Website for Housestaff Competencies). Before starting their rotation residents will be oriented to the Laboratory Medicine Service, provided with a packet of relevant documents including Laboratory Safety Guidelines, and will attest to receipt of these materials (Attachment B: Lab Med Service Resident's Packet)

A. Description

There are 2-3 Laboratory Medicine Residents assigned at all times to individual rotations within the Laboratory Medicine Services at ZSFG. These rotations are in the Microbiology, Clinical Chemistry/Toxicology, and Hematology/Blood Bank Divisions of the Clinical Laboratory.

B. Resident Duties

Resident duties differ on each of the rotations but fall into 3 major categories: test approval, test interpretation, and clinical consultation. Detailed information on resident duties for each of the rotations, guidelines for prospective and retrospective review of blood product usage, the recommended management of issues commonly encountered outside of routine working hours, including when to notify attending faculty, are maintained by the Laboratory Medicine Service, reviewed annually and updated as necessary. Orientation and Learning material for Laboratory Medicine Residents is maintained within each laboratory division and reviewed by Division Directors and Leadership staff as needed.

C. Resident Supervision

Laboratory Medicine (also referred to as Clinical Pathology) residency training is a three year postgraduate program (for Laboratory Medicine only) or two years of a four year combined residency training program in Anatomic Pathology/Clinical Pathology (AP/CP). The UCSF combined AP/CP residency training program or the straight Laboratory Medicine residency training program has flexibility, such that resident competencies and skills are not correlative with year of training. Resident competencies and skills are instead related to type of clinical rotation completed. For example, a resident in his/her final year (4th) year of training may be taking a Clinical Microbiology rotation for the very first time in his/her training. In contrast, another resident may have already completed such a rotation in his/her first year of training.

Laboratory Medicine residency training at ZSFG consists of three core rotations – Microbiology, Chemistry/Toxicology, and Hematology/Blood Bank/Cell Therapy. Microbiology and Chemistry/Toxicology rotations each last one to two week blocks, , the Hematology/Blood Bank rotation lasts one month. Elective rotations are offered in Toxicology and Consultative Hematology / Transfusion Medicine. Each rotation is supervised by the Director of the respective Clinical Laboratory Division. The Laboratory Director or Faculty Designee serves as Training Site Coordinator, ensuring orientation of residents at the beginning of the rotation, appropriate handling and resolution of residency-related issues and maintenance of materials and environment for effective education and learning.

Each resident assigned to a rotation in the Clinical Laboratory is closely supervised by the responsible Division Director during the regular work day. Clinical responsibilities typically consist of test approvals, test interpretations, and clinical consultations. All of these resident functions have direct impact on patient care, as residents make decisions about requests for esoteric testing, interpret laboratory results for diagnostic or therapeutic decisions, and recommend testing strategies for optimum patient management. Initially, all issues and concerns are discussed with and supervised by the respective Division Director at least daily. The resident assumes more responsibility and independence later in the rotation when s/he has become familiar with the issues unique to each division, is knowledgeable about the policies governing these issues, and the Division Director has developed confidence in his/her clinical judgment.

Laboratory Medicine residents also participate in a variety of clinical conferences (e.g., Medicine's Morbidity and Mortality report, Infectious Diseases conference, Cardiology conference, Endocrinology Conference, Poison Control rounds, etc.). These conferences provide a feedback mechanism by which the residents (and respective Division Director) can witness the impact of their decisions. These conferences also provide a feedback mechanism for the Clinical Service in general, in which existing Laboratory Medicine policies can be discussed and modified, if necessary.

In addition to their daily duties, each Laboratory Medicine Service Resident takes call for all Clinical Laboratory Services at the 5 UCSF teaching hospitals (UCSFMC, Mission Bay, Mt. Zion, ZSFG, VAMC) on a rotating basis to provide consultation on laboratory-related issues, approve unusual laboratory tests requests and handle transfusion-related problems arriving outside of routine hours (Mon-Fri 5PM – 8AM, Weekends and Holidays). Faculty members provide backup at all times by long range beepers and/or telephone. Disagreements between a clinical service and the Laboratory Medicine

Resident are resolved by the faculty member responsible for the service. All situations handled by residents while on-call are logged and reviewed and critiqued weekly via internet video conferencing by Clinical Laboratory faculty from all UCSF teaching sites.

Laboratory Medicine residents do not perform invasive procedures, with the exception of bone marrow aspirates / biopsies which would be performed under direct supervision of a Clinical Hematology Fellow or Attending. Some of their duties regarding test utilization or clinical consultation, however, can have serious impact on the acute clinical management and course of the patient (i.e., blood product use, antimicrobial susceptibility test interpretation, etc.). All major decisions having clinical impact are either discussed immediately or reviewed regularly by the responsible Division Director.

D. Resident Evaluation

ZSFG Laboratory Medicine residents are evaluated daily by the responsible Division Director and by all faculty and the Chief of the Service weekly as to their performance while “on-call” (Friday morning conference). Residents are given constant informal feedback on their performance as well as recommendations for improvement, if necessary.

Residents are given a formal in-person evaluation halfway through their rotation, with concrete recommendations for improving their performance if necessary. Residents are formally evaluated at the end of their rotation by the responsible Division Director. The evaluation is discussed and the discussion documented by checking the appropriate box on the online evaluation form (MedHub).

The UCSF Laboratory Medicine Residency Program Director reviews all final evaluations. Copies of all evaluations are available through the Laboratory Medicine Residency Program Director or the Residency Program Coordinator (contact information: phone: 415-353-7359, 185 Berry Street 1036, Suite 100, University of California, San Francisco, San Francisco, CA. 94143 – 0506).

The Director of the Laboratory Medicine Residency Training Program meets with each resident twice annually to review performance, discuss evaluations, and address concerns.

E. Ability to Write Patient Orders

ZSFG Laboratory Medicine residents do not independently write patient orders.

VII. CLINICAL LABORATORY FELLOWSHIP PROGRAMS

In addition to training Laboratory Medicine Residents, the Clinical Laboratory offers accredited postdoctorate fellowship education in Clinical Chemistry/Toxicology. Curriculum development, orientation, supervision and evaluation of fellows is the responsibility of the faculty member overseeing the respective programs, observing UCSF and ZSFG administrative policies and ZSFG Medical Staff Bylaws Rules and Regulations.

VIII. LABORATORY MEDICINE SERVICE CONSULTATION CRITERIA

Formal or informal professional consultation will be provided upon request for a member of the Medical Staff, professional or administrative personnel of the SFDPH, or other clients of the Laboratory Medicine Service. Such consultations will be provided by Laboratory Medicine residents, fellows, faculty or Clinical Laboratory Scientists, as appropriate. A consultation may also be initiated by the Laboratory Medicine Service if a potential problem is discovered that may adversely affect patient care.

IX. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the ZSFG Laboratory Medicine Service.

X. LABORATORY MEDICINE PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT

A. Goals, Objectives

It is the mission of Zuckerberg San Francisco General Clinical Laboratory to:

- Provide accurate, timely, efficient, cost-effective and high quality laboratory services in a safe and supportive work environment.
- Further the UCSF/ZSFG academic missions of research, education, patient care and public service.

The department conducts periodic surveys to assess staff and client satisfaction and to identify new or changed needs for tests or services. The term “client” is used broadly and includes health care providers, patients (inpatients, outpatients, and those within the primary care network), hospital employees and others who interact with the Clinical Laboratory. The department also provides continuing education to housestaff on a regular basis regarding testing procedures, interpretation and optimal utilization of clinical laboratory services.

An MEC Committee, The Laboratory Utilization Committee, has been established, chaired by the ZSFG Director of the Clinical Laboratory. This committee of providers and Lab Leaders from all Hospital and DPH Labs will address issues of medical necessity for new test requests, requests for changes in current laboratory testing, or in send-out testing requests with the goal to provide appropriate testing needed for quality patient care in a responsible, cost-effective manner. Lab testing issues and recommendations for changes in testing will be presented quarterly to the Leadership MEC.

B. Responsibility

The Director of the Clinical Laboratory has overall responsibility for the departmental quality management program which includes performance improvement and patient safety activities.

The Director and/or designated representative of the Department of Laboratory Medicine attends meetings of the ZSFG Performance Improvement/Patient Safety Committee and participates in the activities of other ZSFG committees as appropriate, in order to promote the performance improvement and patient safety goals of the department and of the hospital.

The Laboratory Administrator maintains, coordinates, and distributes documents relating to performance improvement and patient safety activities, assures compliance with all laws, rules and regulations, and is responsible for related administrative functions. The Laboratory Administrator maintains an index of all policies and procedures pertinent to the Performance Improvement and Patient Safety process, as well as minutes of relevant staff meetings and committee meetings.

Division Directors and Clinical Laboratory Scientist Managers within each division, as well as other personnel designated, are responsible for the identification of performance improvement and patient safety issues and the implementation and maintenance of performance improvement and patient safety activities within their areas of expertise and supervision, including the biennial review and update of policies and procedures.

C. Reporting

The Director of the Clinical Laboratory or designated representative provides an annual report to the ZSFG Performance Improvement/Patient Safety and a biennial report to the Medical Executive Committees.

D. Clinical Indicators and Components of the Laboratory Medicine Quality Management Plan

The following procedures will be utilized for the evaluation and review of quality and appropriateness of the activities of this department.

1. Quality control results for each test method.
2. Periodic review and update of procedures and policies for special handling, test methods and reports.
3. Quarterly review of reference lab testing for quality and client services at the monthly Clinical Lab leadership meeting.
4. Participation in:
 - a. Proficiency testing programs of the College of American Pathologists and/or other providers as appropriate, e.g., the Centers for Disease Control and Prevention, the State of California, and commercial suppliers.
 - b. Other quality improvement programs as appropriate, for example Q-Tracks/Q-Probes programs of the College of American Pathologists.
 - c. Biennial accreditation surveys by The Joint Commission.

5. Case reviews by faculty and house staff of the Laboratory Medicine Service.
6. A variety of pre-analytical and post-analytical test variables specific to each testing discipline that have major impact on patient care (e.g., turnaround testing times for key 'stat' tests, relay of critical test results to clinical care providers, specimen rejection rate, readiness and transport time for blood products, etc.)
7. Regular performance evaluations will be conducted for employees, house staff and faculty according to UCSF and ZSFG policies and procedures, as applicable.

E. Monitoring & Evaluation of Appropriateness of Patient Care Services and Response to SAFE Reports

The Director of the Clinical Laboratory will conduct an annual review and approval of the Quality Management (Performance Improvement / Patient Safety) Plan and of the professional practices of the department to assure that they are appropriate and consistent with the plan.

SAFE Reports, complaints, or issues are investigated and reported in writing as soon as possible. The Director or Leadership Designee, reviews each such incident and a response is forwarded, when appropriate, to the ZSFG Quality Management Office, other appropriate hospital committee, authority, and/or the complaining party.

Summaries of SAFE reports shall be reviewed at regular meetings of the Clinical Laboratory Leadership to identify events that require focused additional review. As issues, patterns and trends are identified, further assessment will be performed to determine the cause and extent of specific problems. The procedures to be followed may include audits of patient charts, pilot studies, research protocols, and interviews with clinical staff.

Corrective action may include any of the following, as appropriate:

1. In-service education and training programs for staff, house staff and faculty members.
2. Counseling and proctoring.
3. Staffing changes.
4. Changes in procedures or policies.
5. Changes of reagents and/or equipment.

Appropriate utilization of Clinical Laboratory services by the clinical staff will be promoted by formal and informal interaction between Laboratory Medicine faculty and house staff and members of the clinical departments at departmental rounds, house staff conferences, student lectures and seminars, and individual consultations.

XI. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws, all Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, including weekly call conferences and the annual Medical Staff Meeting. ZSFG Clinical Laboratory faculty who are not physicians are expected to meet the same attendance requirements as medical staff members, with the exception of attendance at the Annual Medical Staff Meeting. For faculty members with part time clinical appointments the expectation for attendance at meetings is reduced in proportion to their appointment.

The leadership of the Laboratory Medicine Service shall meet as frequently as necessary, usually monthly, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

As defined in the ZSFG Medical Staff Bylaws, a quorum is constituted by at least three (3) voting members of the Active Staff for the purpose of conducting business. In accordance with the Bylaws, the Laboratory Medicine Service Chief may extend voting rights to non-medical staff members. This will be documented in committee minutes at the beginning of the Medical Staff year and shall remain in effect for one year.

XII. ADOPTION, REVIEW AND AMENDMENT

Adoption of these Laboratory Medicine Service Rules and Regulations, as well as any revisions or amendments require a majority vote of all active medical staff members and faculty of the Laboratory Medicine Service Department at ZSFG. The Service Chief will conduct a review of these Rules and Regulations at least every other year and propose revisions and amendments to the voting members of the Department.

XIII. REVISION HISTORY

Description:	Supervisor Signoff By:	Signoff Date:
Changed review cycle from “annual” to “at least biannual” in sections III B. (Review of Privilege Request Form) and XII (Adoption, Review and Amendment). Clarified the review and voting process on revisions and amendments of these service rules and regulations in section XII.	E. Fiebig	9/25/2012
Placed in new format. Updated Lab Medicine Service Org Chart. Update references to SFGH LMR Rotation Guidelines (attachments)	E. Fiebig	6/21/2013
Updated Lab Medicine Service Org Chart (Core Lab) Deleted reference to “Community Health Network, CHN” in Clin Lab Director’s Job Description Update Attachment B, Resident’s Packet Omit reference to Fellowship education in Public Health Microbiology, section VII.	B. Haller	9/1/2016

Changed all SFGH to ZSFG Updated Org Chart	B. Haller	9/11/2018
Changed all references to LCR to electronic medical record (EMR) Changed evalute to MedHub (for resident and student evaluations) Changed annual report to MEC to biannual report	B. Haller	5/14/2019
Laboratory Director will recommend annually reference laboratories to the Medical Executive Committee – Changed to the following statement which meets Joint Commission Standards: Clinical Staff can recommend to the Laboratory Director alternative reference laboratories based on clinical need. The Laboratory Director will evaluate and approve Clinical Staff recommendation if indicated.	B. Haller	9/10/2020
Change biannual to “biennial” or “every other year”. Minor formatting and grammar changes.	B. Haller	9/10/2020
Updated location of Laboratory On-Line Manual - https://www.testmenu.com/zsfglab/ Updated Org Chart	B. Haller	9/10/2020
Removed Attachment D. ZSFG Laboratory Resident Survival Manual. To be updated and rewritten to include new test methodologies and testing strategies at ZSFG Clinical Laboratory.	B. Haller	9/10/2020
Updated Company name for Lab Information System	B. Haller	9/12/2022
Updated Appendix II, Laboratory Medicine service Organization Chart	B. Haller	9/12/2022
Changed Chief of Service evaluation of Medical Staff will be once per year instead of every 6 months	B. Haller	9/12/2022
Updated Resident Packet received at Orientation to Rotations	B. Haller	9/12/2022
Omit Attachment C. Add text to R+R stating that Orientation and Learning Material is maintained in each Resident rotation site in the Lab.	B. Haller	9/12/2022
Edit Table of Contents	B. Haller	9/1/2024
Replace “unusual occurrence” reports with “SAFE” reports	B. Haller	9/1/2024

Laboratory Medicine Service Rules and Regulations 2026

Update Appendix II. Organization Chart and Attachment B. Laboratory Medicine Resident's Packet	B. Haller	9/1/2024
Change UCSF's "Associate" Dean to UCSF's "Vice" Dean	B. Haller	9/1/2024
Change Division "Chief" to Division "Director"	B. Haller	9/1/2024
Change "Senior Supervising" Clinical Laboratory Scientists to Clinical Laboratory Scientist "Managers"	B. Haller	9/1/2024
Formatting of Laboratory Medicine Privileges (no change in content)	B. Haller	9/1/2024
Section I. A. Remove Clinisys Inc, Tucson, AZ as Lab Information System. Replaced by EPIC Beaker and SoftBank software for Blood Bank.	B. Haller	9/9/2026
Section V. C. paragraph 2: Change Three Core resident rotations each last two months to each lasting one to two 4-week blocks.	B. Haller	9/9/2026
Section V. C. paragraph 2: Add The Laboratory Director or Faculty Designee serves as Training Site Coordinator.	B. Haller	9/9/2026
Section X. A. Laboratory Medicine PIPS and Utilization Management: Add statement about the MEC Lab Utilization Committee.	B. Haller	9/9/2026
Section X. E. paragraph 2: Monitoring SAFE Reports, The Director or Lab Leadership Designee reviews each such incident.	B. Haller	9/9/2026
Update Appendix II. Laboratory Medicine Service Organization Chart	B. Haller	9/9/2026

XIV. APPENDIX I – LABORATORY MEDICINE PRIVILEGES

Privileges for Zuckerberg San Francisco General

Applicant: Please initial the privileges you are requesting in the Requested column.

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

FOR ALL PRIVILEGES: All complication rates, problem transfusions, deaths, unusual occurrence reports, patient complaints and sentinel events, as well as any specific Department quality indicators, are monitored semiannually.

Requested

Approved

16 LABORATORY MEDICINE

_____	_____	16.10	CATEGORY I – CORE PRIVILEGES PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pathology in Clinical Pathology or Anatomic & Clinical Pathology. Patient care responsibilities encompass supervision and direction of the specimen collection, selection of laboratory procedures appropriate for patient care, analysis, reporting and interpretation of results of diagnostic tests, including recommendations for patient management based on these results in Blood Banking /Transfusion Medicine/Immunohematology, Clinical Chemistry, Toxicology, Hematology, Immunology, Microbiology/Virology, Molecular Diagnostics, Medical Informatics and Laboratory Management. PROCTORING: 1) 6 months by the Chief of the Laboratory Medicine Service or Designee. 2) Review of 10 Case Discussions at weekly Lab Med Service Conferences. 3) 6-month review of QC oversight documentation (incl. proficiency testing and quality test management) REAPPOINTMENT: Renewal of privileges requires every 2 years: 1) review of a minimum of 5 Case Discussions at weekly Lab Med Service Conferences 2) review of QC oversight documentation during the evaluation period
_____	_____	16.11	BONE MARROW INTERPRETATION Review and analysis of bone marrow aspirate and biopsy material for diagnosis or monitoring of conditions affecting the hematopoietic system. PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pathology in Clinical and/or Anatomic Pathology and Hematopathology.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Cases by the Anatomic Pathology Service

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 3 cases by the Anatomic Pathology Service every 2 years.

_____ 16.20

CATEGORY II – SPECIFIC PRIVILEGES

Individuals who do not qualify for core privileges covering all aspects of laboratory medicine may indicate their specific areas of privileging from the list of subspecialties below. Patient care responsibilities within the specific area for which privileges are requested are the same as outlined above for core privileges in Laboratory Medicine.

_____ 16.21
IMMUNOHEMATOLOGY

BLOOD BANKING, TRANSFUSION MEDICINE,

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Medicine, Pediatrics, Obstetrics/Gynecology, General Surgery, or Anesthesia **and** Blood Banking/Transfusion Medicine.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Transfusion Reaction Reports
- 3) Review of 10 Case Discussions at weekly Lab Med Service Conferences

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Transfusion Reaction Reports
- 2) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 3) review of QC oversight documentation during the evaluation period

_____ 16.22

CLINICAL CHEMISTRY, TOXICOLOGY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Chemical Pathology or Clinical Chemistry, Toxicology

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Serum/Urine Protein Electrophoresis Reports
- 3) Review of 10 Case Discussions at weekly Lab Med Service Conferences
- 4) review of QC oversight documentation during the evaluation period

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Serum/Urine Protein Electrophoresis Reports

- 2) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 3) review of QC oversight documentation during the evaluation period

16.24

HEMATOLOGY (excluding Bone Marrow Interpretation)

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Clinical Hematology or Hematopathology.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Blood Smear/Body Fluid Interpretations
- 3) Review of 10 Hemoglobinopathy Interpretations
- 4) Review of 10 Case Discussions at weekly Lab Med Service Conferences

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Blood Smear/Body Fluid Interpretations
- 2) Review of 5 Hemoglobinopathy Interpretations
- 3) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 4) review of QC oversight documentation during the evaluation period

16.25

MICROBIOLOGY / VIROLOGY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Medical Microbiology.

PROCTORING:

- 1) 6 months by the Chief of the Laboratory Medicine Service or Designee.
- 2) Review of 10 Broncho-Alveolar Lavage Interpretations
- 3) Review of 10 Case Discussions at weekly Lab Med Service Conferences

REAPPOINTMENT: Renewal of privileges requires every 2 years:

- 1) Review of 5 Broncho-Alveolar Lavage Interpretations
- 2) Review of 5 Case Discussions at weekly Lab Med Service Conferences
- 3) review of QC oversight documentation during the evaluation period

Privileges for Zuckerberg San Francisco General

I hereby request clinical privileges as indicated above.

Applicant

Date

FOR DEPARTMENTAL USE:

_____ Proctor has been assigned for newly granted privileges.

_____ Proctoring requirements have been satisfied.

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

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

_____ CPR Certification is required.

_____ CPR Certification is not required.

APPROVED BY:

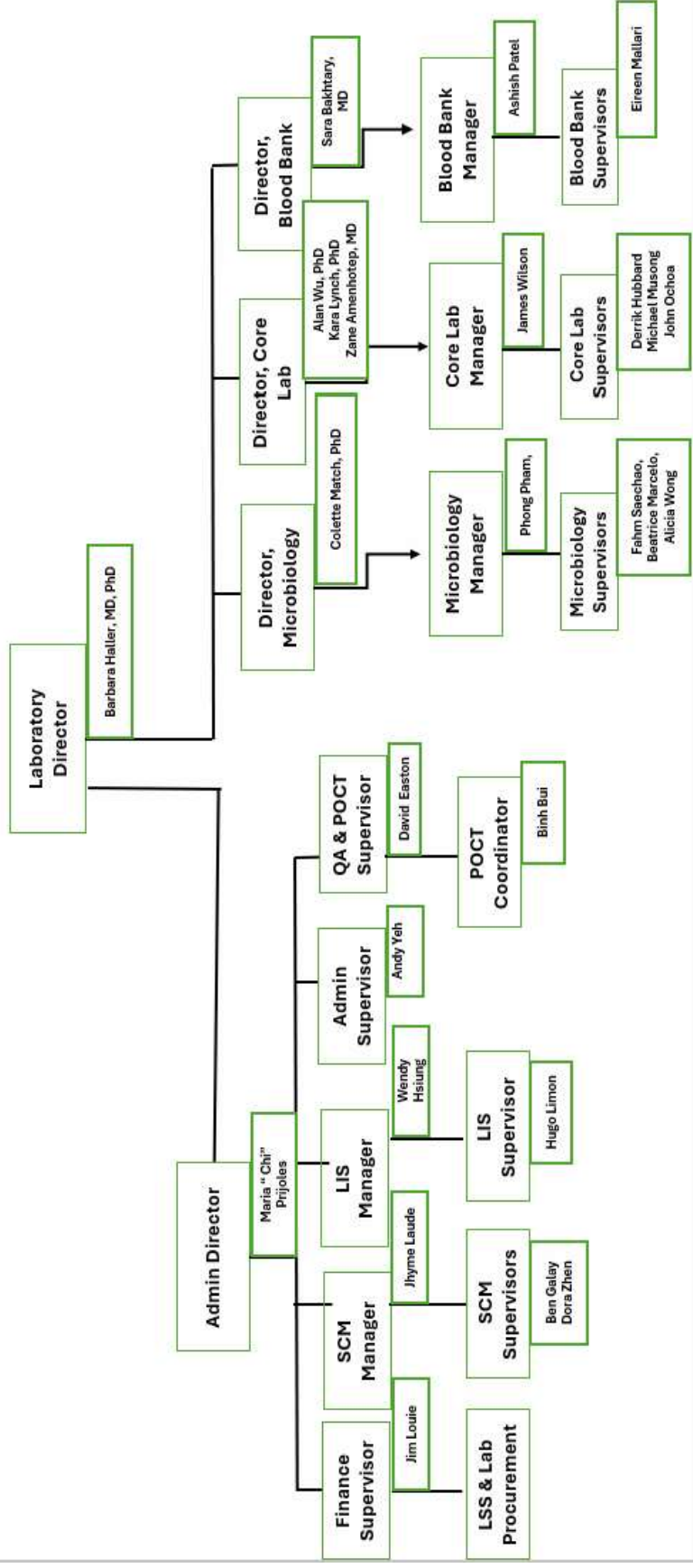
Division Chief

Date

Service Chief

Date

XV. Appendix II



XVI. ATTACHMENT A – CLINICAL SERVICE CHIEF’S JOB DESCRIPTION

University of California, San Francisco – Department of Laboratory Medicine
Zuckerberg San Francisco General
1001 Potrero Avenue, San Francisco CA 94110
Clinical Laboratory

DIRECTOR OF CLINICAL LABORATORY, ZUCKERBERG SAN FRANCISCO GENERAL

JOB DESCRIPTION:

General:

The Director of the Clinical Laboratory at Zuckerberg San Francisco General is accountable to the Chairman of the UCSF Department of Laboratory Medicine and the Associate Dean of the UCSF School of Medicine at ZSFG. This individual also serves as Chief of the Laboratory Medicine Service at ZSFG and as Vice Chair for the UCSF Department of Laboratory Medicine at ZSFG.

The Director of Clinical Laboratory has overall responsibility for the ZSFG Clinical Laboratory, including direction, planning, implementation and maintenance of all professional and administrative activities, training and educational programs conducted by the Department at ZSFG, as well as any other duties that may be assigned or delegated.

Specific responsibilities include, but are not limited to the following:

Administrative Responsibilities:

- Enforces the Medical Staff Bylaws, Rules and Regulations within the Laboratory Medicine Service.
- Assures compliance with the standards and regulations of the Joint Commission on the Accreditation of Healthcare Organizations, and federal, state and local regulatory agencies.
- Participates in departmental, hospital-wide, and university-wide activities, including staff meetings, committees, and related functions.
- Supervises the development, implementation and maintenance of procedures and policies relevant to departmental responsibilities and activities.
- Assures financial integrity of the department. Directs preparation and justification of annual budgets and assures operation within established budgets.

Clinical Responsibilities:

- Assures that the Clinical Laboratory provide accurate, timely and appropriate laboratory testing, efficiently and cost-effectively.
- Coordinates and integrates intradepartmental and interdepartmental services with the primary functions of the San Francisco Health Network.
- Develops effective procedures to promote professional interaction between the Laboratory Medicine Service and patient-care services for improved patient care.
- Assures the development, implementation and maintenance of departmental continuing quality improvement programs.
- Assures that all personnel performing work in or for the ZSFG Clinical Laboratories have the necessary qualifications and competence.
- Keeps current with and implements emerging technologies as necessary.

Academic Responsibilities:

- As Vice Chair of the UCSF Department of Laboratory Medicine, supervises academic activities at ZSFG, as authorized or delegated by the Department Chair at UCSF and/or the Associate Dean for ZSFG.
- Assures and provides general supervision for training programs, elective courses and continuing education programs, as appropriate, for house staff assigned to ZSFG, UCSF medical students and technical staff of the ZSFG Clinical Laboratory.
- Promotes opportunities for continuing education and academic activities, where appropriate, for faculty and staff of the Department of Laboratory Medicine at ZSFG.
- Maintains competence and leadership in the field of Laboratory Medicine by participation in programs for continuing medical education, professional organizations and public service activities, as appropriate.

Approved:

Barbara Haller, MD, PhD
Laboratory Director, UCSF Clinical Laboratory at ZSFG

Date

[Division Chiefs' Job Descriptions are held at Laboratory Medicine Service Office]

XVII. ATTACHMENT B – RESIDENT’S PACKET

**Laboratory Medicine Service
Resident’s Packet**

STATEMENT OF RECEIPT:

I certify that I have received the Laboratory Medicine Resident’s Packet with the following documents enclosed:

Please check off:

- _____ ZSFG Laboratory Safety Guidelines
- _____ ZSFG Confidentiality Agreement (Use of DPH Records & Information Systems)
- _____ Code of Professional Conduct Policy
- _____ On-Call Schedule
- _____ Resident’s Weekly Calendar of Conferences

** ZSFG Clinical Laboratory Test Directory is available @ <https://www.testmenu.com/zsfglab>

Signature: _____

Date: _____

Please complete this form and return it to Andy Yeh in the Administration Office after review.

2019 Zuckerberg San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

PROVIDER NAME: _____

Major site: _____

CLINICAL SERVICE: PEDIATRICS

Other sites: _____

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
CORE				
HCM: Acute/Urgent Care	3 months in length or the time needed to complete 5 chart reviews with at least 1 case representing each core protocol and 1 case of direct observation that represents each core protocol.	5 chart reviews with at least 1 case representing each core protocol every 2 years.		
HCM: Primary Care/Specialty Care	3 months in length or the time needed to complete 5 chart reviews with at least 1 case representing each core protocol and 1 case of direct observation that represents each core protocol.	5 chart reviews with at least 1 case representing each core protocol every 2 years.		
Furnishing Medications/Drug Orders	3 months in length or the time needed to complete 5 chart reviews with at least 1 case representing each core protocol and 1 case of direct observation that represents each core protocol.	5 chart reviews with at least 1 case representing each core protocol every 2 years.		
Tattoo Removal	10 cases with a provider with tattoo removal privilege.	5 cases and 5 chart reviews every 2 years.		
Contraceptive Implant Insertion	3 insertion procedures for a new provider and 2 insertions for an experienced provider with 2 chart reviews	1 case review every 2 years.		

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
Contraceptive Implant Removal	2 Removal procedures for a new provider and 1 removals for an experienced provider with 2 chart reviews.	2 case reviews every 2 years.		
Intrauterine Device Insertion	2 insertion procedures for new provider and 1 insertion procedure for experienced provider with chart review of all observed cases.	1 procedure and 1 chart review every 2 years.		

Chief of Pediatrics or designee

Date

*Clinical data relevant to privileges, or performance evaluation of standardized procedures, is available for review in the provider's file located in our Clinical Service office.

Zuckerberg San Francisco General Hospital and Trauma Center

Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE– NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: CHILDREN'S HEALTH CENTER

I. Policy Statement

- A. It is the policy of the 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 Title 16, CCR Section 1474.
- B. All standardized procedures are to be kept electronically and on file with the Medical Staff Office, Department Chief, and ZSFG Director of Nursing Office.

Program	Practice Location
Children's Health Center (CHC) and Multidisciplinary Assessment Center (MDAC)	ZSFG

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 or specialty care clinic 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. While functioning as a member of the San Francisco Health Network, PAs perform health care-related functions under physician oversight, utilization of standardized procedures and the Physician Assistant Practice Agreement (PAPA).

The NP/PA conducts physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care 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 any staffed outpatient clinic on the ZSFG campus under the operations of the Children's Health Center
2. The role in the outpatient setting may include performing physical exams, diagnosing, and treating illnesses, ordering, and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to the Medical Director of the Children's Health Center and MDAC.
2. A consulting physician, which may include an attending physician or 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, NP, PA, or physician.
 - e. Acute, severe respiratory distress.
 - f. An adverse response to respiratory treatment, or a lack of therapeutic response.

IV. Scope of Practice

Protocol#1	Health Care Management: Acute/Urgent Care
Protocol #2	Health Care Management: Primary Care/Specialty Care
Protocol #3	Furnishing and Drug Orders
Protocol #4	Procedure: Contraceptive Implant Insertion
Protocol #5	Procedure: Contraceptive Implant Removal
Protocol #6	Procedure: Insertion of Intrauterine Device
Protocol #7	Procedure: Destruction of Skin Lesion
Protocol #8	Procedure: Intralesional Steroid Injection
Protocol #9	Procedure: Neonatal Frenotomy

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

1. Active California NP/PA license
2. Successful completion of a master's level or higher program, which conforms to the Board of Registered Nursing (BRN)/Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) standards.
3. Maintenance of national board certification as required for employment and credentialing
4. Maintenance of certification of American Heart Association Basic Life Support for Health care Providers (BLS-HCP).
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 Zuckerberg San Francisco General Hospital and Trauma Center Physical Assistant Practice Agreement (PAPA). Copies of PAPA must be kept at each practice site for each PA.

B. Specialty Training

1. Specialty requirements
 - a. NP specialty certification as an PNP, ANP, FNP, ACNP

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 supervising clinical provider(s) will assess the NP/PA's ability to practice clinically

a. Clinical Practice
The term may be
supervising clinical

- i. Length of proctoring period will be up to three (3) months.
shortened or lengthened at the discretion of the

provider; however, the proctoring period shall not exceed the six (6) months CCSF probationary period.

- ii. The evaluator will be the medical director or assigned delegate.

iii. The method of evaluation in clinical practice will be those needed to demonstrate clinical competence

2. Ongoing Professional Performance Evaluation (OPPE): Affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.

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

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

VII. Development and Approval of Standardized Procedure

A. Method of Development

1. Standardized procedures are developed collaboratively by the NPs/PAs, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval

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

C. Review Schedule

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

D. Revisions

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

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

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions in the Children's Health Center. These urgent problems may be treated during a primary care visit, an urgent care visit, or a specialty care visit.

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, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Therapeutic Treatment Plan

- a. Diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- c. Referral to physician, specialty clinics, and supportive services, as needed.

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, parent/guardian, NP, PA, or physician.
- f. Any problem requiring hospital admission or potential hospital admission that the provider assesses as warranting additional consultation with a physician
- g. Acute, severe respiratory distress.
- h. An adverse response to respiratory treatment, or a lack of therapeutic response.

3. Education

Patient/parent/guardian education should include treatment modalities, discharge information and instructions.

4. Follow-up

As appropriate regarding patient health status and diagnosis which may include inbox management and following clinic standards for replying and managing inbox items via the electronic medical record system.

E. **RECORD KEEPING**

All information from patient visits will be recorded in the electronic medical record (e.g. admission notes, progress notes, procedure notes).

PROTOCOL #2: Health Care Management – Primary Care/Specialty Care

A. DEFINITION

This protocol covers the procedure for age-appropriate health care management in primary care and specialty clinics. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses in the Children's Health Center. Specialty care is delivered in conjunction with a licensed specialist where appropriate.

B. DATA BASE

1. Subjective Data

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

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment

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

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation
- b. Problem that is not resolved after reasonable trial of therapies
- c. Unexplained historical, physical or laboratory findings
- d. Upon request of patient/guardian, NP, PA, or physician
- e. Problem requiring hospital admission or potential hospital admission that the provider assesses as warranting additional consultation with a physician
- f. An adverse response to respiratory treatment, or a lack of therapeutic response, including acute severe respiratory distress.

3. Education

- a. Patient/parent/guardian education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).

- b. Anticipatory guidance and safety education that is age and risk factor appropriate.
- 4. Follow-up
 - As indicated and appropriate to patient health status and diagnosis. This may include inbox management and following clinic standards for replying and managing inbox items using the electronic medical record system.

E. **RECORD KEEPING**

All information relevant to patient care will be recorded in the electronic medical record (e.g. admission notes, progress notes, procedure notes, discharge notes).

PROTOCOL #3: 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. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Board. A copy of the Certificate must be attached to the physician assistants Delegation of Service document. Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, Children’s Health Center, 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: Zuckerberg San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2), and the writing of Drug Orders. (Policy no. 13.5) & California AB1196 (Chapter 748)

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 Schedule II-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. NP/PA 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 Medical Record, or in the Medication Administration Record (MAR). The protocol will include the following:

- i. location of practice
 - ii. diagnoses, illnesses, or conditions for which medication is ordered
 - iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
 - iv. date CURES checked for patient
 - d. To facilitate patient receiving medications from a pharmacist provide the following:
 - i. name of medication
 - ii. strength
 - iii. directions for use
 - iv. name of patient
 - v. name of prescriber and title
 - vi. date of issue
 - vii. quantity to be dispensed
 - viii. license, furnishing license, and DEA license if applicable
2. Patient conditions requiring consultation
 - a. Problem which is not resolved after reasonable trial of therapies.
 - b. Unexplained historical, physical or laboratory findings.
 - c. Upon request of patient/parent/guardian, NP, PA, or physician.
 - d. Failure to improve pain and symptom management.
 - e. Acute, severe respiratory distress.
 - h. An adverse response to respiratory treatment or a lack of therapeutic response.
3. Education
 - a. Instruction on directions regarding the taking of the medications in patient's own language.
 - b. Education on why medication was chosen, expected outcomes, side effects, and precautions.
4. Follow-up
 - a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. RECORD KEEPING

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

PROTOCOL #4: Procedure: Contraceptive Implant Insertion

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm via a preloaded inserter.

1. Location to be performed: Children's Health Center
2. Performance of procedure:
 - a. Indications
Patient desires long-acting, reliable contraception
 - b. Precautions
Chronic use of drugs that are potential inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy. May have drug interactions with some herbal products. See drug precautions/interactions in prescribing information.
 - c. Contraindications:
 1. Known or suspected pregnancy
 2. Hepatic tumors, active liver disease
 3. Known, suspected or history of breast cancer
 4. Undiagnosed abnormal genital bleeding
 5. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, 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 ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Timing of insertion: See prescribing information
 - e. Insertion as described in prescribing information

- f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - g. Referral to physician, specialty clinics, and supportive services, as needed.
 - 2. Patient conditions requiring consultation,
 - a. Acute decompensation of patient situation.
 - b. Difficult insertions
 - c. Upon request of patient, affiliated staff or physician
 - 3. Education
Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.
 - 4. Follow-up
As appropriate for procedure performed.
- E. **RECORD KEEPING**
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate.
- F. **Summary of Prerequisites, Proctoring and Reappointment Competency**

Prerequisite:

Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Established Experience: Documentation of greater than five (5) cases in the past two (2) years.

Limited Experience: Documentation of less than five (5) cases in the past two (2) years

Proctoring Period:

Established Experience: Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Limited Experience: Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

Reappointment Competency Documentation:

Review of one (1) case in the past two (2) years.

PROTOCOL #5: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant previously placed under the skin of the upper arm is removed under local anesthetic.

1. Location to be performed: Children's Health Center
2. Performance of procedure:
 - a. Indications
Patient 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. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
 - c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Timing of removal: See prescribing information
 - e. Removal: as described in prescribing information
 - f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - g. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring consultation
 - a. Acute decompensation of patient situation.
 - b. Difficult implant removal.
 - c. Upon request of patient, affiliated staff or physician
3. Education

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

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Established Experience: Documentation of greater than five (5) cases in the past two (2) years.

Limited Experience: Documentation of less than five (5) cases in the past two (2) years

Proctoring Period:

Established Experience: Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Limited Experience: Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

Reappointment Competency Documentation:
Review of two (2) cases in the past two (2) years.

PROTOCOL #6: Procedure: Intrauterine Device Insertion

A. DEFINITION

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

1. Location to be performed: Children's Health Center

2. Performance of procedure:
 - a. Indications
Patient desires intrauterine device.
 - b. Precautions
See IUD prescribing information
 - c. Contraindications
 1. Pregnancy or suspicion of pregnancy
 2. Acute pelvic inflammatory disease or concern for high risk for pelvic inflammatory disease.
 3. Post-partum endometritis or post abortal endometritis.
 4. Known or suspected uterine or cervical malignancy
 5. Genital bleeding of unknown etiology.
 6. Wilson's disease for Paraguard IUD
 - 7 Allergy to any component of IUD to be placed
 - 8 A previously placed IUD that has not been removed.

B. DATA BASE

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. 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 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, affiliated staff, or physician
 - e. Initiation or adjustment of medication other than those in the formularies.
 - f. If patient desires removal and string is not readily available.

g. Problem requiring hospital admission or potential hospital admission.

3. Education
Discharge information and instructions.

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

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

Prerequisite: a. Completion of training on site by a qualified provider.
Proctoring Period: a. Observed performance of a minimum of 3 insertion procedures for a new provider and 2 insertion procedures for an experienced provider. b. Chart reviews of all observed cases.
Reappointment Competency: a. Perform two insertion procedures every two years. b. Review of one case in the past two years.

PROTOCOL #7: Procedure: Destruction of Skin Lesion

A. DEFINITION

Destruction of skin lesion by cryotherapy (liquid nitrogen)

1. Location to be performed: Children's Health Center

2. Performance of procedure:

- i. Indications: removal of warts or molluscum contagiosum lesions and provider-applied, in-office treatment is preferred over patient-applied topical therapies or topical therapies have failed
- ii. Precautions: Scarring, infection, pigment change, risk of nail dystrophy when treating periungual warts, cosmetically sensitive areas such as the face, diagnostic uncertainty
- iii. Contraindications: none, recommend consulting dermatology attending for any patients with >7 lesions

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 department 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 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 (parent consent if patient is a minor) 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.

3. Patient conditions requiring Attending Consultation:

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

4. Education: Post-procedure counseling and instructions.

5. Follow-up: As needed for reassessment and repeat treatment.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care a. Attestation of completion of CHC cryotherapy training (slides and/or recording) b. Training on site by qualified provider.
Proctoring Period a. New practitioner to procedure, a minimum of 2 successful observed demonstrations of procedure b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations of procedure c. Chart review of all observed cases.
Reappointment Competency: a. Perform two procedures every two years. b. Review of one case in the past two years.

PROTOCOL #8: Procedure: Intralesional Steroid Injection

A. DEFINITION

Injection of steroid into skin

1. Location to be performed: Pediatric Dermatology Clinic at Children's Health Center
2. Performance of procedure to be confirmed and reviewed with dermatology attending:
 - i. Indications: treatment of keloids, cystic acneii. Precautions: bleeding, skin atrophy
 - iii. Contraindications: skin atrophy, active infection, open wound

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 ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent (parent consent when patient is a minor) is 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. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient, NP, PA, or physician
- e. Problem requiring hospital admission or potential hospital admission.

3. Education
Discharge information and instructions.

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care a. Review of proper technique per qualified dermatology attending b. Training completed under the supervision of the dermatology attending
--

Proctoring Period a. New practitioner to procedure, a minimum of 5 successful observed demonstrations of the procedure with at least two per condition (keloids, cystic acne) b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 2 successful observed demonstrations c. Chart review of all observed cases.
--

Reappointment Competency: a. Perform two procedures for each of the 2 conditions every two years. b. Review of one case for each condition in the past two years.

PROTOCOL #9: Procedure: Neonatal Lingual Frenotomy

A. DEFINITION

Lingual frenotomy is the release of a tight lingual frenulum, called ankyloglossia, which causes restricted tongue movement that can contribute to latch difficulties with breastfeeding, insufficient transfer of breast milk, and maternal nipple pain and trauma.

1. Location to be performed: Children's Health Center
2. Performance of procedure:
 - i. Indications: Ankyloglossia with functional breastfeeding impairment, particularly maternal nipple pain associated with latch and/or poor infant feeding (inability to maintain latch, poor milk transfer, poor weight gain), that is not improving with conservative measures such as lactation consultation, positioning changes, or nipple shields
 - ii. Precautions: bleeding disorder, thick lingual frenulum
 - iii. Contraindications: lack of Vitamin K injection administration at birth

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 ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Parent/guardian 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. Uncommon, unfamiliar, unstable, and complex patient conditions
 - d. Upon request of patient, NP, PA, or physician
 - e. Problem requiring hospital admission or potential hospital admission.

3. Education
Discharge information and instructions.

4. Follow-up
As appropriate.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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

- | |
|---|
| <ol style="list-style-type: none"> a. Review of proper technique b. Training on site by qualified provider. |
|---|

Proctoring Period

- | |
|--|
| <ol style="list-style-type: none"> a. New practitioner to procedure: a minimum of 2 successful observed demonstrations of procedure b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstration of the procedure c. Chart review of all observed cases. |
|--|

Reappointment Competency:

- | |
|--|
| <ol style="list-style-type: none"> 1. Perform 2 procedures every 2 years. 2. 1 chart review procedure every 2 years. |
|--|

PROTOCOL #10: Procedure: Tattoo Removal

A. DEFINITION

The removal of a tattoo (or multiple tattoos) from a patient's skin using the Medlite C6 laser or current relevant laser as approved by the clinic leadership team. The treatment is conducted in conjunction and consultation with a laser technician from the contractor providing laser equipment services to ZSFG/SFDPH. Treatment is scheduled every six to eight weeks, until such time as the desired cosmetic outcome is achieved or complications arise requiring the cessation, suspension, or modification of therapy.

1. Location to be performed: Zuckerberg San Francisco General Hospital and affiliated SFDPH ambulatory settings

2. Performance of procedure:

i. Indications: The presence of one or more tattoos on the patients skin, with a primary focus on 1) gangs; 2) sex trafficking; 3) hateful speech (e.g., racial slurs); 4) breast oncology; 5) abusive relationships; 6) incidents during which patients were having mental health crises; 7) tattoos which limit patients' abilities to find gainful employment especially in areas not usually covered by clothing (face, neck, hands, forearms etc.)

ii. Precautions:

1. A health screening questionnaire is completed by all program participants prior to acceptance into the program.
2. Provider check in with patients prior to each treatment session.
3. Extensive post-treatment counseling regarding after-care is conducted following each treatment session, along with any supplies needed to properly care for the treatment site.

iii. Contraindications:

1. Immunodeficiency
2. Pregnancy
3. Breastfeeding
4. Acute intoxication
5. Open wounds at or near treatment site
6. Acute infection at or near treatment site.
7. History of allergic reaction during prior treatment or tattoo placement

B. DATA BASE

1. Subjective Data

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

2. Objective Data

- a. Physical exam appropriate to tattoo removal.
- b. The tattoo removal is performed following standard medical technique

according to the departmental resources (i.e. specialty guidelines).

C. DIAGNOSIS

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

D. PLAN

1. Therapeutic Treatment Plan

- a. For minors, patient/guardian consent obtained before procedure is performed.
- b. Time out performed.
- c. Diagnostic tests for purposes of disease identification.
- d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained historical, physical or laboratory findings
- c. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient/parent/guardian, NP, PA, or physician
- e. Problem requiring hospital admission or potential hospital admission.

3. Education

Discharge information and instructions.

4. Follow-up

Six to eight weeks following treatment or as needed to address any concerns or complications.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

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

Proctoring Period:

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

Reappointment Competency:

- a. Perform two tattoo removal procedures every two years.
- b. Review of one case in the past two years.

SP Authors: Tina Chang, NP	
Medical Director:	
Approval Body:	Date Approved:
CIDP	
Credentials Committee	
Medical Executive Committee	
Joint Conference Committee	



SFHN Credentials Committee Standardized Procedure and/or Privileges Submission Form

Directions:

1. Summarize the content changes that were made to the SP/protocols or Privileges using the table in Section I
2. Complete Section II: Follow instructions outlined in table
3. Email the revised SP with track changes and this completed form to the Michelle Mai, ZSFG Medical Staff Analyst (michelle.mai@sfdph.org), the CIDP Coordinator (erika.kiefer@sfdph.org), Nursing Manager (Jennifer.Berke@sfdph.org), and CIDP Co-Chairs (vagn.petersen@sfdph.org) (Vanessa.Aspeticueta@sfdph.org).

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form: Tina Chang, NP	
Standardized Procedure Title:	Pediatric SP
Department:	Children's Health Center
Dept Chief:	Shon Jain, MD
SP Author(s):	Tina Chang, NP
Update #1:	Formatting and changes to align with 2023 preamble, removal of language not applicable to CHC, changed circumstances requiring physician consultation, removal of requirement of 6 months women's health experience related to implant insertion/removal, other minor updates, updated inbox management as requested by medial director, updated # of procedures needed for credentialing and reappointment
Reason/Explanation for Revision:	Updated terms (i.e. SFGH => ZSFG, CHN => SFHN, etc), removed CASARC from Peds SP; removed irrelevant language pertaining to inpatient care; allow NPs to contact inpatient directly for potential admission without need to consult with CHC MD (i.e. hyperbilirubinemia), allow NPs to see patients with "complex" or "uncommon" conditions without MD consultation, removal of specified list of credentialing bodies for board certification (left it open to what is required for employment and credentialing)

Update #2:	Added 3 new protocol procedures: - <u>cryotherapy</u>: warts and molluscum only, training with clinic powerpoint and/or video - <u>intralesional steroid injection</u>: cystic acne and keloids only; procedure to be done only by APPs staffing pediatric dermatology and under supervision of dermatology attending, number of procedures to be performed during proctoring is 5 with at least two of each condition - <u>neonatal frenotomy</u>: indications for procedure, observation and training requirements
Reason/Explanation for Revision:	Adding procedures within scope of APP to expand access to patients needing these procedures. Additionally, current NPs at CHC desire to perform these procedures that were lacking in previous SP.

*Include additional rows to table, if needed



Department of Public Health

Section II: Standardized Revisions

Daniel Lurie
Mayor

Mary Mercer, MD
Chief of Staff

Update the SP as instructed below.

Preamble	- The Preamble is the portion of the SP that precedes the Protocols, the first pages of the SP, outlined I-VII, includes sections “Policy Statement, Functions to be Performed,” etc. - The Preamble was updated in 2023 to include changes in legislation, regulations, and practice. (CIDP, 10/2023)
Equity	Ensure language within the SP is inclusive. Examples include but are not limited to: - Do not use race/ethnicity descriptors unless necessary - Do not use sex assigned at birth unless necessary - Use “their” rather than “him/her” (CIDP, 8/2022)
ZSFG	Change “San Francisco General Hospital” to “Zuckerberg San Francisco General Hospital” and SFGH to ZSFG (CIDP, 10/2016) “Community Health Network” change to “San Francisco Health Network” “CHN” change to “SFHN”
Qualified Provider	Insert the following after every use of words “qualified provider:” who has completed proctoring and subsequently maintained their eligibility for performing the procedure. <i>Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.</i> (Credentials Committee, 11/2023)
Prerequisites	Onsite training no longer to be listed as a prerequisite. Instead, the training to be completed once procedure is approved for the provider and then before the provider initiates proctoring. Update protocols to reflect this change (Credentials Committee, 11/2023)