Zuckerberg San Francisco General
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OB/GYN CLINICAL SERVICE RULES AND REGULATIONS TABLE OF CONTENTS

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I. OB/GYN CLINICAL SERVICE ORGANIZATION

The Rules and Regulations of the Clinical Service of Obstetrics, Gynecology and Reproductive Sciences define certain standards of practice and other rules for members of the clinical service.

Standards of clinical practice will be consistent with those standards established by the American College of Obstetricians and Gynecologists, as set forth in the document, Standards for Obstetric Gynecologic Services. If any apparent conflict exists, the standard defined in this document will prevail.

These Rules and Regulations will supplement those set forth in the ZSFG Bylaws, Rules and Regulations of the Medical Staff of Zuckerberg San Francisco General Hospital & Trauma Center. Should a conflict exist between these Rules and Regulations and those of the Medical Staff, the Medical Staff standards will prevail, except in circumstances where the clinical service adopts a more stringent standard.

A. SCOPE OF SERVICE

The Department of Obstetrics, Gynecology and Reproductive Sciences provides full-scope obstetric and gynecologic services, including inpatient and outpatient obstetrics, inpatient and outpatient gynecologic care and gynecologic surgery and abortion care. Sub-specialty care is also provided in maternal-fetal medicine, gynecologic-oncology, gynecologic-urology, complex family planning, and reproductive infectious diseases. There is 24-hour, in-hospital coverage by active or courtesy physician members of the medical staff plus by certified nurse midwives. Additionally, there is a physician on back-up duty 24 hours per day.

The scope of service includes but is not limited to:

1. Obstetrics
    a. Normal antenatal, intrapartum and postpartum care, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist.
    b. Complicated antenatal, intrapartum and postpartum care;
    c. Antenatal testing;
    d. Basic obstetric ultrasound; and
    e. Perinatal genetics services.

2. Inpatient Gynecology
    a. Gynecologic surgery, admission of patients with gynecologic diagnoses and consultation on inpatients admitted to other services, encompassing the usual scope of Board-Certified Obstetrician-Gynecologist.
    b. Specialty services:
        1) Laser therapy of vulva, vagina and cervix;
        2) Surgery for incontinence and pelvic organ prolapse (gynecologic-urology);
        3) Surgery for treatment of gynecologic cancer; and
        4) Minimally invasive gynecologic surgery.
3. Outpatient Gynecology
    a. Broad range of outpatient services, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist.
    b. Specialty clinics include:
        1) Dysplasia including colposcopy, cryotherapy, and loop excision;
        2) Gynecologic urology;
        3) Gynecologic oncology;
        4) Reproductive endocrine and infertility services, and
        5) Gender expansive care
4. Family Planning
    a. Broad range of family planning services, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist;
    b. Tubal sterilization;
    c. Complex contraception clinic, and
    c. Abortion, up to 25 weeks 6 days by ultrasound

1) Exclusions: Terminations beyond 26 weeks may be performed in special circumstances where maternal health is compromised by the pregnancy after discussion and approval by the Medical Director of the Women's Option's Center, a representative of the Ethics Committee, the Chief Nursing Officer, and, when appropriate, consultation with relevant medical specialist(s). The indications for terminations beyond 26 weeks for fetal indications will be assessed by an attending neonatologist to determine the degree of fetal compromise and thus the appropriateness of offering the termination.

B. MEMBERSHIP REQUIREMENTS

Membership in the Medical Staff of Zuckerberg San Francisco General Hospital & Trauma Center is a privilege that shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in ZSFG Medical Staff Bylaws, Article II, Medical Staff Membership, Rules and Regulations, and accompanying manuals as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION AND STAFFING OF THE OB/GYN CLINICAL SERVICE

An organizational chart and duties of the OB/GYN Clinical Service appears in Appendix C.

The Officers of the OB/GYN Clinical Service are:

1. Chief of Service;
2. Medical Director of Obstetric Service;
3. Medical Director of Gynecologic Service;
4. Medical Director, Obstetrics, Midwifery and Gynecology (OMG) Clinic;
5. Medical Director, Family Planning Service;
6. Director of Resident Education;
7. Director of Medical Student Education;
8. Chair Nurse Midwifery Service Leadership Council; and
9.
10. Director of QI

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the OB/GYN Clinical Service is in accordance with ZSFG Bylaws Article II, Medical Staff Membership and ZSFG Credentialing Manual, Appointments/ Reappointments and accompanying manuals as well as these Clinical Service Rules and Regulations.

1. Current licensure to practice in the State of California is required. No member shall engage in patient care responsibilities unless his/her license is current and clear.
2. CPR or neonatal resuscitation certification is encouraged but not required.
3. In accordance with ZSFG Bylaws, all practitioners providing medication or supervising others who prescribe or furnish medications must have a valid federal DEA certificate.
4. Active and Courtesy Members are required to be Board-Certified by or Active Candidates of the American Board of Obstetrics and Gynecology as per the Hospital bylaws

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the OB/GYN Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, Credentialing Procedure Manual, 1.3 – Reappointment Process as well as these Clinical Service Rules and Regulations.

1. Re-appointment will occur every 2 years. At this time, the following will be reviewed:
   a. Review of QI file: reports of peer review cases, complaints by staff or patients, sentinel events, or problems with the performance of certain procedures; and

b. Review of levels of clinical activity in each category of obstetrical and gynecological care.

2. Active medical staff members must perform a minimum number of procedures or activities in the prior two years as specified in the table below.

a. If activity thresholds have not been met in a category of privileges requested by the member, then a program of educational activities and proctoring will be designed by the members of the department. Once completed, the privilege in the core category may be approved by the service chief. Exceptions to proctoring may be granted in certain circumstances with approval of a majority of active staff members. For courtesy staff members who perform the predominance of their clinical activities at other hospitals, a letter of good standing from the medical staff office at the primary hospital is sufficient proof of adequate clinical activity.

b. If there has been no activity in any category in the prior 2 years, the staff member will be contacted and asked whether he or she intends to remain a member of the ZSFG medical staff. If there is no response within 60 days or if the individual states that they intend to resign from the medical staff, the ZSFG Medical Staff Office should be notified of the member's resignation. This holds for active staff members. For courtesy staff members, see above under 2a.

c. If the individual states that he or she does intend to remain on the SGFH Medical Staff and to maintain their privileges, the department will devise a time-limited proposal for additional professional activity, with specification of proctoring thresholds, if necessary. Upon satisfactory completion of requisite activity, privileging will continue in those areas.

Reappointment Requirements:	
OBSTETRICS	
Outpatient clinic: obstetrics	50 clinic visits
Basic obgyn ultrasound (IUP, dating, adnexa etc)	10 interpretations
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, laceration repair)	15 cases
GYNECOLOGY	
Outpatient clinic: gynecology	50 clinic visits
Inpatient gynecology and gynecologic surgery	15 operative procedures
Emergency gynecology and gynecologic surgery	15 procedures including at least 4 laparoscopies or laparotomies
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	10 procedures
Laser therapy	2 cases
~~Hysteroscopic sterilization~~	~~2 operative procedures~~
Moderate sedation/analgesia	5 case reviews and documented completion of module
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	15 operative procedures
Urogynecology	15 operative procedures
Maternal-Fetal Medicine	Care of 20 patients

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of Affiliated Professionals to ZSFG through the OB/GYN Clinical

Service is in accordance with ZSFG Bylaws, Rules and Regulations, Credentialing Manual, 3.1 – Affiliated

Professional Staff, and accompanying manuals as well as these Clinical Service Rules and Regulations. Affiliated professionals within the ZSFG Department of Ob/Gyn include certified nurse midwives (CNM) who work in the Family Birth Center (H22), Women's Options Center (6G), and Obstetrics, Midwifery, and Gynecology Clinic (5M), and Licensed Clinical Psychologists who work in 5M.

D. DEFINITIONS OF MEDICAL STAFF CATEGORIES

All members of the medical staff in the ZSFG Department concurrently shall be a member of the academic or clinical faculty of the University of California, San Francisco, School of Medicine, Department of Obstetrics, Gynecology, and Reproductive Sciences.

1. Active staff members are defined as any of the following:
    a. Academic faculty member;
    b. Clinical faculty members who regularly attend at ZSFG, but who do not have active staff membership at other hospitals; and
    c. UCSF fellows who are assigned the predominance of their clinical responsibilities at the ZSFG.
2. Courtesy staff members are defined as any of the following:
    a. Academic and Clinical faculty members who have active staff membership at other hospitals and who perform the predominance of their clinical practice at hospitals other than ZSFG; and
    b. Clinical faculty members who do not regularly attend at ZSFG and who do not have active staff membership at other hospitals.
    c. Many courtesy staff are board-certified sub-specialists (gyn-oncology, reproductive endocrinology, maternal-fetal medicine) who offer specialty services that our generalist Ob/Gyn staff members are not able to provide.
3. The term "regularly attend" is defined as an attending who is assigned to a clinical service activity for 30 or more days per year.
4. Temporary Privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

The OB/GYN Clinical Services privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article IV: Clinical Privileges, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations, privileges to practice in the Clinical Service of Obstetrics and Gynecology will be commensurate with documentation of clinical training of an acceptable standard of clinical practice.

Privileges are delineated by consensus of the Active Members of the Clinical Service, subject to the approval of the Credentials Committee of the Medical Staff. Delineation of privileges will be reviewed yearly and at other times as necessary.

B. CATEGORIES OF PRIVILEGES

1. Privileges shall be defined in two categories: core and special
    a. Core privileges are defined as the cognitive and procedural clinical activities customarily performed by fully trained obstetricians or gynecologists.
    b. Special privileges are defined as procedural clinical activities that are not customarily performed by fully trained obstetricians or gynecologists and which require additional training, experience, and expertise to perform.
2. Core privileges will be granted in the following areas;
    a. Outpatient gynecology and family planning;
    b. Outpatient obstetrics;
    c. Inpatient gynecology; and
    d. Inpatient obstetrics.

3. Special privileges will be those sub-specialty areas and specialized procedures designated by the department as requiring skills (see table below and Privilege Form).
4. All new appointees to the Active Staff of the department must undergo a provisional period of no less than 3 months. During the provisional period, the clinician will be expected to satisfactorily complete proctoring.

C. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The OB/GYN Clinical Services Privilege Request Form shall be reviewed annually.

D. CLINICAL PRIVILEGES & MODIFICATION/CHANGE TO PRIVILEGES

The OB/GYN Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article IV: Clinical Privileges, Rules and Regulations and accompanying manuals. All requests for clinical privileges will be evaluated and approved by the Chief of OB/GYN Clinical Service.

The process for modification/change to the privileges for members of the OB/GYN Clinical Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

IV. PROCTORING AND MONITORING

Proctoring is defined as an evaluation of a member's clinical training, skills, and judgment by a peer clinician who is fully privileged in the area being evaluated. It is intended to evaluate the clinical skills of the member in performing clinical services, but not to evaluate their abilities as a teaching or supervising clinician, which will be done in other ways.

A. CIRCUMSTANCES REQUIRING PROCTORING

All medical staff members initially granted privileges shall complete a period of proctoring, in accordance with the following monitoring requirements below. Proctoring may be accomplished in any the following settings:

1. After initial appointment to the Medical Staff and performed within the first 6 months after joining the ZSFG medical staff.
    a. For physicians who completed residency at UCSF and will join the department soon after completion of the residency, proctored procedures during the Chief Residency year will be considered applicable toward proctoring requirements. There are therefore fewer cases required to be proctored upon joining Medical Staff for former UCSF residents as shown in the Table below.
2. When a member requests privileges for a procedure in which there has been insufficient clinical activity in the prior 2 years.
3. When a member requests special privileges in a category or procedure for which they recently have completed training.
4. At the time of reappointment to the Medical Staff, if it is found that proctoring at the time of initial appointment was incomplete or insufficient.

B. PROCTORING AFTER INITIAL APPOINTMENT

Individuals' privileges are subject to review and revision at initial appointment, throughout the period of proctoring, at the time of reappointment, at any time as judged necessary by the Chief of Service or at any time recommended by a two-thirds vote of a quorum of the clinical service's Active Staff.

The number of cases that must be proctored are contained in the tables below.

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Individual Proctoring Plan for Former UCSF Resident or Fellow:

OBSTETRICS	
Outpatient clinic: obstetrics	Review of 3 medical records
Basic ob/gyn ultrasound (IUP, dating, adnexa, etc)	Interpretation of 3 ultrasound exams
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, lac repair)	Observed care of 2 patients, including 1 Cesarean
GYNECOLOGY	
Outpatient clinic: gynecology	Review of 3 medical records
Inpatient gynecology and gynecologic surgery	3 observed operative procedures including at least one laparotomy and one laparoscopy
Emergency gynecology and gynecologic surgery	2 reviewed procedures including at least one laparoscopy
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	2 observed operative procedures
Laser therapy	2 observed procedures
~~Hysteroscopic sterilization~~	~~2 observed procedures~~
Moderate sedation/analgesia	Review of 5 cases
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	2 observed procedures
Urogynecology	2 observed procedures
Maternal-Fetal Medicine	Observed care of 2 patients

Individual Proctoring Plan for Non-UCSF Resident or Fellow:

OBSTETRICS	
Outpatient clinic: obstetrics	Review of 5 medical records
Basic ob.gyn ultrasound (IUP, dating, etc)	Interpretation of 5 ultrasound exams
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, lac repair)	Observed care of 5 patients, including 2 Cesarean deliveries
GYNECOLOGY	
Outpatient clinic: gynecology	Review of 5 medical records
Inpatient gynecology and gynecologic surgery	5 observed operative procedures including one laparotomy and one laparoscopy
Emergency gynecology and gynecologic surgery	3 reviewed operative procedures including at least one laparoscopy
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	3 observed operative procedures
Laser therapy	2 observed procedures
~~Hysteroscopic sterilization~~	~~2 observed procedures~~
Moderate sedation/analgesia	Review of 5 cases
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	3 observed procedures
Urogynecology	3 observed procedures
Maternal-Fetal Medicine	Observed care of 3 patients

C. QUALIFICATIONS OF PROCTORS

1. Proctoring will be carried out by Active members of the staff who enjoy unrestricted privileges in the category subject to proctoring.
    a. In certain cases, the proctoring of privileges, which are not held by another member of the Active Staff, may be performed by a Board-Certified Member of the Active Staff at the direction of the Chief of Service. At the discretion of the Chief of Service, such proctoring may be supplemented by consultation with a physician who holds unrestricted privileges in that category at another affiliated hospital (UCSF affiliated), or who holds unrestricted privileges in a similar field at Zuckerberg San Francisco General Hospital & Trauma Center
2. One or two primary proctors will be assigned for each individual, but this does not preclude other members from service as proctors in individual cases.

V. EDUCATION OF MEDICAL STAFF

The CME requirements set forth in the current ZSFG Bylaws, Rules and Regulations of the Medical Staff of

Zuckerberg San Francisco General Hospital & Trauma Center shall apply as the minimum required by the Department. The Obstetrics & Gynecology Clinical Service members are encouraged to attend UCSF department courses for CME credits.

VI. OB/GYN CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that house staff assumes progressively increasing responsibility for patient care according to their level of training ability and experience. House Staff providing clinical services shall do so only under the supervision of active or courtesy medical staff that have ultimate responsibility for patient care, are members of the University of California, San Francisco Faculty, and have appropriate clinical privileges. Details are in Appendix B. A summary is below.

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSESTAFF

House staff care for patients under supervision of attending physicians in all clinical settings described in I.A. Scope of Service. Attending physicians are immediately available for consultation in all clinical settings.

Attending physicians are present 24 hours per day to supervise all deliveries and surgical procedures. Guidelines for calling the Attending in other situations are disseminated to the residents yearly and are available on the residents' website.

B. RESIDENT EVALUATION PROCESS

The Ob/GYN residency program has a robust system for monitoring and evaluating competencies of residents. It includes electronic global evaluations by multiple faculty members every 6 weeks, assessment of surgical competency for benchmark cases (e.g. R1=Cesarean: R2=Laparoscopy; R3=Abdominal Hysterectomy; R4=Vaginal Hysterectomy), assessment at weekly case conferences, and assessment in surgical skills labs and obstetric simulations. The Ob/Gyn Residency program's evaluation system for accessing competency of its residents has been approved by the ACGME. Residents' evaluations are reviewed twice yearly with the resident by the Residency Program Director or Associate Director. Their contracts are renewed annually assuming clinical, educational and professional competencies have been met. Remediation or discipline occurs as necessary according to the UCSF GME Guidelines.

C. ABILITY TO WRITE PATIENT CARE ORDERS

1. House staff may write patient care orders with the following exceptions:
    a. DNR;
    and
    b. AMA.

VII. OB/GYN CLINICAL SERVICE CONSULTATION CRITERIA

The Obstetric or Gynecology On-Call resident physician is notified via EMR of inpatient consultation requests. Attending physicians supervise all inpatient consultations. For outpatient consultations, the electronic medical record system is used.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital & Trauma Center Medical Staff Bylaws, Rules and Regulations, which include provision for due process where applicable, will govern all disciplinary action involving members of the ZSFG OB/GYN Clinical Service.

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY (PIPS)

The Department of Obstetrics, Gynecology and Reproductive Sciences at Zuckerberg San Francisco General Hospital & Trauma Center is committed to a systematic and comprehensive program of Quality Improvement, through the PIPS program, in an effort to promote the highest possible standard of care for patients.

A. GOALS & OBJECTIVES

1. Demonstrate a commitment to continuous improvement in obstetrical and gynecological services;
2. Objectively examine aspects of care in order to improve the overall services of the department;
3. Monitor morbidity and mortality to reduce them to the lowest possible rate;
4. Facilitate a multi-disciplinary approach to the assessment and development of health care services;
5. Ensure that the delivery of sexual and reproductive health care by personnel in training is competently and fully supervised;
6. Pursue opportunities to continually improve the patient care experience, including patient satisfaction with services delivered;
7. Implement and document actions to improve care with follow-up, periodic review, and evaluation; and
8. Provide ongoing education on approach and methods of continuous quality improvement and utilization management.

B. RESPONSIBILITY

Overall responsibility for monitoring and evaluation of this program is assigned to the Chief of Service. The departmental Quality Improvement committee and the data assistant facilitate implementation of this program. All members of the department are expected to actively participate in the Quality Improvement (QI) activities outlined in this program.

1. Chief of Service
    a. Assures that care delivered by Medical Staff meets acceptable standards;
    b. Assures that the monitoring and evaluation encompasses the full scope of care delivered;
    c. Investigates any specific cases where the quality of care has been questioned: evaluates, takes corrective action as needed, and implements follow-up plans;
    d. Facilitates formation of strategies for resolution of identified problems and monitors progress;
    e. Works collaboratively with other departments and services for resolution of issues that require interdepartmental cooperation;
    f. Assures reporting of potential litigation events to the UC Risk Manager;
    g. Assures that the systematic review of patterns of practice and clinical trends are an integral part of the staff evaluation and provider credentialing process;
    h. Disseminates the results of QI activities to clinic chiefs and individual providers, as appropriate; and
    i. Appoints a departmental Director of Quality Improvement.

2. Departmental Quality Improvement Committee
    a:Identifies potential QI activities
    b. Reviews on-going contribution of activities to continuous improvement of patient care.
    c. Is chaired by the departmental Director of Quality Improvement.
3. The QI Data Assistant
    a. Provides administrative support to departmental members for selected QI activities.
    b. Performs and monitors documentation of QI activities to assure completeness and consistency.
    c. Work under the direction of the Chief and MSO to perform data retrieval.
4. Medical Providers (Physicians, Residents, CNMs, and Nurse Practitioners)
    a. Participate in assigned Medical Staff Committees (according to hospital by-laws).
    b. Participate in peer evaluation of performance as requested.
    c. Maintain departmental standards by incorporating quality improvement into clinical practice.
    d. Report unusual occurrences (events/trends) outside the expected outcome to UC Risk Management.

e
6. Non-Medical Departmental Clinic Staff
    a. Work with the Medical Staff to deliver quality patient care.
    b. Work as members of multi-disciplinary groups to address problems identified as a result of QI activities.
    c. Perform QI activities to identify areas for potential improvement in patient satisfaction and

experience.

d. Serve as patient advocates regarding the care experience.

7. ZSFG Quality Management Staff

a. Organize and support the departmental QI activities by obtaining requested data and assuring that there is support staff to document the proceedings; and

b. Perform assessment on institution-wide indicators.

C. REPORTING

1. Results of Quality Improvement activities are disseminated in the following manner:

a. Results of department-specific activities reviewed by the QI Committee are shared with department faculty at least quarterly;

b. Summary information is presented to the ZSFG Medical Staff Quality and Utilization Management Committee on a semi-annual basis;

c. Minutes of all meetings in which quality improvement activities are discussed are distributed to appropriate staff and faculty. Copies of all minutes are maintained electronically; and

d. Feed-back information is provided to all parties involved in QI or peer-review actions.

2. Access to documents produced by the QI Program outside the department is limited to: Chief of Staff; Chair, Medical Staff Quality and Utilization Management Committee; and Risk Managers. Additional access may be granted at the discretion of the Chief of Service.

3. The Chief of Service is responsible for addressing patient care problems which involve other clinical services. This responsibility may be delegated to the appropriate section directors.

4. Patient care will be referred to the Hospital PIPS Committee when:

a. They consistently cross clinical service/departmental lines;

b. Further assistance is needed in their resolution;

c. Operational link with risk management when deemed necessary by the Chief of the Service or the PIPS Chief.

D. CLINICAL INDICATORS

1. Indicators are used to monitor the outcome or process of the provision of care. Thresholds (TH) are targets for clinical performance, using current literature or aggregate hospital experience, and are established for each indicator developed. Indicators above threshold are observed closely and/or investigated. If they remain above threshold, investigation is begun

2. Indicators for obstetrics, gynecology, and abortion services will be recommended by the Quality Improvement Committee to the department as a whole. Review of indicators will occur at least once a year, or more often as needed.

3. On a periodic basis (not to exceed once a month), the QI Data Assistant (or designee) will review all medical records of patients admitted to the obstetrical, gynecologic, and abortion services once discharged. Each record will be evaluated to determine whether an indicator definition is met.

4. When an indicator is present, the medical record of the case will be reviewed as follows.

a. All cases with indicators are reviewed. One Ob case per week, and one gyn case per 5 weeks is reviewed at Ob or Gyn M&M conference with a focus on systems issues, communication and areas in which care might have been improved. Those casesthat are not reviewed in M&M are referred to a clinician reviewer to review.

b. Each case is evaluated by clinician(s) who completes the M&M Review Forms (see Appendix D) and designates whether there is no deficiency, suggestion to clinician, room for improvement, or deficiency. For cases presented in M&M conference, designations are determined via consensus of clinicians present at the conference. For cases individually reviewed, it is up to the discretion of the reviewer to request additional opinions if needed. The reviewer also determines whether the case should be referred to the Peer Review Committee. If the attending of the case is not present at the M&M conference, a copy of the evaluation form is sent to them for review.

c. The QI Data Assistant tracks the status of all medical records being reviewed by clinician reviewers.

5. The QI Data Assistant keeps statistical records regarding patient cases reviewed, the percentage of cases that met the definition of an indicator, a comparison of observed indicator rates to established thresholds, and the percentage distribution of the dispositions of cases reviewed by clinician reviewers. These statistical summaries are presented to the Quality Improvement Committee and evaluated by the Chief of Service (or designate) prior to reappointment to medical staff.

E. QUALITY OF CARE INDICATORS

1. Inpatient Obstetrics
    1. Apgar score < 5 at 5 minutes (TH 2%)
    2. Cord UA pH less than 7.00 or base excess greater than -12 (TH 1%)
    3. Delivery of infant weighing < 1,200 grams (NA)
    4. C-Section for fetal indication (TH 5%)
    5. 4th degree laceration (TH 1%)
    6. Transfusion or greater than 1,500 cc of blood loss (TH 4%)
    7. Eclampsia (TH 1%)
    8. ICU Admission (TH 1%)
    9. Unplanned Return to OR (TH 1%)
    10. Unplanned removal, injury, or repair of an organ during surgery (TH 1%)
    11. Perinatal death (TH 1%)
    12. Maternal death (TH 1%)
    13. Readmission for PP complications (TH 2%)
    14. Surgical procedure on undelivered patient (TH 1%)
    15. Other [no threshold].

2. Inpatient Gynecology
    1. Unplanned readmission within 14 days (TH 4%)
    2. Admission/procedure after >1 vst to ER (TH 3%)
    3. Antibiotics >24 hrs after surg or adm (TH 5%)
    4. Unplanned admission of Come and Go patient (no 6G pt) (TH 5%)
    5. Unplanned admission to ICU (TH 2%)
    6. Unplanned return to the operating room (TH 3%)
    7. Unplanned removal, injury or repair of an organ during surgery (TH 4%)
    8. Death during admission (TH 0%)
    9. Hospital admission > 5 days (non-oncology pt) (TH 7%)
    10. Procedure time > 6 hours (non-oncology pts) Transfusion for intraoperative blood loss (TH 5%)
    11. Post operative transfusion (no 6G patients) (TH 3%)
    12. Development of infection not present on adm (TH 2%)

3. Women's Options Center
    1. Bleeding complications
        a. Transfusion
        b. UAE (IR)
    2. Damage to organs
        a. Cervical laceration requiring suture

b. Perforation
3. Anesthesia complications
4. Hospital admission
   a. Embolization
   b. Pain management
   c. Subsequent surgery
   d. Observation of bleeding
   e. No ride
   f. Other
5. Reaspiration
   a. Within 24 hours of original procedure
   b. After 24 hours of original procedure

F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

The focus of Quality Improvement activities is on high-volume (HV), high-risk (HR), or problem-prone (PP) services. Other aspects of care may be selected because of their direct relationship to patient satisfaction, which is also a focus of QI activities. The following aspects of care are selected for review and monitoring:

a. Inpatient Obstetrics: delivery Outcomes (HV)
b. Inpatient Gynecology: surgical and non-surgical outcomes (HV, HR)
c. Women's Options Center Services
   1. Conscious Sedation Monitoring Compliance (HR)
   2. Abortion Outcomes (HV)

1. Quality Improvement Committee
   a. The Committee meets at least quarterly, in sessions separate from regularly scheduled Department meetings.
   b. Membership
      1. Departmental Director of Quality Improvement (chair)
      2. Medical Director of the Obstetrics, Midwifery & Gynecology Outpatient Clinic
      3. Medical Director of the Women's Options Center
      4. Medical Director of the Family Birth Center
      5. Medical Director of Gynecology
      6. Nurse midwife representative (s)
      7. Representative to the ZSFG QI Committee
      8. Representative to the ZSFG Risk Management Committee
      9.
      10. QI Data assistant
      11. At large member(s), appointed by the department Chief of Service
      12. Chief of Service is an ex-officio, voting member
   c. Activities
      1. Present and discuss reports of hospital QI and Risk Management Committees
      2. Review indicator statistics and follow up of indicator cases
      3. Review report from departmental Peer Review Committee
      4. Review reports of M&M Conferences
      5. Designate, execute, and review focusedstudies to explore patterns observed

   d. Because the Department of Obstetrics, Gynecology and Reproductive Sciences at ZSFG is a part of a larger educational institution (UCSF), on-going education is an important component of its activities. Where additional educational needs are identified, interventions are scheduled as appropriate.
   e. Issues that cross departmental lines are referred by the Chief to the appropriate clinical or non- clinical department for evaluation and resolution. Further departmental involvement in efforts to improve these processes is assigned by the Chief or designee.
   f. Most issues require a multi-disciplinary approach, and with the assistance of the hospital Quality Management staff, groups are organized to assess the deficiencies and recommend steps for resolution, initiate responses, and evaluate results.

g. The Quality Improvement Program is reviewed periodically for effectiveness and evidence of improvement in patient care. Plans are made, at that time, to identify indicators for monitoring care in the upcoming period.

h. Problem Resolution

1. Assessment: patient care problems are assessed with an appropriate tool which may include:
    a. Medical records audit using pre-determined, clinically valid criteria
    b. Observation of clinical practice (see also Proctoring Plan)
    c. Fact-finding and discussion with clinical staff
2. Recommendations may include:
    a. Review of charts by attending physician or Section Directors.
    b. Education and training with unit staff.
    c. Procedure changes
    d. Staff meetings
    e. Equipment changes
    f. Development of standards of care.
    g. Individual staff remediation and appropriate disciplinary action
3. Remedial action for identified problems may include:
    a. Changing or creating new policies and treatment protocols
    b. Education of faculty, nursing staff, etc
    c. Proctoring and counseling
    d. Recommendations for equipment purchase and use
    e. Adherence to blood & fluid safety precautions, and infection control guidelines.

2. Peer Review Committee

a. The Peer Review Committee is expected to review clinical performance or professional behavioral issues regarding individual provider staff members.

b. Cases reviewed may arise from the following sources:
    1. Indicator cases referred to the Committee by a clinician reviewer;
    2. Cases from the M&M Conference identified as requiring peer review evaluation;
    3. Unusual Occurrence Reports (UORs) submitted to the Chief of Service; and
    4. Complaints from patients or staff submitted to the Chief of Service.

c. The Peer Review Committee will be composed of the physician and CNM members of the departmental Quality Improvement Committee.

d. The Peer Review Committee will meet “as needed” (if there are cases for review) after the completion of a Quality Improvement Committee meeting, or in extraordinary session if necessary.

e. A “Peer Review Committee Record” will be completed and stored in a secure location.

f. Peer Review Committee meetings will be closed to non-members and its proceedings will be considered to be confidential and protected by Section 1157 regulations.

3. Morbidity and Mortality (M&M) conferences

a. Separate Obstetrical Morbidity and Mortality (Ob M&M) and Gynecology Morbidity and Mortality (Gyn M&M) Conferences are held regularly and attended by all available active attending faculty and residents on service at Zuckerberg San Francisco General Hospital & Trauma Center.

b. During Ob and Gyn M&M we review cases of patients who delivered recently and who meet quality indicators requiring review. In addition, all cases that have met specific quality indicators are peer-reviewed. The process is discuss above.

e.

f. Additional Morbidity and Mortality Conferences are held monthly in conjunction with the Pediatric Department. This M&M Conference reviews all deaths and major morbidity, with special attention to readmissions, untoward drug effects, complications (by clinical indicator) and maternal

or fetal deaths.

4. Ongoing Professional Performance Evaluation (OPPE)
   a. Practitioner-specific information identified as a result of Peer Review and other QI activities are reviewed by the Chief as part of the reappointment process and every year. .
   b. Activity reports for Obstetrics, Gynecology and Family Planning and outpatient OBGYN clinics are created for all provider staff and are maintained in the departmental credentialing file. These reports include
   volume of cases, And number of those reviewed with "opportunity for improvement" or "deficiency" ratings.
   c. An OPPE form is completed by the Chief or designee each year to ensure adequate volume and quality of care for each clinician. This is supplied to us by the hospital.

5. Other Patient Care Conferences
   a. Pre-Operative Conference: Weekly review by multiple faculty of surgical plan for the following week's gynecologic operative cases.
   b. Gynecologic Tumor Board meets once monthly for treatment planning of gynecologic cancers at ZSFG.
   c. Ultrasound Conference occurs once monthly for review of Obstetric and Gynecologic Ultrasounds.
   d. Dysplasia case conference occurs weekly.
   e. High risk obstetrics case conferences occurs twice per week
   e. Ob/Gyn Medical Staff Meetings: The ob/gyn attending staff meets at least monthly. Patient care problems are discussed, solutions are recommended, and the resolution of problems tracked.

6. Ongoing Review of All OMG Charts
   a. All charts of medical students and unlicensed resident physicians are reviewed by the attending MD.
   b. Outpatient-only physicians who are Courtesy staff are paired with an Active staff member during clinical sessions so are subject to observation during the clinical session. Any quality issues that are noted by the Active staff physician are brought to the QI committee. In addition, 5 charts are reviewed at the time of re-appointment.

7. Unusual Occurrence (aka "SAFE" reports)
   a. All reports will be reviewed by the Chief of Service and Medical Director of the appropriate service (5M, 6G, H22 etc) who assigns review and response to responsible attending. A plan will be developed if quality of care has been compromised to ensure that the problem has been resolved.

8. Oral or Written Patient Complaints
   a. Oral or written patient complaints will be reviewed by the Chief of Service and Head Nurse and acted on or assigned for review and response to the responsible attending.

11. Missed Appointments
   a. All missed appointments are reviewed by the clinic nurse or clinician. When appropriate, another appointment is made. . If follow-up fails, the PCP is notified and/or a public health nurse can be called upon for assistance.

X. MEETING REQUIREMENTS

A. COMMITTEE MEETINGS

In accordance with ZSFG Medical Staff Bylaws 7.2.I, All Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

The OB/GYN Clinical Services shall meet as frequently as necessary, but at least monthly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

Refer to Appendix C for Committee Assignment for members of the OB/GYN Clinical Service.

B. FACULTY MEETINGS

All faculty must attend at least 75% of all regularly scheduled faculty meetings. Anticipated absenteeism should be communicated to the Chief of Service in a prompt manner.

Minutes of all faculty meetings will be maintained in the service, and distributed to all faculty members in a timely manner.

1. M&M Conferences
    a. Faculty are expected to attend any M&M conference wherein a patient they cared for is being discussed. If unable to attend, they are expected to learn about the proceedings of the M&M from an attendee. In addition, faculty are expected to attend at least 50% of either Ob or Gyn M&M Conferences according to their clinical duties. Outpatient only physicians do not have this requirement.

XI. ADDITIONAL OB/GYN SERVICE SPECIFIC INFORMATION

A. ATTENDING PHYSICIAN RESPONSIBILITIES

1. Obstetrics Service Attending
    a.
    b. The OB Attending is expected to be in-house and readily available during their shift, which may be overnight or a 24 hours. Responsibilities include:
        1. Conducting teaching rounds with house staff and students each weekday
        2. Attendance at all deliveries and other major procedures
        3. Supervision of house staff for all admissions, discharges and significant changes in the plan of care
        4. Review and co-sign all antenatal-testing procedures
        5. Review and co-sign all obstetrics ultrasounds performed by house staff
        6. Review of e-consults submitted to the Obstetrics and Gynecology services
        7. Collaboration with nursing staff to ensure effective, efficient, quality care.
        8. It is the responsibility of the attending to arrange for alternate coverage in situations of anticipated absence.
2. Gynecology Service Attending
    a.
    b. The GYN Attending will be responsible for the following:
        1. Attendance at all operative procedures scheduled by the team
        2. Coverage of emergency procedures
        3. Conducting teaching rounds with house staff and students each weekday
        4. Supervision of house staff for all ED and inpatient consult admissions, discharges and significant changes in plans of care
        5. Review of e-consults submitted to the Gynecology service
        6. Review and approval of all scheduled surgical cases
        7. It is the responsibility of the GYN Attending to arrange for alternate coverage in situations of anticipated absence.
4. Family Planning Service Attending
    a.
    b. The family Planning Attending will be responsible for the following:
        1. Attendance at all abortion surgical procedures
        2. Supervision of Family Planning Resident and medical students assigned to

Women's Options Center;

3. Supervision of pre-operative examinations;
4. Review and co-sign all ultrasounds performed by house staff; and
5. Collaboration with nursing staff to ensure effective, efficient, quality care.

5. 5M Outpatient Attending

b. The 5M Attending will be responsible for the following:

1. Attendance at the outpatient clinic from start to finish with only brief periods of absence to attend to other urgent clinical needs;
2. Supervision of all house staff and medical students in 5M;
3. Review and co-sign all ultrasounds performed by house staff and advanced practice providers in 5M;
4. Collaboration with nursing staff to ensure effective, efficient, quality care.

6. Night and Weekend Attending

a. The attending physician on nights and weekends is expected to be in-house and readily available at all times.

b. The Night and Weekend Attending will be responsible for the following:

1. Attendance at all deliveries (except those uncomplicated deliveries attended by a Certified Nurse Midwife or Attending Family Medicine Physician), unless concurrent clinical situations prevent such attendance;
2. Attendance at all surgical cases in the operating room.
3. Supervision of house staff for all ED and inpatient consults, admissions, discharges and significant changes in plans of care;
4. Review and co-sign all ultrasounds performed by house staff; and
5. The Night and Weekend Attending is expected to call in the back-up attending when the level of clinical activity jeopardizes adequate coverage of attending responsibilities.

7. Back-up Attending

a. A back-up attending physician is assigned at all times. During the day, the back-up attending is typically attending another service like clinic or Women's Options, which both have multiple attendings. On nights, holidays and weekends, a back-up attending is scheduled and expected to be available to be called in from home should the necessity arise.

b. The Back-up attending will be called in at the discretion of the Obstetrics Attending or at the request of the Ob/Gyn Chief Resident. The Back-up Attending will also be expected to fill in for the Obstetrics Attending in the event of illness or other urgent absence.

B. MEDICAL RECORDS

The members of the OB/GYN Clinical Service are committed to the maintenance of complete, accurate and timely medical records. The requirements are set forth in the Zuckerberg San Francisco General Hospital & Trauma Center Bylaws, and Rules and Regulations of the Medical Staff, which define the minimum standard for records in the clinical service. All operative procedures must include a pre-operative and post-operative note by the attending surgeon of record.

C. INFORMED CONSENT

All decisions for treatment should involve the active participation of the patient, and informed consent should be made after appropriate discussion of risks, benefits and alternatives.

Documentation of "Informed Consent" on Medical Staff-approved forms is required for all the following:

1. All surgical procedures performed in the operating room;
2. All procedures in which tissue is removed;
3. All procedures involving laser therapy;
4.
5.
7. Amniocentesis;
8. External cephalic version; and
9. IUD insertion, contraceptive implant insertion.

XII. ADOPTION AND AMENDMENT

The OB/GYN Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the OB/GYN Service annually via email or at an OB/GYN Clinical Service Meeting.

These Rules and Regulations may be adopted and revised on a voice vote of a majority of Active Staff members, providing that at least 72 hours' notice has been given.

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

XIII. APPENDIX A CLINICAL SERVICE PRIVILEGE FORM

Delineation Of Privileges

Obstetrics And Gynecology 2019

Provider Name:

Privilege	Requested	Approved	

I. **OBGYN OBSTETRICS and GYNECOLOGY 2019**

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

II. **CORE PRIVILEGES**

1.06 OUTPATIENT CLINIC: OBSTETRICS

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 50 clinic visits in the previous 2 years

a. Prenatal Care Visits, Both Low And High Risk Patients. If indicated for patient and/or provider safety, site may also include the patient's home, a community location, or another safe, private location.

b. Interpretation Of Fetal Monitoring

Treatment Of Medical Complications Of Pregnancy Including, But Not Limited To: Pregnancy Induced Hypertension, Chronic Hypertension, Diabetes Mellitus, Renal Disease, Coagulopathies, Cardiac Disease, Anemias And Hemoglobinopathies, Thyroid Disease, Sexually Transmitted Disease, Pulmonary Disease, Thromboembolic Disorders, Infectious Disease, Ectopic Pregnancy, Early Pregnancy Failure, First Trimester Bleeding and Miscarriage Management.

2.06 BASIC OB/GYN ULTRASOUND

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: Interpretation of 5 ultrasound exams. Interpretation of 3 ultrasound exams for UCSF-trained Fellows/Residents.

REAPPOINTMENT: Interpretation of 10 ultrasound exams in the previous two years

a. Localization Of Intrauterine Pregnancy (Ie. Diagnose Iup)

b. Estimation Of Gestational Age, Fetal Weight

c. Fetal Presentation
d. Evaluation Of Vaginal Bleeding, Placental Location
e. Measurement Of Cervical Length
f. Amniotic Fluid Estimation (AFI)

3.06 INPATIENT OBSTETRICAL CARE

Provider Name:

Privilege	Requested	Approved	

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Note: Procedures marked with an asterisk may only be performed by obstetrician gynecologists, unless the physician has received additional obstetrical training and experience and has been approved by the Chief of OB/GYN & RS to perform these procedures.

PROCTORING: Observed care of 3 patients, each of whom has received at least one of the procedures below. For UCSF-trained residents and fellows: observed care of 2 patients, each of whom has received at least one procedure below.

REAPPOINTMENT: 15 procedures in the previous two years

a. Routine Inpatient Antepartum, Intrapartum, And Postpartum Care
b. Management Of Spontaneous And Induced Labor
c. Pudendal Block* And Local Anesthesia
d. Fetal Assessment, Antepartum And Intrapartum
e. Internal Fetal Monitoring
f. Normal Cephalic Vaginal Delivery
g. Episiotomy And Repair, Including 1St And 2Nd Degree Lacerations
h. Exploration And Repair Of The Vagina And Cervix
i. Deliver Placenta

j. Evaluate, Diagnose, Treat, And Provide Consultation For Medical Conditions Complicating Pregnancy (Beyond That Contained In Routine Inpatient Antepartum,
Intrapartum, And Postpartum Care)*

k. Fetal Scalp Sampling*
l. Tubal Ligation, Post-Partum*
m. Non-Genetic Amniocentesis*
n. Forceps Delivery*
o. Delivery By Vacuum Extraction*
p. Manual Or Instrumental Extraction Of The Placenta And Fragments*
q. Cesarean Section (Primary Surgeon)*
r. Treatment of Cervical Insufficiency (Cervical Cerclage))*
s. External Version Of Breech Presentation*
t. Vaginal Breech Delivery*
u. Vaginal Multiple Fetus Delivery*
v. Repair Of Rectal Injury (3rd And 4th Degree Laceration)*
w. Cesarean Hysterectomy*

Provider Name:

Privilege	Requested	Approved	

x. Vaginal Birth After Caesarean Section*

y. Pregnancy Termination Via Labor Induction*

4.06 OUTPATIENT CLINIC: GYNECOLOGY

Evaluate, diagnose, treat, and provide consultation, pre-and post-operative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgical disorders and injuries of the mammary glands. When inpatient gynecologic care privileges have been approved, procedures in this privilege group also can be performed in the hospital operating room.

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: Review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 50 clinic visits in the previous 2 years

a. Preventive Health Visits: Well Women, Family Planning Visits
b. Problem-Oriented Gynecologic Visits
c. Microscopic Diagnosis Of Urine And Vaginal Smears
d. Colposcopy
e. Vulvar, Vaginal And Cervical Biopsy
f. Endometrial Biopsy
g. Cervical Or Endometrial Polypectomy
h. Insertion And Removal Of Intrauterine Contraceptive (IUC)
i. Insertion And Removal Of Contraceptive Implant
j. Pessary Fitting
k. Trigger Point Injection
l. Cryosurgery (Cervix, Vulva, Vagina)
m. Loop Electrosurgical Excision Procedure (LEEP), Cervix
n. Bartholin Duct Procedures (Incision And Drainage, Marsupialization)
o. Dilation And Curettage, Suction Curettage And Manual Uterine Aspiration, Including Abortions Up To 18 Weeks' Gestation

p. Simple Cystometry
q. Paracervical And Intracervical Block
r. Insertion Of Cervical Dilator
s. Anoscopy

5.06 INPATIENT GYNECOLOGY AND GYNECOLOGIC SURGERY

Provider Name:

Privilege	Requested	Approved	

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 5 observed operative procedures, including at least one laparotomy and one laparoscopy.

REAPPOINTMENT: 15 operative procedures in the previous two years

a. Admission Of Patients With Gynecologic Issues

b. Care Of Admitted Post-Op And Non-Operative Gyn Patients
c. Repair Of Vaginal, Vulvar Or Cervical Lacerations
d. Drainage Or Removal Of Pelvic Abscess (Vaginal, Laparoscopic Or Open)
e. Placement Of Intra-Uterine Balloon Catheter To Manage Bleeding
f. Excision, I&D Or Surgical Management Of Vulvar Or Vaginal Lesions And Abscesses
g. Dilatation And Curettage, Suction Curettage, Manual Uterine Aspiration; Diagnostic Or Therapeutic, Including Abortions Up To 18 Weeks' Gestation

h. Cervical Cone Biopsy, LEEP Procedure
i. Hysterectomy, Abdominal
j. Hysterectomy, Vaginal
k. Hysterectomy, Laparoscopic-Assisted Or Total Laparoscopic
l. Exploratory Laparotomy
m. Adnexal Procedures (Open Or Laparoscopic) Such As: Salpingectomy, Salpingostomy, Oophorectomy, Ovarian Detorsion, Ovarian Cystectomy, Ovarian Biopsy, Salpingo-Oophorectomy

n. Myomectomy, Abdominal Or Vaginal

o. Incidental Appendectomy
p. Fistula Repairs (Vesicovaginal Or Rectovaginal)
q. Repair Simple Rent/ Tear Of Bowel Or Bladder
r. Perineoplasty, Labiaplasty
s. Repair Of Cystocoele, Rectocele, Enterocele
t. Tuboplasty
u. Hernia Repair (Incisional Or Umbilical)
v. Paracentesis
w. Wound Management: I&D, Skin Debridement Wound Dehiscence, Wound Closure
x. Cytoscopy

Provider Name:

Privilege	Requested	Approved	

y. Hysteroscopy: Diagnostic Or Operative Including Polypectomy, Myomectomy,Adhesiolysis, Septum Removal, Endometrial Ablation
z. Laparoscopy, Diagnostic Or Operative Including Adnexal Procedures, Management Of Ectopic, Chromopertubation, Adhesiolysis, Biopsy, Fulgaration Or Excision Of Endometriosis, Myomectomy

aa. Tubal Sterilization With Cautery, Rings, Or Clips

bb. Non-Hysteroscopic Endometrial Ablation Techniques: Hta, Thermal Balloon, Nova-

cc. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgical privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be for their expertise in gynecologic surgery.

6.06 EMERGENCY GYNECOLOGY AND GYNECOLOGIC SURGERY

Evaluate, diagnose, treat, and provide consultation, inpatient care and pre-and post-operative care necessary to correct or treat female patients of all ages presenting urgently or already hospitalized with injuries and disorders of the female reproductive

system and the genitourinary system such as ectopic pregnancy, adnexal torsion, ruptured ovarian cyst, miscarriage, reproductive infections, uterine bleeding and trauma.

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 3 observed operative procedures including at least one laparoscopy.

REAPPOINTMENT: 15 procedures in the previous two years including at least 4 laparoscopies or laparotomies

a. Admission Of Patients With Gynecologic Issues
b. Care Of Admitted Post-Op And Non-Operative Gyn Patients
C. Surgical And Non-Surgical Treatment Of Ectopic Pregnancy And Suspected Ectopic
d. Surgical And Non-Surgical Treatment Of Miscarriage
e. Placement Of Intra-Uterine Balloon Catheter To Manage Bleeding
f. Exam Under Anesthesia
g. Excision, I&D Or Surgical Management Of Vulvar And Vaginal Lesions And Abscesses
h. Dilatation And Curettage, Suction Curettage, Manual Uterine Aspiration; Diagnostic Or Therapeutic, Including Abortions Up To 18 Weeks' Gestation.
i. Exploratory Laparotomy
j. Diagnostic Laparoscopy, Lysis Of Adhesions
k. Adnexal Procedures (Open Or Laprascopic) Including: Salpingectomy, Salpingostomy, Oophorectomy, Ovarian Cystectomy, Ovarian Drilling, Ovarian Biopsy, Ovarian Detorsion, Oophoropexy
l. Drainage Or Removal Of Pelvic Abscess (Vaginal, Laparoscopic Or Open)

Provider Name:

Privilege	Requested	Approved	
m. Repair Of Vaginal, Vulvar Or Cervical Lacerations And Trauma			
n. Myomectomy, Abdominal Or Vaginal			
o. Repair Simple Rent/Tear Of Bowel Or Bladder			
p. Paracentesis			
q. Wound Management: Skin Debridement, Wound Dehiscence, Wound Closure			
r. Cystoscopy			
s. Emergent Hysteroscopy			
t. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgical privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be for their expertise in gynecologic surgery.			

III. 24.10 WAIVED TESTING PRIVILEGES

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

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

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

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

a. Fecal Occult Blood Testing (Hemoccult®)
b. Vaginal Ph Testing (Ph Paper)
c. Urine Chemstrip® Testing
d. Urine Pregnancy Test (Sp® Brand Rapid Test)

IV. SPECIAL PRIVILEGES

1.25 ABORTIONS GREATER THAN 18 WEEKS' GESTATION

(Also Request 24.25 To Practice In Women'S Options Center)

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 3 observed operative procedures. 2 observed operative procedures for UCSF- trained Fellows/Residents.

REAPPOINTMENT: 10 procedures in the previous two years

a. Abortions by dilation and evacuation at greater than 18 weeks' gestation

Provider Name:

Privilege	Requested	Approved	

b. Intra-Fetal Or Intra-Amniotic Injection

2.25 LASER THERAPY

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Appropriate training, complete the laser safety module prepared by the SFGH Laser Safety Committee at http://insidechnsf.chnsf.org/det/HealthStream.htm and baseline eye examination within the previous 1 year.

PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at SFGH. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at SFGH.

a. Laser Therapy Of The Cervix
b. Laser Therapy Of The Vagina, Vulva, And Perineum
c. Laser Conization Of The Cervix

3.25 HYSTEROSCOPIC STERILIZATION

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

TRAINING AND PROCTORING:

1. Providers must be trained in hysteroscopy and have current gynecologic endoscopy privileges in the SFGH Department of Obstetrics and Gynecology
2. As required by the FDA, the physician must attend a training course sponsored

by the manufacturer of the Essure System (Conceptus)

3. After training, the provider must be proctored for two Essure procedures. Proctoring may be performed at SFGH by a provider privileged for this procedure at SFGH or may be proctored at an outside institution by a qualified provider
4. Once proctoring has been completed, certification in the Essure procedure will be issued by Conceptus. This certification is a required prerequisite for approval of this privilege at SFGH.
5. Providers who have been certified by Conceptus at another institution may apply for this privilege at SFGH after being proctored for one procedure by an SFGH physician who currently holds the privilege.

REAPPOINTMENT: 2 operative procedures in the previous two years

a. Essure Tubal Occlusion Procedure

4.25 UROGYNECOLOGY

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 15 operative procedures in the previous two years

Provider Name:

Privilege	Requested	Approved	

a. Urodynamics
b. Intravesical and Intraurethral Injections
c. Abdominal Bladder Neck Suspension Procedures
d. Vaginal Bladder Neck Suspension Procedures
e. Vaginal Vault Suspension Procedures
f. Urethral Procedures: Dilation Of Urethral Stricture
g. Colpocleisis

5.25 PROCEDURAL SEDATION

Procedural sedation privilege is required for those who will work in Women's Options Center.

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

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

Association PROCTORING: Review of 5 cases. Review of 5 cases for UCSF-

Fellows/Residents.

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

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

1.43 GYNECOLOGIC ONCOLOGY

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

Current certification or active participation in the examination process leading to subspecialty certification in gynecologic oncology by the American Board of Obstetrics and Gynecology

PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 15 operative procedures in the previous two years, at least 5 of which are performed at SFGH

a. Evaluate, Diagnose, Treat, And Provide Consultation And Treatment To Female Patients With Gynecologic Cancer And Complications Resulting There From, Including Carcinomas Of The Cervix, Ovary, Fallopian Tubes, Uterus, Vulva, And Vagina And The Performance Of Procedures On The Bowel, Urethra, And Bladder As Indicated.

b. Radical Hysterectomy For Treatment Of Invasive Carcinoma Of The Cervix

Provider Name:

Privilege	Requested	Approved	

c. Radical Surgery For Treatment Of Gynecologic Malignancy To Include Procedures On Bowel, Ureter, Or Bladder, As Indicated

d. Treatment Of Invasive Carcinoma Of Vulva By Radical Vulvectomy
e. Treatment Of Invasive Carcinoma Of The Vagina By Radical Vaginectomy

2.43 MATERNAL-FETAL MEDICINE

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Successful completion of postgraduate training program in Maternal and Fetal Medicine and current certification or active participation in the examination process leading to subspecialty certification in maternal and fetal medicine by the American Board of Obstetrics and Gynecology.

PROCTORING: Observed care of 3 patients

REAPPOINTMENT: Care of 20 patients in the previous

2 years

a. Evaluate, Diagnose, Treat, And Provide Consultation Regarding Patients With Medical And Surgical Complications Of Pregnancy Such As Maternal Cardiac, Pulmonary, Metabolic, Connective Tissue Disorders, And Fetal Malformations, Conditions, Or Disease

b. Genetic Amniocentesis And Chronic Villus Sampling.

c. Level 2 Obstetrical Ultrasound, Including Doppler

d. Invasive Fetal Procedures, Including Cordocentesis, Intrauterine Fetal Transfusion, Cardiocentesis, And Fetal Injections.

e. Management Of Labor, Operative Deliveries And Postpartum Care For High-Risk Obstetric Patients, Including Use Of Pudendal Block And Local Anesthesia, If Indicated.

f. Treatment Of Cervical Insufficiency (Cervical Cerclage)

3.43 ADDICTION MEDICINE

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

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

PROCTORING: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

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

1.51 DUAL DEPARTMENT APPOINTMENT

ONLY FOR THOSE WHO DO NOT HAVE A PRIMARY APPOINTMENT IN OB/GYN
Physicians trained in specialties other than obstetrics and gynecology may apply for dual appointment in the Department of Obstetrics and Gynecology for specified privileges, assuming that training and experience in a residency, fellowship, or clinical practice can be documented.

2.51 Women's Option Center Procedures (Dual Department Appointment Only)

Provider Name:

Privilege	Requested	Approved	

PREREQUISITES:

1. Successful completion of an ACGME accredited postgraduate training program in family medicine, internal medicine, or pediatrics
2. Current medical staff appointment to a SFGH clinical department (other than the Department of Obstetrics and Gynecology)
3. Completion of a fellowship program in family planning or documentation of training and experience in performing the requested procedures in residency, fellowship, or clinical practice. If a family planning fellowship has not been completed, clinical experience in the past 5 years of practice must include, at a minimum,
   - Insertion of contraceptive implants (5 procedures)
   - Insertion of intrauterine contraceptives (5 procedures)
   - Abortions up to 18 weeks' gestation (50 procedures)
   - Abortions greater than 18 weeks' gestation (50 procedures)
   - Basic obstetrical ultrasound as an adjunct to abortion (15 procedures)

PROCTORING:

- Insertion of contraceptive implants (2 procedures)
- Insertion of intrauterine contraceptives (2 procedures)
- Abortions up to 18 weeks' gestation (5 procedures)
- Abortions greater than 18 weeks' gestation (5 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (5 procedures)

REAPPOINTMENT (procedures in the past 2 years):

- Insertion of contraceptive implants (2 procedures)
- Insertion of intrauterine contraceptives (2 procedures)
- Abortions up to 18 weeks' gestation (10 procedures)
- Abortions greater than 18 weeks' gestation (10 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (10 procedures)

24.511 Insertion Of Contraceptive Implants (5 procedures)

24.512 Insertion Of Intrauterine Contraceptives (5 procedures)

24.513 Abortions Up To 18 Weeks' Gestation (50 procedures)

1.512 Abortions Greater Than 18 Weeks' Gestation (50 procedures)

2.512 Basic Obstetrical Ultrasound As An Adjunct To Abortion

24.61 LICENSED CLINICAL PSYCHOLOGIST

Provide individual counseling and psychotherapy at the New Generations Health Center

PREREQUISITES: Must hold a doctoral degree in Psychology from an approved APA accredited program and must be licensed by the State of California, Board of Psychology.

PROCTORING: Review of 5 cases by a clinical psychologist on the SFGH Medical

Staff. REAPPOINTMENT: Review of 3 cases by a clinical psychologist on the SFGH

Medical Staff.

24.65 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

Provider Name:

Privilege	Requested	Approved	

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

Applicant Date

V. **APPROVED BY**

Division Chief Date
Service Chief Date

XIV. APPENDIX B. HOUSESTAFF COMPETENCIES AND SUPERVISON

House Staff providing clinical services shall do so only under the supervision of active or courtesy medical staff who have ultimate responsibility for patient care, are members of the University of California, San Francisco Faculty, and have appropriate clinical privileges.

A. ATTENDING RESPONSIBILITY

Zuckerberg San Francisco General Hospital & Trauma Center Medical Staff Bylaws, JCAHO Standards and California law require that the attending physician oversee and assume ultimate responsibility for the care of each patient. Accordingly, house staff shall be always supervised by and accountable to a member of the ZSFG Medical Staff with a University of California faculty appointment. In order to discharge that responsibility, close supervision and active participation in decision-making is required.

1. Inpatient Attending Rounding/Supervision
    a. The attending physician will discuss the management of the patient with House Staff at least once a day and as necessary in light of material changes or developments in the patient's clinical status.
    b. The attending physician will be available and participate in major decision-making (.e.g., DNR, admission, or discharge orders) at all times.

2. Outpatient Attending Supervision
    a. Attending physicians will oversee the care provided to all outpatients. Attending physicians are assigned to specific outpatient sessions, which may vary from week to week. Attending physicians will be physically present in the outpatient clinics to supervise the care provided by house staff. It is the attending physician's responsibility to arrange coverage for absences.

3. Attending Supervision of Major Procedures/Complex Medical Treatments
    a. The attending physician will provide direct supervision for the main portion of all major operative procedures, including all surgery performed in the main operating room, the Birth Center, and 6G, and all advanced outpatient procedures (e.g. hysteroscopy, cystoscopy, and electro-excisional procedures of the cervix). The attending physician will determine each house staff officer's scope of practice and level of supervision required according to the year of post-graduate training and demonstrated clinical skills.

4. Attending Supervision of Informed Consent Process
    a. All patients with medical decision-making capacity must be given adequate information about the risks, benefits, and alternatives for any treatment, operation, or special diagnostic or therapeutic procedure, which involves significant risk of bodily harm.
    b. The attending physician is responsible for ensuring adequate disclosure is made prior to procedures requiring informed consent, for supervising the informed consent process and ensuring appropriate documentation in the medical record. The attending physician may delegate the task to a licensed physician, but the attending physician should document his or her confirmation that informed consent was obtained in the medical record prior to the procedure.
    c. The patient has a right to know the names and professional relationships of the physicians involved in her medical care. Accordingly, the patient shall be informed which attending physician will be supervising the procedure and, prior to the procedure, when a different attending physician is substituted
    due to scheduling changes, etc.
    d. In the event of a medical emergency, when immediate services are required to alleviate severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required, if delay of such treatment would lead to serious disability or death, the treating physician, preferably the attending, should document the existence and nature of the emergency and the necessity of the proposed or rendered treatment. There is no requirement that the physician seek consultation ("the two attending" rule).

B. HOUSE STAFF RESPONSIBILITES

1. House Staff Compliance

a. House Staff shall comply with the ZSFG Medical Staff Bylaws, Rules and Regulations, Departmental Rules and Regulations, Hospital Policies and Procedures and the Principles of Medical Ethics of the American Medical Association and participate in the ZSFG PIPS and Risk Management Programs.

2. Responsibilities

a. House Staff will be able to always identify an available supervising attending physician during patient care. House staff must consult the attending physician, directly or through the chain of command, as appropriate, prior to material changes in the plan of care of a major surgical or obstetrical procedure.

b. House staff should not proceed with the care or procedure unless and until there is meaningful consultative interaction with the Attending physician, directly or through the chain of command, as appropriate.

c. House Staff must consult the attending physician, directly or through the chain of command, as appropriate, with questions or concerns regarding patient care and when the plan of care requires that house staff undertake at treatment outside the House Staff member's level of commensurate with his or her level of advancement and responsibility.

C. MEDICAL RECORDS DOCUMENTATION BY ATTENDINGS/HOUSE STAFF

These are delineated in Section XI.B of the OB/GYN Clinical Service Rules and Regulations. Operative reports, discharge summaries, and consultation notes may be written or dictated by House Staff as appropriate but must ultimately be reviewed and signed by the attending physician.

D. HOUSE STAFF EVALUATION AND DISCIPLINARY ACTION

1. Evaluation

a. House staff are evaluated informally by more senior house staff and by attending physicians as clinical rotations are underway. A formal electronic evaluation is compiled at the end of each rotation, kept on file by the Residency Program, and distributed to the resident and his or her faculty advisor. Residents are not advanced to the next postgraduate training year without successful completion of clinical rotations, the annual in-service examination, any delinquent medical records, and their personal house staff experience statistics.

2. Disciplinary Action: disciplinary actions may occur at the direction of the Residency Program.

XV. APPENDIX C- OB/GYN CLINCAL SERVICE ORGANIZATION CHART

Chief of Service,	Rebecca Jackson, MD
Medical Director Obstetric Service	Ben Li, M.D.
Medical Director Gynecology Service	Josie Urbina, M.D.
Medical Director, OMG Clinic	Anna Altshuler, MD
Perinatal Coordinator, OMG Clinic	Savannah Washington, CNM.
Medical Director, Women's Options Center	Eleanor Drey, MD, EdM
Site Director, Resident Education & Training	Biftu Mengesha, M.D., M.A.S.
Site Director, Medical Student Education	Naomi Stotland, M.D.
Medical Director, Reproductive Infections	Nika Seidman, M.D., M.A.S.
Chair of Midwifery Council	Kara Myers, CNM
Director of Quality Improvement	Ana Delgado, CNM

MEDICAL STAFF COMMITTEE ASSIGNMENTS

Ambulatory Care Committee	Anna Altshuler, MD
Credentials Committee	Anna Altshuler, M.D., Kara Myers, CNM
Interdisciplinary Practice	Kara Myers, CNM
Medical Executive Committee	Rebecca Jackson, M.D.
Operating Room Committee	Josie Urbina, M.D.
Performance Improvement & Patient Safety (PIPS)	Ana Delgado, CNM.
Perinatal Linkage Committee	Ana Delgado, CNM
Clinical Practice Group	Rebecca Jackson MD
Risk Management Committee	Rebecca Jackson, MD
Transfusion Committee	Naomi Stotland, MD
Moderate Sedation Committee	Eleanor Drey, MD EdM
Ethics Committee	Yasaswi Kislovskiy, MD and Eleanor Drey, MD, EdM

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

XVI APPENDIX D OB/GYN M&M REVIEW FORMS

A.

Zuckerberg San Francisco General Department of OB/GYN
Quality Assurance Committee Confidential Peer Review — Obstetrics

MRN:	
Delivery date:	
Indicator date (if different):	
Indicators identified:	

Clinical Summary:

Apgars at 1/5/10 minutes: ____/____/____ CUA:_____ CUV:_____

Impact of structural determinants of health on hx/outcomes:

SYSTEMS ISSUES (this will be used to keep track of systems issues identified over time)

Contributing factors in this case included: (check all that apply, add detail for clarity):

☐ Fetal monitoring	
☐ Orientation/training	
☐ Competency (knowledge/skill deficit)	
☐ Communication among staff	
☐ Communication with patient/family	
☐ Policies/procedures/rules	
☐ Staffing/fatigue	
☐ Equipment failure	
☐ Medication issue	
☐ Adequate time given to process information during informed consent	
☐ In-person interpreter used	
☐ Telephone interpreter used	
☐ Family and chosen support people able to participate in decision-making	

Please answer if it applies:

Was a team debrief done?	☐ Yes	☐ No		PPH guidelines used	☐ Yes	☐ No	
Code OB used effectively	☐ Yes	☐ No		VAVD worksheet used	☐ Yes	☐ No	
C/S decision grades used effectively	☐ Yes	☐ No		Shoulder worksheet used	☐ Yes	☐ No	

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San Francisco, CA 94110

Reviewer's Comments (Include specific suggestions to clinicians and explanations of any OI or deficiency; include systems issues from debrief form if relevant)

Designations* (Fill in for key providers/ decision-makers only; this will be used for OPPE. Individual providers will be notified of their designation.)

Provider Name	Designation**		Comments (optional)
	☐ No deficiency ☐ Opp for improv	☐ Suggestion ☐ Deficiency	
	☐ No deficiency ☐ Opp for improv	☐ Suggestion ☐ Deficiency	
	☐ No deficiency ☐ Opp for improv	☐ Suggestion ☐ Deficiency	
	☐ No deficiency ☐ Opp for improv	☐ Suggestion ☐ Deficiency	
	☐ No deficiency ☐ Opp for improv	☐ Suggestion ☐ Deficiency	

* For all deficiencies reviewers are expected to notify involved providers by phone call or in person (or choose someone to do so). For key providers, regardless of designation, peer review forms will be securely emailed.

**Definitions:

- *No deficiency*: Care provided was appropriate.
- *Suggestion to clinician*: Care was appropriate, but suggest alternative management possibilities.
- *Opportunity for improvement*: A different course of action likely would have improved care or outcome; insufficient documentation of care; incomplete perioperative evaluation.
- *Deficiency*: A deficiency in management resulted in a potential or actual avoidable injury to a patient.

Injury: (only if OI or Def)	
☐ None	☐ Long-term morbidity
☐ Short-term morbidity	☐ Death
Action:	
☐ No further action	☐ Refer to QI committee

Reviewed by _____ **Date** _____

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B.

Zuckerberg San Francisco General Department of OB/GYN

Quality Assurance Committee Confidential Peer Review—Gynecology

MRN:	Clinical indicator(s):
Discharge date:	

Clinical Summary:

Reviewer's Comments:

Reviewed by _____ Date _____

Conclusions:	Faculty	House staff	Other
No deficiency	☐	☐	☐
Suggestion to clinician	☐	☐	☐
Opportunity for improvement	☐	☐	☐
Deficiency	☐	☐	☐

If deficiency or Opportunity for improvement, describe:

☐ Attending /CNM present – OR – Date Attending/CNM notified _____

Injury:
☐ None ☐ Short-term morbidity
☐ Long-term morbidity ☐ Death

Action:
☐ No further action
☐ Refer to QI Committee

QI Committee Actions:

Date _____

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Revised 11/17/2012

OB/GYN CLINICAL SERVICE RULES AND REGULATIONS

~~2023~~

2025

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

OB/GYN CLINICAL SERVICE
RULES AND REGULATIONS
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I. OB/GYN CLINICAL SERVICE ORGANIZATION

The Rules and Regulations of the Clinical Service of Obstetrics, Gynecology and Reproductive Sciences define certain standards of practice and other rules for members of the clinical service.

Standards of clinical practice will be consistent with those standards established by the American College of Obstetricians and Gynecologists, as set forth in the document, Standards for Obstetric Gynecologic Services. If any apparent conflict exists, the standard defined in this document will prevail.

These Rules and Regulations will supplement those set forth in the ZSFG Bylaws, Rules and Regulations of the Medical Staff of Zuckerberg San Francisco General Hospital & Trauma Center. Should a conflict exist between these Rules and Regulations and those of the Medical Staff, the Medical Staff standards will prevail, except in circumstances where the clinical service adopts a more stringent standard.

A. SCOPE OF SERVICE

The Department of Obstetrics, Gynecology and Reproductive Sciences provides full-scope obstetric and gynecologic services, including inpatient and outpatient obstetrics, inpatient and outpatient gynecologic care and gynecologic surgery and abortion care. Sub-specialty care is also provided in maternal-fetal medicine, gynecologic-oncology, gynecologic-urology, complex family planning, and reproductive infectious diseases. There is 24-hour, in-hospital coverage by active or courtesy physician members of the medical staff plus by certified nurse midwives. Additionally, there is a physician on back-up duty 24 hours per day.~~.~~

The scope of service includes but is not limited to:

1. Obstetrics
   a. Normal antenatal, intrapartum and postpartum care, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist.
   b. Complicated antenatal, intrapartum and postpartum care;
   c. Antenatal testing;
   d. Basic obstetric ultrasound; and
   e. Perinatal genetics services.

2. Inpatient Gynecology
   a. Gynecologic surgery, admission of patients with gynecologic diagnoses and consultation on inpatients admitted to other services, encompassing the usual scope of Board-Certified Obstetrician-Gynecologist.
   b. Specialty services:
      1) Laser therapy of vulva, vagina and cervix;
      2) Surgery for incontinence and pelvic organ prolapse (gynecologic-urology); ~~and~~
      3) Surgery for treatment of gynecologic cancer; and
      4) Minimally invasive gynecologic surgery.

3. Outpatient Gynecology
   a. Broad range of outpatient services, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist.
   b. Specialty clinics include:
      1) Dysplasia including colposcopy, cryotherapy, and loop excision;
      2) Gynecologic urology;
      3) Gynecologic oncology; ~~and~~
      4) Reproductive endocrine and infertility services, and
      5) Gender expansive care

4. Family Planning
   a. Broad range of family planning services, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist;
   b. Tubal sterilization;
   c. Complex contraception clinic, and
   c. Abortion, up to ~~25~~24 weeks, 0 days~~25~~ weeks 6 days by ultrasound
      1) Exclusions: Terminations beyond ~~24~~25 weeks 0 days ~~25~~26 weeks ~~by BPD of 58mm (or its~~

~~equivalent in femur length, if that is the more appropriate measurement)~~ may be performed in special circumstances where maternal health is compromised by the pregnancy after discussion and approval by the Medical Director of the Women's Option's Center, a representative of the Ethics Committee, the Chief Nursing Officer, and, when appropriate, consultation with relevant medical specialist(s). The indications for terminations beyond ~~24 weeks 0~~26 weeks ~~days~~ for fetal indications will be assessed by an attending neonatologist to determine the degree of fetal compromise and thus the appropriateness of offering the termination.

B. MEMBERSHIP REQUIREMENTS

Membership in the Medical Staff of Zuckerberg San Francisco General Hospital & Trauma Center is a privilege that shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in ZSFG Medical Staff Bylaws, Article II, Medical Staff Membership, Rules and Regulations, and accompanying manuals as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION AND STAFFING OF THE OB/GYN CLINICAL SERVICE

An organizational chart and duties of the OB/GYN Clinical Service appears in Appendix C.

The Officers of the OB/GYN Clinical Service are:

1. Chief of Service;
2. Medical Director of Obstetric Service;
3. Medical Director of Gynecologic Service;
4. Medical Director, Obstetrics, Midwifery and Gynecology (OMG) Clinic;
5. Medical Director, Family Planning Service;
6. Director of Resident Education;
7. Director of Medical Student Education;
8. Chair Nurse Midwifery Service Leadership Council; and
9. ~~Director of Interdepartmental Nurse Midwife Education Program.~~
10. Director of QI

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the OB/GYN Clinical Service is in accordance with ZSFG Bylaws Article II, Medical Staff Membership and ZSFG Credentialing Manual, Appointments/ Reappointments and accompanying manuals as well as these Clinical Service Rules and Regulations.

1. Current licensure to practice in the State of California is required. No member shall engage in patient care responsibilities unless his/her license is current and clear.
2. CPR or neonatal resuscitation certification is encouraged but not required.
3. In accordance with ZSFG Bylaws, all practitioners providing medication or supervising others who prescribe or furnish medications must have a valid federal DEA certificate.
4. Active and Courtesy Members are required to be Board-Certified by or Active Candidates of the American Board of Obstetrics and Gynecology as per the Hospital bylaws

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the OB/GYN Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, Credentialing Procedure Manual, 1.3 – Reappointment Process as well as these Clinical Service Rules and Regulations.

1. Re-appointment will occur every 2 years. At this time, the following will be reviewed:
   a. Review of QI file: reports of peer review cases, complaints by staff or patients, sentinel events, or problems with the performance of certain procedures; and
   b. Review of levels of clinical activity in each category of obstetrical and gynecological care.

2. Active medical staff members must perform a minimum number of procedures or activities in the prior two years as specified in the table below.

a. If activity thresholds have not been met in a category of privileges requested by the member, then a program of educational activities and proctoring will be designed by the members of the department. Once completed, the privilege in the core category may be approved by the service chief. Exceptions to proctoring may be granted in certain circumstances with approval of a majority of active staff members. For courtesy staff members who perform the predominance of their clinical activities at other hospitals, a letter of good standing from the medical staff office at the primary hospital is sufficient proof of adequate clinical activity.

b. If there has been no activity in any category in the prior 2 years, the staff member will be contacted and asked whether he or she intends to remain a member of the ZSFG medical staff. If there is no response within 60 days or if the individual states that they intend to resign from the medical staff, the ZSFG Medical Staff Office should be notified of the member's resignation. This holds for active staff members. For courtesy staff members, see above under 2a.

c. If the individual states that he or she does intend to remain on the SGFH Medical Staff and to maintain their privileges, the department will devise a time-limited proposal for additional professional activity, with specification of proctoring thresholds, if necessary. Upon satisfactory completion of requisite activity, privileging will continue in those areas.

Reappointment Requirements:	
OBSTETRICS	
Outpatient clinic: obstetrics	50 clinic visits
Basic obgyn ultrasound (IUP, dating, adnexa etc)	10 interpretations
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, laceration repair)	15 cases
GYNECOLOGY	
Outpatient clinic: gynecology	50 clinic visits
Inpatient gynecology and gynecologic surgery	15 operative procedures
Emergency gynecology and gynecologic surgery	15 procedures including at least 4 laparoscopies or laparotomies
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	10 procedures
Laser therapy	2 cases
~~Hysteroscopic sterilization~~	~~2 operative procedures~~
~~Urogynecology~~	~~10 operative procedures~~
Moderate sedation/analgesia	5 case reviews and documented completion of module
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	15 ~~10~~ operative procedures
Urogynecology	15 ~~10~~ operative procedures
Maternal-Fetal Medicine	Care of 20 patients

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of Affiliated Professionals to ZSFG through the OB/GYN Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, Credentialing Manual, 3.1 – Affiliated

Professional Staff, and accompanying manuals as well as these Clinical Service Rules and Regulations. Affiliated professionals within the ZSFG Department of Ob/Gyn include certified nurse midwives (CNM) who work in the Family Birth Center (H22), Women's Options Center (6G), and Obstetrics, Midwifery, and Gynecology Clinic (5M), and Licensed Clinical Psychologists who work in 5M. ~~and New Generations Health Center.~~

D. DEFINITIONS OF MEDICAL STAFF CATEGORIES

All members of the medical staff in the ZSFG Department concurrently shall be a member of the academic or clinical faculty of the University of California, San Francisco, School of Medicine, Department of Obstetrics, Gynecology, and Reproductive Sciences.

1. Active staff members are defined as any of the following:
    a. Academic faculty member;
    b. Clinical faculty members who regularly attend at ZSFG, but who do not have active staff membership at other hospitals; and
    c. UCSF fellows who are assigned the predominance of their clinical responsibilities at the ZSFG.
2. Courtesy staff members are defined as any of the following:
    a. Academic and Clinical faculty members who have active staff membership at other hospitals and who perform the predominance of their clinical practice at hospitals other than ZSFG; and
    b. Clinical faculty members who do not regularly attend at ZSFG and who do not have active staff membership at other hospitals.
    c. Many courtesy staff are board-certified sub-specialists (gyn-oncology, reproductive endocrinology, maternal-fetal medicine) who offer specialty services that our generalist Ob/Gyn staff members are not able to provide.
3. The term "regularly attend" is defined as an attending who is assigned to a clinical service activity for 30 or more days per year.
4. Temporary Privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

The OB/GYN Clinical Services privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article IV: Clinical Privileges, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations, privileges to practice in the Clinical Service of Obstetrics and Gynecology will be commensurate with documentation of clinical training of an acceptable standard of clinical practice.

Privileges are delineated by consensus of the Active Members of the Clinical Service, subject to the approval of the Credentials Committee of the Medical Staff. Delineation of privileges will be reviewed yearly and at other times as necessary.

B. CATEGORIES OF PRIVILEGES

1. Privileges shall be defined in two categories: core and special
    a. Core privileges are defined as the cognitive and procedural clinical activities customarily performed by fully trained obstetricians or gynecologists.
    b. Special privileges are defined as procedural clinical activities that are not customarily performed by fully trained obstetricians or gynecologists and which require additional training, experience, and expertise to perform.
2. Core privileges will be granted in the following areas;
    a. Outpatient gynecology and family planning;
    b. Outpatient obstetrics;
    c. Inpatient gynecology; and
    d. Inpatient obstetrics.

3. Special privileges will be those sub-specialty areas and specialized procedures designated by the department as requiring skills (see table below and Privilege Form).
4. All new appointees to the Active Staff of the department must undergo a provisional period of no less than 3 months. During the provisional period, the clinician will be expected to satisfactorily complete proctoring.

C. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The OB/GYN Clinical Services Privilege Request Form shall be reviewed annually.

D. CLINICAL PRIVILEGES & MODIFICATION/CHANGE TO PRIVILEGES

The OB/GYN Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article IV: Clinical Privileges, Rules and Regulations and accompanying manuals. All requests for clinical privileges will be evaluated and approved by the Chief of OB/GYN Clinical Service.

The process for modification/change to the privileges for members of the OB/GYN Clinical Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

IV. PROCTORING AND MONITORING

Proctoring is defined as an evaluation of a member's clinical training, skills, and judgment by a peer clinician who is fully privileged in the area being evaluated. It is intended to evaluate the clinical skills of the member in performing clinical services, but not to evaluate their abilities as a teaching or supervising clinician, which will be done in other ways.

A. CIRCUMSTANCES REQUIRING PROCTORING

All medical staff members initially granted privileges shall complete a period of proctoring, in accordance with the following monitoring requirements below. Proctoring may be accomplished in any the following settings:

1. After initial appointment to the Medical Staff and performed within the first 6 months after joining the ZSFG medical staff.
    a. For physicians who completed residency at UCSF and will join the department soon after completion of the residency, proctored procedures during the Chief Residency year will be considered applicable toward proctoring requirements. There are therefore fewer cases required to be proctored upon joining Medical Staff for former UCSF residents as shown in the Table below.
2. When a member requests privileges for a procedure in which there has been insufficient clinical activity in the prior 2 years.
3. When a member requests special privileges in a category or procedure for which they recently have completed training.
4. At the time of reappointment to the Medical Staff, if it is found that proctoring at the time of initial appointment was incomplete or insufficient.

B. PROCTORING AFTER INITIAL APPOINTMENT

Individuals' privileges are subject to review and revision at initial appointment, throughout the period of proctoring, at the time of reappointment, at any time as judged necessary by the Chief of Service or at any time recommended by a two-thirds vote of a quorum of the clinical service's Active Staff.

The number of cases that must be proctored are contained in the tables below.

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

Individual Proctoring Plan for Former UCSF Resident or Fellow:

OBSTETRICS	
Outpatient clinic: obstetrics	Review of 3 medical records
Basic ob/gyn ultrasound (IUP, dating, adnexa, etc)	Interpretation of 3 ultrasound exams
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, lac repair)	Observed care of 2 patients, including 1 Cesarean
GYNECOLOGY	
Outpatient clinic: gynecology	Review of 3 medical records
Inpatient gynecology and gynecologic surgery	3 observed operative procedures including at least one laparotomy and one laparoscopy
Emergency gynecology and gynecologic surgery	2 ~~observed~~ reviewed procedures including at least one laparoscopy
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	2 observed operative procedures
Laser therapy	2 observed procedures
~~Hysteroscopic sterilization~~	~~2 observed procedures~~
~~Urogynecology~~	~~2 observed procedures~~
Moderate sedation/analgesia	Review of 5 cases
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	2 observed procedures
Urogynecology	2 observed procedures
Maternal-Fetal Medicine	Observed care of 2 patients

Individual Proctoring Plan for Non-UCSF Resident or Fellow:

OBSTETRICS	
Outpatient clinic: obstetrics	Review of 5 medical records
Basic ob.gyn ultrasound (IUP, dating, etc)	Interpretation of 5 ultrasound exams
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, lac repair)	Observed care of 5 patients, including 2 Cesarean deliveries
GYNECOLOGY	
Outpatient clinic: gynecology	Review of 5 medical records
Inpatient gynecology and gynecologic surgery	5 observed operative procedures including one laparotomy and one laparoscopy
Emergency gynecology and gynecologic surgery	3 ~~observed~~ reviewed operative procedures including at least one laparoscopy
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	3 observed operative procedures
Laser therapy	2 observed procedures
~~Hysteroscopic sterilization~~	~~2 observed procedures~~
~~Urogynecology~~	~~3 observed procedures~~
Moderate sedation/analgesia	Review of 5 cases
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	3 observed procedures
Urogynecology	3 observed procedures
Maternal-Fetal Medicine	Observed care of 3 patients

C. QUALIFICATIONS OF PROCTORS

1. Proctoring will be carried out by Active members of the staff who enjoy unrestricted privileges in the category subject to proctoring.
    a. In certain cases, the proctoring of privileges, which are not held by another member of the Active Staff, may be performed by a Board-Certified Member of the Active Staff at the direction of the Chief of Service. At the discretion of the Chief of Service, such proctoring may be supplemented by consultation with a physician who holds unrestricted privileges in that category at another affiliated hospital (UCSF affiliated), or who holds unrestricted privileges in a similar field at Zuckerberg San Francisco General Hospital & Trauma Center
2. One or two primary proctors will be assigned for each individual, but this does not preclude other members from service as proctors in individual cases.

V. EDUCATION OF MEDICAL STAFF

The CME requirements set forth in the current ZSFG Bylaws, Rules and Regulations of the Medical Staff of Zuckerberg San Francisco General Hospital & Trauma Center shall apply as the minimum required by the

Department. The Obstetrics & Gynecology Clinical Service members are encouraged to attend UCSF department courses for CME credits.

VI. OB/GYN CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that house staff assumes progressively increasing responsibility for patient care according to their level of training ability and experience. House Staff providing clinical services shall do so only under the supervision of active or courtesy medical staff that have ultimate responsibility for patient care, are members of the University of California, San Francisco Faculty, and have appropriate clinical privileges. Details are in Appendix B. A summary is below.

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSESTAFF

House staff care for patients under supervision of attending physicians in all clinical settings described in I.A. Scope of Service. Attending physicians are immediately available for consultation in all clinical settings.

Attending physicians are present 24 hours per day to supervise all deliveries and surgical procedures. Guidelines for calling the Attending in other situations are disseminated to the residents yearly and are available on the residents' website.

B. RESIDENT EVALUATION PROCESS

The Ob/GYN residency program has a robust system for monitoring and evaluating competencies of residents. It includes electronic global evaluations by multiple faculty members every 6 weeks, assessment of surgical competency for benchmark cases (e.g. R1=Cesarean: R2=Laparoscopy; R3=Abdominal Hysterectomy; R4=Vaginal Hysterectomy), assessment at weekly case conferences, and assessment in surgical skills labs and obstetric simulations. The Ob/Gyn Residency program's evaluation system for accessing competency of its residents has been approved by the ACGME. Residents' evaluations are reviewed twice yearly with the resident by the Residency Program Director or Associate Director. Their contracts are renewed annually assuming clinical, educational and professional competencies have been met. Remediation or discipline occurs as necessary according to the UCSF GME Guidelines.

C. ABILITY TO WRITE PATIENT CARE ORDERS

1. House staff may write patient care orders with the following exceptions:
    a. DNR;
    and
    b. AMA.

VII. OB/GYN CLINICAL SERVICE CONSULTATION CRITERIA

The Obstetric or Gynecology On-Call resident physician is ~~paged to notify~~notified via EMR of inpatient consultation requests. Attending physicians supervise all inpatient consultations. For outpatient consultations, the electronic medical record system is used.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital & Trauma Center Medical Staff Bylaws, Rules and Regulations, which include provision for due process where applicable, will govern all disciplinary action involving members of the ZSFG OB/GYN Clinical Service.

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY (PIPS)

The Department of Obstetrics, Gynecology and Reproductive Sciences at Zuckerberg San Francisco General Hospital & Trauma Center is committed to a systematic and comprehensive program of Quality Improvement, through the PIPS program, in an effort to promote the highest possible standard of care for patients.

A. GOALS & OBJECTIVES

1. Demonstrate a commitment to continuous improvement in obstetrical and gynecological services;

2. Objectively examine aspects of care in order to improve the overall services of the department;
3. Monitor morbidity and mortality ~~and~~ to reduce them to the lowest possible rate;
4. Facilitate a multi-disciplinary approach to the assessment and development of health care services;
5. Ensure that the delivery of sexual and reproductive health care by personnel in training is competently and fully supervised;
6. Pursue opportunities to continually improve the patient care experience, including patient satisfaction with services delivered;
7. Implement and document actions to improve care with follow-up, periodic review, and evaluation; and
8. Provide ongoing education on approach and methods of continuous quality improvement and utilization management.

B. RESPONSIBILITY

Overall responsibility for monitoring and evaluation of this program is assigned to the Chief of Service. The departmental Quality Improvement committee and the data assistant facilitate implementation of this program. All members of the department are expected to actively participate in the Quality Improvement (QI) activities outlined in this program.

1. Chief of Service
   a. Assures that care delivered by Medical Staff meets acceptable standards;
   b. Assures that the monitoring and evaluation encompasses the full scope of care delivered;
   c. Investigates any specific cases where the quality of care has been questioned: evaluates, takes corrective action as needed, and implements follow-up plans;
   d. Facilitates formation of strategies for resolution of identified problems and monitors progress;
   e. Works collaboratively with other departments and services for resolution of issues that require interdepartmental cooperation;
   f. Assures reporting of potential litigation events to the UC Risk Manager;
   g. Assures that the systematic review of patterns of practice and clinical trends are an integral part of the staff evaluation and provider credentialing process;
   h. Disseminates the results of QI activities to clinic chiefs and individual providers, as appropriate; and
   i. Appoints a departmental Director of Quality Improvement.

2. Departmental Quality Improvement Committee
   a.~~a.~~Identifies potential QI activities
   b. Reviews on-going contribution of activities to continuous improvement of patient care.
   c. Is chaired by the departmental Director of Quality Improvement.

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3. The QI Data Assistant
   a. Provides administrative support to departmental members for selected QI activities.
   b. Performs and monitors documentation of QI activities to assure completeness and consistency.
   c. Work under the direction of the Chief and MSO to perform data retrieval.
4. Medical Providers (Physicians, Residents, CNMs, and Nurse Practitioners)
   a. Participate in assigned Medical Staff Committees (according to hospital by-laws).
   b. Participate in peer evaluation of performance as requested.
   c. Maintain departmental standards by incorporating quality improvement into clinical practice.
   d. Report unusual occurrences (events/trends) outside the expected outcome to UC Risk Management.

~~5. Nursing Personnel~~
   ~~a.Work with the Medical Staff to deliver quality patient care.~~
   ~~b.Identify problem areas in patient management and collaborate with the Chief and/ o~~Wer ~~designee for resolution.~~
   ~~c.Identify and resolve patient care problems within their scope of nursing practice.~~

6. Non-Medical Departmental Clinic Staff
   a. Work with the Medical Staff to deliver quality patient care.
   b. Work as members of multi-disciplinary groups to address problems identified as a result of QI

activities.

c. Perform QI activities to identify areas for potential improvement in patient satisfaction and experience.

d. Serve as patient advocates regarding the care experience.

7. ZSFG Quality Management Staff

a. Organize and support the departmental QI activities by obtaining requested data and assuring that there is support staff to document the proceedings; and

b. Perform assessment on institution-wide indicators.

C. REPORTING

1. Results of Quality Improvement activities are disseminated in the following manner:

a. Results of department-specific activities reviewed by the QI Committee are shared with department faculty at least quarterly;

b. Summary information is presented to the ZSFG Medical Staff Quality and Utilization Management Committee on a semi-annual basis;

c. Minutes of all meetings in which quality improvement activities are discussed are distributed to appropriate staff and faculty. Copies of all minutes are maintained ~~in the Quality Improvement binder in the departmental office~~ electronically; and

d. Feed-back information ~~will be~~ is provided to all parties involved in QI or peer-review actions.

2. Access to documents produced by the QI Program outside the department is limited to: Chief of Staff; Chair, Medical Staff Quality and Utilization Management Committee; and Risk Managers. Additional access may be granted at the discretion of the Chief of Service.

3. The Chief of Service is responsible for addressing patient care problems which involve other clinical services. This responsibility may be delegated to the appropriate section directors.

4. Patient care will be referred to the Hospital PIPS Committee when:

a. They consistently cross clinical service/departmental lines;

b. Further assistance is needed in their resolution;

c. Operational link with risk management when deemed necessary by the Chief of the Service or the PIPS Chief.

D. CLINICAL INDICATORS

1. Indicators are used to monitor the outcome or process of the provision of care. Thresholds (TH) are targets for clinical performance, using current literature or aggregate hospital experience, and are established for each indicator developed. Indicators above threshold are observed closely and/or investigated. If they remain above threshold, investigation is begun ~~They represent the level or point at which stimulus is strong enough to signal the need for departmental response to indicator data and the beginning of the process of investigating opportunities for improvement.~~

2. Indicators for obstetrics, gynecology, and abortion services will be recommended by the Quality Improvement Committee to the department as a whole. Review of indicators will occur at least once a year, or more often as needed.

3. On a periodic basis (not to exceed once a month), the QI Data Assistant (or designee) will review all medical records of patients admitted to the obstetrical, gynecologic, and abortion services once discharged. Each record will be evaluated to determine whether an indicator definition is met. ~~, in which case it is considered to be a "kick-out" case.~~

4. When an indicator is present, the medical record of the ~~"kick-out"~~ case will be reviewed as follows.

a. All cases with indicators ~~kick-outs that occur~~ are reviewed. One Ob case per week, and one gyn case per 5 weeks is reviewed at Ob or Gyn M&M conference with a focus on systems issues, communication and areas in which care might have been improved. ~~, and at least one case is reviewed in our Ob and Gyn M&M conferences. During the M&M conference one clinician is assigned to record the findings and completes review of the case.~~ Those casesthat are not reviewed in M&M are referred to a clinician reviewer to review.

b. Each case is evaluated by clinician(s) who completes the M&M Review Forms (see Appendix D) and designates ~~The clinician reviewers complete the "Kick-Out Evaluation From" and designates~~ whether there is no deficiency, suggestion to clinician, room for improvement, or deficiency. For cases presented in M&M conference, designations are determined via consensus of clinicians present at the conference. For cases individually reviewed, it is up to the discretion of the reviewer to request additional opinions if needed. The reviewer also determines whether the case should be referred to the Peer Review Committee. If the attending of the case is not present at the M&M conference, a copy of the ~~Kick-Out~~evaluation form is ~~given~~ sent to them for review.

c. The QI Data Assistant ~~will~~ tracks the status of all medical records being reviewed by clinician reviewers.

5. The QI Data Assistant ~~will~~ keeps statistical records regarding patient cases reviewed, the percentage of cases that met the definition of an indicator, a comparison of observed indicator rates to established thresholds, and the percentage distribution of the dispositions of cases reviewed by clinician reviewers. These statistical summaries ~~will be~~are presented to the Quality Improvement Committee and ~~will be~~ evaluated by the Chief of Service (or designate) prior to reappointment to medical staff.

E. QUALITY OF CARE INDICATORS

1. Inpatient Obstetrics
   1. Apgar score < 5 at 5 minutes (TH 2%)
   2. Cord UA pH less than 7.00 or base excess greater than -12 (TH 12%)
   3. Delivery of infant weighing < 1,200 grams (NA)
   4. C-Section for fetal indication (TH 5%)
   5. 4th degree laceration (TH 1%)
   6. Transfusion or greater than 1,500 cc of blood loss (TH 45%)
   7. Eclampsia (TH 1%)
   8. ICU Admission (TH 12%)
   9. Unplanned Return to OR (TH 1%)
   10. Unplanned removal, injury, or repair of an organ during surgery (TH 15%)
   11. Perinatal death (TH 10%)
   12. Maternal death (TH 10%)
   13. Readmission for PP complications (TH 2%)
   14. Surgical procedure on undelivered patient (TH 1%)
   15. Other [no threshold].

2. Inpatient Gynecology
   1. Unplanned readmission within 14 days (TH 4%)
   2. Admission/procedure after >1 vst to ER (TH 3%)
   3. ~~Cardiopulmonary arrest (TH 1%)~~
   4. ~~4.~~3. Antibiotics >24 hrs after surg or adm (TH 5%)
   5. ~~5.~~4. Unplanned admission of Come and Go patient (no 6G pt) (TH 5~~10~~%)
   6. ~~6.~~5. Unplanned admission to ICU (TH 2%)
   7. ~~7.~~6. Unplanned return to the operating room (TH 3~~2~~%)
   8. ~~8.~~7. Unplanned removal, injury or repair of an organ during surgery (TH 45%)
   9. ~~9.~~8. Death during admission (TH 0%)
   10. ~~10.~~9. Hospital admission > 5 days (non-oncology pt) (TH 7~~10~~%)
   11. ~~11.~~ Procedure time > 64 hours (non-oncology pts) ~~(TH 10%)~~
   12. ~~12.~~10. Transfusion for intraoperative blood loss (TH 5~~10~~%)
   13. ~~13.~~11. Post operative transfusion (no 6G patients) (TH 3%)
   14. ~~14.~~12. Development of infection not present on adm (TH 2%)
   15. ~~Other~~

3. Women's Options Center
    1. Bleeding complications
        a. Transfusion
        b. UAE (IR)
    2. Damage to organs
        a. Cervical laceration requiring suture
        b. Perforation
    ~~b.~~3. Anesthesia complications
    ~~3.~~4. Hospital admission
        a. Embolization
        b. Pain management
        ~~a.~~c. Subsequent surgery
        d. Observation of bleeding
        e. No ride
        ~~b.~~f. Other
    ~~4.~~5. Reaspiration
        a. Within 24 hours of original procedure
        ~~a.~~b. After 24 hours of original procedure

F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

The focus of Quality Improvement activities is on high-volume (HV), high-risk (HR), or problem-prone (PP) services. Other aspects of care may be selected because of their direct relationship to patient satisfaction, which is also a focus of QI activities. The following aspects of care are selected for review and monitoring:

a. Inpatient Obstetrics: delivery Outcomes (HV)
b. Inpatient Gynecology: surgical and non-surgical outcomes (HV, HR)
c. Women's Options Center Services
    1. Conscious Sedation Monitoring Compliance (HR)
    2. Abortion Outcomes (HV)

1. Quality Improvement Committee
    a. The Committee ~~will meet~~ meets at least quarterly, in sessions separate from regularly scheduled Department meetings.
    b. Membership
        1. Departmental Director of Quality Improvement (chair)
        2. Medical Director of ~~the Women's Health Center~~ the Obstetrics, Midwifery & Gynecology Outpatient Clinic
        3. Medical Director of the Women's Options Center
        4. Medical Director of the Family Birth Center
        ~~3.Representative member of the Obstetrics Division~~
        5~~4~~. ~~Representative member~~Medical Director of ~~the~~ Gynecology ~~Division~~
        6~~5~~. Nurse midwife representative (s)
        7~~6~~. Representative to the ZSFG QI Committee
        8~~7~~. Representative to the ZSFG Risk Management Committee
        9~~8~~. ~~Departmental MSO~~
        10~~9~~. QI Data assistant
        11~~0~~. At large member(s), appointed by the department Chief of Service
        12~~1~~. Chief of Service is an ex-officio, voting member
    c. Activities
        1. Present and discuss reports of hospital QI and Risk Management Committees
        2. Review indicator statistics and ~~, including~~ follow up of ~~"kick-out" cases~~indicator cases
        3. Review report from departmental Peer Review Committee
        4. Review report~~s~~ of M&M Conferences
        5. Designate, execute, and review focus~~ed~~ studies to explore patterns observed
        ~~c.~~
    d. Because the Department of Obstetrics, Gynecology and Reproductive Sciences at ZSFG is a part of a larger educational institution (UCSF), on-going education is an important component of its activities.

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Where additional educational needs are identified, interventions are scheduled as appropriate.

e. Issues that cross departmental lines are referred by the Chief to the appropriate clinical or non- clinical department for evaluation and resolution. Further departmental involvement in efforts to improve these processes is assigned by the Chief or designee.

f. Most issues require a multi-disciplinary approach, and with the assistance of the hospital Quality Management staff, groups are organized to assess the deficiencies and recommend steps for resolution, initiate responses, and evaluate results.

g. The Quality Improvement Program is reviewed periodically for effectiveness and evidence of improvement in patient care. Plans are made, at that time, to identify indicators for monitoring care in the upcoming period.

h. Problem Resolution

1. Assessment: patient care problems are assessed with an appropriate tool which may include:
    a. Medical records audit using pre-determined, clinically valid criteria
    b. Observation of clinical practice (see also Proctoring Plan)
    c. Fact-finding and discussion with clinical staff ~~d. Clinical Research~~
2. Recommendations may include:
    a. Review of charts by attending physician or Section Directors.
    b. Education and training with unit staff.
    c. Procedure changes
    d. Staff meetings
    e. Equipment changes
    f. Development of standards of care.
    g. Individual staff remediation and appropriate disciplinary action
3. Remedial action for identified problems may include:
    a. Changing or creating new policies and treatment protocols
    b. Education of faculty, nursing staff, etc
    c. Proctoring and counseling
    d. Recommendations for equipment purchase and use
    e. Adherence to blood & fluid safety precautions, and infection control guidelines.

2. Peer Review Committee

a. The Peer Review Committee is expected to review clinical performance or professional behavioral issues regarding individual provider staff members.

b. Cases reviewed may arise from the following sources:
    1. ~~"Kick out"~~Indicator cases referred to the Committee by a clinician reviewer;
    2. Cases from the M&M Conference identified as requiring peer review evaluation;
    3. Unusual Occurrence Reports (UORs) submitted to the Chief of Service; and
    4. Complaints from patients or staff submitted to the Chief of Service.

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c. The Peer Review Committee will be composed of the physician and CNM members of the departmental Quality Improvement Committee.

d. The Peer Review Committee will meet "as needed" (if there are cases for review) after the completion of a Quality Improvement Committee meeting, or in extraordinary session if necessary.

e. A "Peer Review Committee Record" will be completed and stored in a secure location.

f. Peer Review Committee meetings will be closed to non-members and its proceedings will be considered to be confidential and protected by Section 1157 regulations.

3. Morbidity and Mortality (M&M) conferences

a. Separate Obstetrical Morbidity and Mortality (Ob M&M) and Gynecology Morbidity and Mortality (Gyn M&M) Conferences are held regularly and attended by all available active attending faculty and residents on service at Zuckerberg San Francisco General Hospital & Trauma Center.

b. During Ob and Gyn M&M we review cases of patients who delivered recently and who meet quality indicators requiring review. In addition, all cases that have met specific quality indicators are peer-

reviewed. The process is discuss above.

~~c. Cases discussed will come from three sources.~~
~~1. Patients recently discharged from ZSFG where one of the Obstetrical or Gynecologic indicators appears to be present~~
~~2. Cases not previously presented to the M&M Conference that are referred through the indicator review process (Ob, Gyn, and Women's Option Center)~~
~~3. Cases that arise from the Obstetrics, Midwifery and Gynecology clinic (5M)~~
~~d. For all cases discussed, the M&M Review Forms (see Appendix D) will be completed. An assessment is made as to whether there was a deficiency, an opportunity for improvement, or no deficiency in care provided. Recommendations for further QI follow-up or activities will be made and tracked for completion.~~
e. ~~An aggregate report of cases presented to the M&M Conference will be produced by the departmental director of Quality Improvement and presented to the Quality Improvement Committee at each of its meetings.~~
f. Additional Morbidity and Mortality Conferences are held monthly in conjunction with the Pediatric Department. This M&M Conference reviews all deaths and major morbidity, with special attention to readmissions, untoward drug effects, complications (by clinical indicator) and maternal or fetal deaths.

4. Ongoing Professional Performance Evaluation (OPPE)
   a. Practitioner-specific information identified as a result of Peer Review and other QI activities are reviewed by the Chief as part of the reappointment process and every ~~6 months~~year. .
   b. ~~Bi-annual a~~Activity reports for Obstetrics, Gynecology and Family Planning and outpatient OBGYN clinics are created for all provider staff and are maintained in the departmental credentialing file. These reports include volume of cases, ~~number of those with indicators, and result of review of the cases with indicators (no deficiency, room for improvement, deficiency).~~ And number of those reviewed with "opportunity for improvement" or "deficiency" ratings.
   c. An OPPE form is completed by the Chief or ~~his/her~~ designee each ~~6 months~~ year to ensure adequate volume and quality of care for each clinician. ~~(Appendix E)~~ This is supplied to us by the hospital.

5. Other Patient Care Conferences
   a. ~~Weekly GYN~~ Pre-Operative Conference~~s~~: Weekly ~~R~~review by multiple faculty of surgical plan for the following week's gynecologic operative cases.
   b. Gynecologic Tumor Board meets once monthly for ~~prospective planning and retrospective~~ treatment planning ~~review of treatment~~ of gynecologic cancers at ZSFG.
   c. Ultrasound Conference occurs once monthly for review of Obstetric and Gynecologic Ultrasounds.
   d. Dysplasia case conference occurs weekly.
   e. High risk obstetrics case conferences occurs twice per week
   e. Ob/Gyn Medical Staff Meetings: The ob/gyn attending staff meets at least monthly. Patient care problems are discussed, solutions are recommended, and the resolution of problems tracked.

6. Ongoing Review of All OMG Charts
   a. All charts of medical students and unlicensed resident physicians are reviewed by the attending MD.
   b. Outpatient-only physicians who are Courtesy staff are paired with an Active staff member during clinical sessions so are subject to observation during the clinical session. Any quality issues that are noted by the Active staff physician are brought to the QI committee. In addition, 5 charts are reviewed at the time of re-appointment.

7. Unusual Occurrence (aka "SAFE" reports)
   a. All reports will be reviewed by the Chief of Service and Medical Director of the appropriate service (5M, 6G, H22 etc) who assigns review and response to responsible attending. A plan will be developed if quality of care has been compromised to ensure that the problem has been resolved.

8. Oral or Written Patient Complaints
   a. Oral or written patient complaints will be reviewed by the Chief of Service and Head Nurse and acted on or ~~and forwarded to the Outpatient Grievance Committee and~~ assigned for review and response to the responsible attending.

~~9. Drug Adverse Reactions~~
   ~~a. All are identified through daily chart review and appropriate follow-up, and completion of adverse drug reaction form.~~

~~10. Nosocomial Infections~~
   ~~a. Staph skin infection reported at M&M Conference.~~
   ~~b. Surgical wound infection reported at M&M Conference.~~

11. Missed Appointments
   a. All missed appointments are reviewed by the clinic nurse or clinician. When appropriate, another appointment is made. ~~by mail or phone~~. If follow-up fails, the PCP is notified and/or a public health nurse can be called upon for assistance.

X. MEETING REQUIREMENTS

A. COMMITTEE MEETINGS

In accordance with ZSFG Medical Staff Bylaws 7.2.I, All Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

The OB/GYN Clinical Services shall meet as frequently as necessary, but at least monthly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

Refer to Appendix C for Committee Assignment for members of the OB/GYN Clinical Service.

B. FACULTY MEETINGS

All faculty must attend at least 75% of all regularly scheduled faculty meetings. Anticipated absenteeism should be communicated to the Chief of Service in a prompt manner.

Minutes of all faculty meetings will be maintained in the service, and distributed to all faculty members~~, and forwarded to the Medical Staff Office~~ in a timely manner.

1. M&M Conferences
   a. Faculty are expected to attend any M&M conference wherein a patient they cared for is being discussed. If unable to attend, they are expected to learn about the proceedings of the M&M from an attendee. In addition, faculty are expected to attend at least 50% of either Ob or Gyn M&M Conferences according to their clinical duties. Outpatient only physicians do not have this requirement.

XI. ADDITIONAL OB/GYN SERVICE SPECIFIC INFORMATION

A. ATTENDING PHYSICIAN RESPONSIBILITIES

1. Obstetrics Service Attending
   a. ~~The role of attending physician on the Obstetric Service will generally rotate on a weekly basis.~~
   b. ~~On all weekdays (excluding holidays) t~~The OB Attending is expected to be in-house and readily available ~~from the time of morning rounds through the time of evening rounds.~~during their shift, which may be overnight or a 24 hours. Responsibilities include:
      1. Conducting teaching rounds with house staff and students each weekday

~~(excluding holidays)~~

2. Attendance at all deliveries and other major procedures
3. Supervision of house staff for all admissions, discharges and significant changes in the plan of care
4. Review and co-sign all antenatal-testing procedures
5. Review and co-sign all obstetrics ultrasounds performed by house staff
6. Review of e-consults submitted to the Obstetrics and Gynecology services
7. Collaboration with nursing staff to ensure effective, efficient, quality care.
8. It is the responsibility of the attending to arrange for alternate coverage in situations of anticipated absence.

2. Gynecology Service Attending

a. ~~The role of attending physician on the Gynecology Service will generally rotate on a weekly basis.~~

b. The GYN Attending will be responsible for the following:

1. Attendance at all operative procedures scheduled by the team
2. ~~Daytime c~~Coverage of emergency procedures
3. Conducting teaching rounds with house staff and students each weekday ~~(excluding holidays)~~
4. Supervision of house staff for all ED and inpatient consult admissions, discharges and significant changes in plans of care
5. Review of e-consults submitted to the Gynecology service
6. Review and approval of all scheduled surgical cases
7. It is the responsibility of the GYN Attending to arrange for alternate coverage in situations of anticipated absence.

4. Family Planning Service Attending

a. ~~The role of attending physician on the Family Planning Service will generally rotate on a daily basis.~~

b. The family Planning Attending will be responsible for the following:

1. Attendance at all abortion surgical procedures~~, whether performed in an outpatient or inpatient setting;~~
2. Supervision of Family Planning Resident and medical students assigned to Women's Options Center;
3. Supervision of pre-operative examinations;
4. Review and co-sign all ultrasounds performed by house staff; and
5. Collaboration with nursing staff to ensure effective, efficient, quality care.

5. 5M Outpatient Attending

~~a. Attending physicians are generally assigned to 5M for the same ½ day clinic session each week.~~

b. The 5M Attending will be responsible for the following:

1. Attendance at the outpatient clinic from start to finish with only brief periods of absence to attend to other urgent clinical needs;
2. Supervision of all house staff and medical students in 5M;
3. Review and co-sign all ultrasounds performed by house staff and advanced practice providers in 5M;
4. Collaboration with nursing staff to ensure effective, efficient, quality care.

6. Night and Weekend Attending

a. The attending physician on nights and weekends is expected to be in-house and readily available at all times.

b. The Night and Weekend Attending will be responsible for the following:

1. Attendance at all deliveries (except those uncomplicated deliveries attended by a Certified Nurse Midwife or Attending Family Medicine Physician), unless concurrent clinical situations prevent such attendance; ~~and~~
2. Attendance at all surgical cases in the operating room.
3. Supervision of house staff for all ED and inpatient consults, admissions, discharges and significant changes in plans of care;
4. Review and co-sign all ultrasounds performed by house staff; and
5. The Night and Weekend Attending is expected to call in the back-up attending when the level of clinical activity jeopardizes adequate coverage of attending responsibilities.

7. ~~Night and Weekend~~ Back-up Attending

a. A back-up attending physician ~~will be~~is assigned at all times. During the day, the back-up attending is typically attending another service like clinic or Women's Options, which both have multiple

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attendings. On nights, holidays and weekends, a back-up attending is scheduled and ~~every weeknight and weekend and is~~ expected to be available to be called in from home should the necessity arise.

b. The Back-up attending will be called in at the discretion of the ~~Night and Weekend~~Obstetrics Attending or at the request of the Ob/Gyn Chief Resident. The Back-up Attending will also be expected to fill in for the Obstetrics Attending in the event of illness or other urgent absence.

B. MEDICAL RECORDS

The members of the OB/GYN Clinical Service are committed to the maintenance of complete, accurate and timely medical records. The requirements are set forth in the Zuckerberg San Francisco General Hospital & Trauma Center Bylaws, and Rules and Regulations of the Medical Staff, which define the minimum standard for records in the clinical service. All operative procedures must include a pre-operative and post-operative note by the attending surgeon of record.

C. INFORMED CONSENT

All decisions for treatment should involve the active participation of the patient, and informed consent should be made after appropriate discussion of risks, benefits and alternatives.

Documentation of "Informed Consent" on Medical Staff-approved forms is required for all the following:

1. All surgical procedures performed in the operating room;
2. All procedures in which tissue is removed;
3. All procedures involving laser therapy;
4. ~~Vaginal breech delivery; operative vaginal delivery (forceps, vacuum)~~
5. ~~Cesarean delivery;~~
6. ~~Tubal sterilization;~~
7. Amniocentesis;
8. External cephalic version; and
9. IUD insertion, contraceptive implant insertion.
10. ~~10.~~

XII. ADOPTION AND AMENDMENT

The OB/GYN Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the OB/GYN Service annually via email or at an OB/GYN Clinical Service Meeting.

These Rules and Regulations may be adopted and revised on a voice vote of a majority of Active Staff members, providing that at least 72 hours' notice has been given.

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

XIII. APPENDIX A CLINICAL SERVICE PRIVILEGE FORM

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.

OBGYN OBSTETRICS and GYNECOLOGY (2015) (1010, 0711 MEC)

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

Requested	Approved	
		24.00 CORE PRIVILEGES
		24.01 OUTPATIENT CLINIC: OBSTETRICS
		PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.
		PROCTORING: review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.
		REAPPOINTMENT: 50 clinic visits in the previous 2 years
		A. Prenatal care visits, both low and high risk patients
		B. Interpretation of fetal monitoring
		C. Treatment of medical complications of pregnancy including, but not limited to: pregnancy induced hypertension, chronic hypertension, diabetes mellitus, renal disease, coagulopathies, cardiac disease, anemias and hemoglobinopathies, thyroid disease, sexually transmitted disease, pulmonary disease, thromboembolic disorders, infectious disease, ectopic pregnancy and other accidents of pregnancy, such as incomplete, complete, or missed abortion
		24.02 BASIC OB/GYN ULTRASOUND
		PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.
		PROCTORING: Interpretation of 5 ultrasound exams. Interpretation of 3 ultrasound exams for UCSF-trained Fellows/Residents.
		REAPPOINTMENT: Interpretation of 10 ultrasound exams in the previous two years
		A. Localization of intrauterine pregnancy (ie. diagnose IUP)
		B. Evaluation of fetal viability and heart rate
		C. Estimation of gestational age, fetal weight
		D. Fetal presentation
		E. Evaluation of vaginal bleeding, placental location
		F. Measurement of cervical length
		G. Amniotic fluid estimation (AFI)

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

Requested Approved

24.03 INPATIENT OBSTETRICAL CARE

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Note: Procedures marked with an asterisk may only be performed by obstetrician gynecologists, unless the physician has received additional obstetrical training and experience and has been approved by the Chief of OB/GYN & RS to perform these procedures.

PROCTORING: Observed care of 3 patients, each of whom has received at least one of the procedures below. For UCSF-trained residents and fellows: observed care of 2 patients, each of whom has received at least one procedure below.

REAPPOINTMENT: 15 procedures in the previous two years

_____	_____	A. Routine inpatient antepartum, intrapartum, and postpartum care
_____	_____	B. Management of spontaneous and induced labor
_____	_____	C. Pudendal block* and local anesthesia
_____	_____	D. Fetal assessment, antepartum and intrapartum
_____	_____	E. Internal fetal monitoring
_____	_____	F. Normal cephalic vaginal delivery
_____	_____	G. Episiotomy and repair, including 1st and 2nd degree lacerations
_____	_____	H. Exploration and repair of the vagina and cervix
_____	_____	I. Deliver placenta
_____	_____	J. Evaluate, diagnose, treat, and provide consultation for medical conditions complicating pregnancy (beyond that contained in routine inpatient antepartum, intrapartum, and postpartum care)*
_____	_____	K. Fetal scalp sampling*
_____	_____	L. Tubal sterilization, post-partum*
_____	_____	M. Non-genetic amniocentesis*
_____	_____	N. Forceps delivery*
_____	_____	O. Delivery by vacuum extraction*
_____	_____	P. Manual or instrumental extraction of the placenta and fragments*
_____	_____	Q. Cesarean section (primary surgeon)*
_____	_____	R. Repair of incompetent cervix (cervical cerclage)*
_____	_____	S. External version of breech presentation*
_____	_____	T. Vaginal breech delivery*
_____	_____	U. Vaginal multiple fetus delivery*
_____	_____	V. Repair of rectal injury (3rd and 4th degree laceration)*
_____	_____	W. Cesarean hysterectomy*
_____	_____	X. Vaginal birth after caesarean section*
_____	_____	Y Pregnancy termination via labor induction *

Requested Approved

_____ ___ _____ **24.04 OUTPATIENT CLINIC: GYNECOLOGY**

Evaluate, diagnose, treat, and provide consultation, pre-and post-operative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgical disorders and injuries of the mammary glands. When inpatient gynecologic care privileges have been approved, procedures in this privilege group also can be performed in the hospital operating room.
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.
REAPPOINTMENT: 50 clinic visits in the previous 2 years

_____ _____ A. Preventive health visits: well-women, family planning visits
_____ _____ B. Problem-oriented gynecologic visits
_____ _____ C. Microscopic diagnosis of urine and vaginal smears
_____ _____ D. Colposcopy
_____ _____ E. Vulvar, vaginal and cervical biopsy
_____ _____ F. Endometrial biopsy
_____ _____ G. Cervical or endometrial polypectomy
_____ _____ H. Insertion and removal of intrauterine contraceptive (IUC)
_____ _____ I. Insertion and removal of contraceptive implant
_____ _____ J. Pessary fitting
_____ _____ K. Trigger point injection
_____ _____ L. Cryosurgery (cervix, vulva, vagina)
_____ _____ M. Loop electrosurgical excision procedure (LEEP), cervix
_____ _____ N. Bartholin duct procedures (incision and drainage, marsupialization)
_____ _____ O. Dilation and curettage, suction curettage and manual uterine aspiration
_____ _____ P. Simple cystometry
_____ _____ Q. Paracervical and intracervical block
_____ _____ R. Insertion of cervical dilators
_____ _____ S. Anoscopy

Requested Approved

_____ ___ _____ **24.05 INPATIENT GYNECOLOGY AND GYNECOLOGIC SURGERY**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of

Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 5 observed operative procedures, including at least one laparotomy and one laparoscopy.
REAPPOINTMENT: 15 operative procedures in the previous two years

_____ _____ _____ A. Admission of patients with gynecologic issues

_____ _____ _____ B. Care of admitted post-op and non-operative gyn patients

_____ _____ _____ C. Repair of vaginal, vulvar or cervical lacerations

_____ _____ _____ D. Drainage or removal of pelvic abscess (vaginal, laparoscopic or open)

_____ _____ _____ E. Placement of intra-uterine balloon catheter to manage bleeding

_____ _____ _____ F. Excision, I&D or surgical management of vulvar or vaginal lesions and abscesses

_____ _____ _____ G. Dilatation and curettage, suction curettage, manual uterine aspiration; diagnostic or therapeutic

_____ _____ _____ H. Cervical cone biopsy, LEEP procedure

_____ _____ _____ I. Hysterectomy, abdominal

_____ _____ _____ J. Hysterectomy, vaginal

_____ _____ _____ K. Hysterectomy, laparoscopic-assisted or total laparoscopic

_____ _____ _____ L. Exploratory laparotomy

_____ _____ _____ M. Adnexal procedures (open or laparoscopic) including: salpingectomy, salpingostomy, oophorectomy, ovarian cystectomy, ovarian drilling, ovarian biopsy, ovarian detorsion, oophoropexy

_____ _____ _____ N. Myomectomy, abdominal or vaginal

_____ _____ _____ O. Incidental appendectomy

_____ _____ _____ P. Fistula repairs (vesicovaginal or rectovaginal)

_____ _____ _____ Q. Repair simple rent/ tear of bowel or bladder

_____ _____ _____ R. Perineoplasty, labiaplasty

_____ _____ _____ S. Repair of cystocoele, rectocele, enterocele

_____ _____ _____ T. Tuboplasty

_____ _____ _____ U. Hernia repair (incisional or umbilical)

_____ _____ _____ V. Paracentesis

_____ _____ _____ W. Wound management: I&D, skin debridement wound dehiscence, wound closure

_____ _____ _____ X. Cystoscopy

_____ _____ _____ Y. Hysteroscopy: diagnostic or operative including polypectomy, myomectomy, adhesiolysis, septum removal, endometrial ablation

_____ _____ _____ Z. Laparoscopy, diagnostic or operative including adnexal procedures, management of ectopic, chromopertubation, adhesiolysis, biopsy, fulgaration or excision of endometriosis, myomectomy

_____ _____ _____ AA. Tubal sterilization with cautery, rings, or clips

_____ _____ _____ BB. Non-hysteroscopic endometrial ablation techniques

_____ _____ CC. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgery privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be their expertise in gynecologic surgery.
Requested Approved

_____ _____ 24.06 EMERGENCY GYNECOLOGY AND GYNECOLOGIC SURGERY

Evaluate, diagnose, treat, and provide consultation, inpatient care and pre-and post-operative care necessary to correct or treat female patients of all ages presenting urgently or already hospitalized with injuries and disorders of the female reproductive system and the genitourinary system such as ectopic pregnancy, adnexal torsion, ruptured ovarian cyst, miscarriage, reproductive infections, uterine bleeding and trauma.
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00
PROCTORING: 3 observed operative procedures including at least one laparoscopy.
REAPPOINTMENT: 15 procedures in the previous two years including at least 4 laparoscopies or laparotomies

_____ _____ A. Admission of patients with gynecologic issues

_____ _____ B. Care of admitted post-op and non-operative gyn patients

_____ _____ C. Surgical and non-surgical treatment of ectopic pregnancy and suspected ectopic pregnancy

_____ _____ D. Surgical and non-surgical treatment of miscarriage

_____ _____ E. Placement of intra-uterine balloon catheter to manage bleeding

_____ _____ F. Exam under anesthesia

_____ _____ G. Excision, I&D or surgical management of vulvar and vaginal lesions and abscesses

_____ _____ H. Dilatation and curettage, suction curettage, manual uterine aspiration; diagnostic or therapeutic

_____ _____ I. Exploratory laparotomy

_____ _____ J. Diagnostic laparoscopy, lysis of adhesions

_____ _____ K. Adnexal procedures (open or laparoscopic) such as: salpingectomy, salpingostomy, oophorectomy, ovarian detorsion, ovarian cystectomy, ovarian biopsy,salpingo-oophorectomy

_____ _____ L. Drainage or removal of pelvic abscess (vaginal, laparoscopic or open)

_____ _____ M. Repair of vaginal, vulvar or cervical lacerations and trauma

_____ _____ N. Myomectomy, abdominal or vaginal

_____ _____ O. Repair simple rent/tear of bowel or bladder

_____ _____ P. Paracentesis

_____ _____ Q. Wound management: skin debridement, wound dehiscence, wound closure

_____ _____ R. Cystoscopy

_____ _____ S.Emergent hysteroscopy

_____24.10 WAIVED TESTING PRIVILEGES

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges providers satisfy competency expectations for waived testing by The Joint Commission. PREREQUISITES: Currently Board Admissible, Board Certified, or Re- Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology or General Surgery.
PROCTORING:By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

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

_____A.Fecal Occult Blood Testing (Hemoccult®)

_____B.Vaginal pH Testing (pH Paper)

_____C.Urine Chemstrip® Testing

_____ __ _____D. Urine Pregnancy Test (SP® Brand Rapid Test)

_____ __ _____**24.20 SPECIAL PRIVILEGES**

_____ __ _____**24.21 SECOND TRIMESTER ABORTION PROCEDURES** (also request 24.25 to practice in Women's Options Center)

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.

PROCTORING: 3 observed operative procedures. 2 observed operative procedures for UCSF trained Fellows/Residents.

REAPPOINTMENT: 10 procedures in the previous two years

_____ __ _____A. Second trimester abortion by dilation and evacuation

_____ __ _____B. Intra-fetal or intra-amniotic injection

_____ __ _____**24.22 LASER THERAPY**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Appropriate training, complete the laser safety module prepared by the ZSFG Laser Safety Committee at http://insidechnsf.chnsf.org/det/HealthStream.htm and baseline eye examination within the previous 1 year.

PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at ZSFG. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at ZSFG.

_____ _____A. Laser therapy of the cervix

_____ _____B. Laser therapy of the vagina, vulva, and perineum

_____ _____C. Laser conization of the cervix

Requested Approved

_____ __ _____**24.23 HYSTEROSCOPIC STERILIZATION**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.

TRAINING AND PROCTORING:

1. Providers must be trained in hysteroscopy and have current gynecologic endoscopy privileges in the ZSFG Department of Obstetrics and Gynecology
2. As required by the FDA, the physician must attend a training course sponsored by the manufacturer of the Essure System (Conceptus)
3. After training, the provider must be proctored for two Essure procedures. Proctoring may be performed at ZSFG by a provider privileged for this procedure at ZSFG or may be proctored at an outside institution by a qualified provider
4. Once proctoring has been completed, certification in the Essure procedure will be issued by Conceptus. This certification is a required prerequisite for approval of this privilege at ZSFG.
5. Providers who have been certified by Conceptus at another institution may apply for this privilege at ZSFG after being proctored for one procedure by an ZSFG physician who currently holds the privilege.

REAPPOINTMENT: 2 operative procedures in the previous two years

_____ __ _____ A. ESSURE tubal occlusion procedure

_____ __ _____ **24.24 UROGYNECOLOGY**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.

PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 15 operative procedures in the previous two years

_____ __ _____ A. Urodynamics

_____ __ _____ B. Intravesical and intraurethral injections

_____ __ _____ C. Abdominal bladder neck suspension procedures

_____ __ _____ D. Vaginal bladder neck suspension procedures

_____ __ _____ E. Vaginal vault suspension procedures

_____ __ _____ F. Urethral procedures: dilation of urethral stricture

_____ __ _____ G. Colpocleisis

Requested Approved

_____ __ _____ **24.25 PROCEDURAL SEDATION**

Procedural sedation privilege is required for those who will work in Women's Options Center.

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Obstetrics and Gynecology or the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00, and has completed at least one of the following:

1) Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,

2) Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
3) Current Basic Life Support (BLS) certification by the American Heart Association

PROCTORING: Review of 5 cases. Review of 5 cases for UCSF-trained Fellows/Residents.

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

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

24.41 GYNECOLOGIC ONCOLOGY

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Current certification or active participation in the examination process leading to subspecialty certification in gynecologic oncology by the American Board of Obstetrics and Gynecology

PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained
Fellows/Residents.

REAPPOINTMENT: 15 operative procedures in the previous two years, at least 5 of which are performed at ZSFG

A. Evaluate, diagnose, treat, and provide consultation and treatment to female patients with gynecologic cancer and complications resulting there from, including carcinomas of the cervix, ovary, fallopian tubes, uterus, vulva, and vagina and the performance of procedures on the bowel, ureter, and bladder as indicated.

B. Radical hysterectomy for treatment of invasive carcinoma of the cervix

C. Radical surgery for treatment of gynecologic malignancy to include procedures on bowel, ureter, or bladder, as indicated

D. Treatment of invasive carcinoma of vulva by radical vulvectomy

E. Treatment of invasive carcinoma of the vagina by radical vaginectomy

Requested Approved

24.42 MATERNAL-FETAL MEDICINE

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Successful completion of postgraduate training program in Maternal and Fetal Medicine and current certification or active participation in the examination process leading to subspecialty certification in maternal and fetal medicine by the American Board of Obstetrics and Gynecology or having been given his privilege at ZSFG prior to 10/17/00

PROCTORING: Observed care of 3 patients. Observed care of 2 patients for UCSF-trained Fellows/Residents.
REAPPOINTMENT: Care of 20 patients in the previous 2 years

A. Evaluate, diagnose, treat, and provide consultation to female patients with medical and surgical complications of pregnancy such as maternal cardiac, pulmonary, metabolic, connective tissue disorders, and fetal malformations, conditions, or disease

B. Genetic amniocentesis

C. Level 2 obstetrical ultrasound, including Doppler

D. Invasive fetal procedures, including cordocentesis, intrauterine fetal transfusion, cardiocentesis, thoracentesis

24.50 DUAL DEPARTMENT APPOINTMENT

FOR PHYSICIANS WHO DO NOT HAVE A PRIMARY APPOINTMENT IN OB/GYN. Physicians trained in specialties other than obstetrics and gynecology may apply for dual appointment in the Department of Obstetrics and Gynecology for specified privileges, assuming that training and experience in a residency, fellowship, or clinical practice can be documented.

24.51 **WOMEN'S OPTION CENTER PROCEDURES (Dual Department Appointment only)**

PREREQUISITES:

1. Successful completion of an ACGME accredited postgraduate training program in family medicine, internal medicine, or pediatrics
2. Current medical staff appointment to a ZSFG clinical department (other than the Department of Obstetrics and Gynecology)
3. Completion of a fellowship program in family planning or documentation of training and experience in performing the requested procedures in residency, fellowship, or clinical practice.

If a family planning fellowship has not been completed, clinical experience in the past 5 years of practice must include, at a minimum:

- Insertion of contraceptive implants (5 procedures)
- Insertion of intrauterine contraceptives (5 procedures)
- First trimester abortion (through 14 weeks) (50 procedures)
- Second trimester abortion (15 weeks and later) (50 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (15 procedures)

PROCTORING:

- Insertion of contraceptive implants (2 procedures)
- Insertion of intrauterine contraceptives (2 procedures)
- First trimester abortion (through 14 weeks) (5 procedures)
- Second trimester abortion (15 weeks and later) (5 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (5 procedures)

REAPPOINTMENT (procedures in the past 2 years):

- Insertion of contraceptive implants (2 procedures)
- Insertion of intrauterine contraceptives (2 procedures)
- First trimester abortion (through 14 weeks) (10 procedures)
- Second trimester abortion (15 weeks and later) (10 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (10 procedures)

24.511—Insertion of contraceptive implants

24.512—Insertion of intrauterine contraceptives

24.513—First trimester abortion (through 14 weeks)

24.514—Second trimester abortion (through 15 weeks and later)

~~24.515: Basic obstetrical ultrasound as an adjunct to abortion~~

~~**24.61 LICENSED CLINICAL PSYCHOLOGIST**~~

~~Provide individual counseling and psychotherapy at the New Generations Health Center~~
~~PREREQUISITES: Must hold a doctoral degree in Psychology from an approved APA accredited program and must be licensed by the State of California, Board of Psychology.~~
~~PROCTORING: Review of 5 cases by a clinical psychologist on the ZSFG Medical Staff.~~
~~REAPPOINTMENT: Review of 3 cases by a clinical psychologist on the ZSFG Medical Staff.~~

~~**24.65 CTSI (Clinical and Translational Science Institute) - Clinical Research**~~

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

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

~~Applicant signature:Date:~~

~~Department Chief signature:_Date:~~

Delineation Of Privileges

Obstetrics And Gynecology 2019

Provider Name:

Privilege	Requested	Approved

I. OBGYN OBSTETRICS and GYNECOLOGY 2019

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

II. CORE PRIVILEGES

1.06 OUTPATIENT CLINIC: OBSTETRICS

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PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 50 clinic visits in the previous 2 years

a. Prenatal Care Visits, Both Low And High Risk Patients. If indicated for patient and/or provider safety, site may also include the patient's home, a community location, or another safe, private location.

b. Interpretation Of Fetal Monitoring

Treatment Of Medical Complications Of Pregnancy Including, But Not Limited To: Pregnancy Induced Hypertension, Chronic Hypertension, Diabetes Mellitus, Renal Disease, Coagulopathies, Cardiac Disease, Anemias And Hemoglobinopathies, Thyroid Disease, Sexually Transmitted Disease, Pulmonary Disease, Thromboembolic Disorders, Infectious Disease, Ectopic Pregnancy, Early Pregnancy Failure, First Trimester Bleeding and Miscarriage Management. ~~And Other Accidents O Pregnancy, Such As Incomplete, Complete, Or Missed Abortion~~

2.06 BASIC OB/GYN ULTRASOUND

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: Interpretation of 5 ultrasound exams. Interpretation of 3 ultrasound exams for UCSF-trained Fellows/Residents.

REAPPOINTMENT: Interpretation of 10 ultrasound exams in the previous two years

a. Localization Of Intrauterine Pregnancy (Ie. Diagnose Iup)

b. Evaluation Of Fetal Viability And Heart Rate

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c. Estimation Of Gestational Age, Fetal Weight

d. Fetal Presentation

e. Evaluation Of Vaginal Bleeding, Placental Location

f. Measurement Of Cervical Length

g. Amniotic Fluid Estimation (AFI)

3.06 INPATIENT OBSTETRICAL CARE

Provider Name:

Privilege	Requested	Approved

PREREQUISITES: Successful completion of an ACGME accredited postgraduate

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training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Note: Procedures marked with an asterisk may only be performed by obstetrician gynecologists, unless the physician has received additional obstetrical training and experience and has been approved by the Chief of OB/GYN & RS to perform these procedures.

PROCTORING: Observed care of 3 patients, each of whom has received at least one of the procedures below. For UCSF-trained residents and fellows: observed care of 2 patients, each of whom has received at least one procedure below.

REAPPOINTMENT: 15 procedures in the previous two years

a. Routine Inpatient Antepartum, Intrapartum, And Postpartum Care

b. Management Of Spontaneous And Induced Labor

c. Pudendal Block* And Local Anesthesia

d. Fetal Assessment, Antepartum And Intrapartum

e. Internal Fetal Monitoring

f. Normal Cephalic Vaginal Delivery

g. Episiotomy And Repair, Including 1St And 2Nd Degree Lacerations

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h. Exploration And Repair Of The Vagina And Cervix

i. Deliver Placenta

j. Evaluate, Diagnose, Treat, And Provide Consultation For Medical Conditions Complicating Pregnancy (Beyond That Contained In Routine Inpatient Antepartum, Intrapartum, And Postpartum Care)*

k. Fetal Scalp Sampling*

l. Tubal Ligation, Post-Partum*

m. Non-Genetic Amniocentesis*

n. Forceps Delivery*

o. Delivery By Vacuum Extraction*

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p. Manual Or Instrumental Extraction Of The Placenta And Fragments*

q. Cesarean Section (Primary Surgeon)*

r. Treatment of Cervical Insufficiency (Cervical Cerclage))*

s. External Version Of Breech Presentation*

t. Vaginal Breech Delivery*

u. Vaginal Multiple Fetus Delivery*

v. Repair Of Rectal Injury (3rd And 4th Degree Laceration)*

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w. Cesarean Hysterectomy*

Provider Name:

Privilege	Requested	Approved

x. Vaginal Birth After Caesarean Section*

y. Pregnancy Termination Via Labor Induction*

4.06 OUTPATIENT CLINIC: GYNECOLOGY

Evaluate, diagnose, treat, and provide consultation, pre-and post-operative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgical disorders and injuries of the mammary glands. When inpatient gynecologic care privileges have been approved, procedures in this privilege group also can be performed in the hospital operating room.

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: Review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 50 clinic visits in the previous 2 years

a. Preventive Health Visits: Well Women, Family Planning Visits

b. Problem-Oriented Gynecologic Visits

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c. Microscopic Diagnosis Of Urine And Vaginal Smears

d. Colposcopy

e. Vulvar, Vaginal And Cervical Biopsy

f. Endometrial Biopsy

g. Cervical Or Endometrial Polypectomy

h. Insertion And Removal Of Intrauterine Contraceptive (IUC)

i. Insertion And Removal Of Contraceptive Implant

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j. Pessary Fitting

k. Trigger Point Injection

l. Cryosurgery (Cervix, Vulva, Vagina)

m. Loop Electrosurgical Excision Procedure (LEEP), Cervix

n. Bartholin Duct Procedures (Incision And Drainage, Marsupialization)

o. Dilation And Curettage, Suction Curettage And Manual Uterine Aspiration, Including Abortions Up To 18 Weeks' Gestation

p. Simple Cystometry

q. Paracervical And Intracervical Block

r. Insertion Of Cervical Dilator

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s. Anoscopy

5.06 INPATIENT GYNECOLOGY AND GYNECOLOGIC SURGERY

Provider Name:

Privilege	Requested	Approved

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 5 observed operative procedures, including at least one laparotomy and one laparoscopy.

REAPPOINTMENT: 15 operative procedures in the previous two years

a. Admission Of Patients With Gynecologic Issues

b. Care Of Admitted Post-Op And Non-Operative Gyn Patients

c. Repair Of Vaginal, Vulvar Or Cervical Lacerations

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d. Drainage Or Removal Of Pelvic Abscess (Vaginal, Laparoscopic Or Open)

e. Placement Of Intra-Uterine Balloon Catheter To Manage Bleeding

f. Excision, I&D Or Surgical Management Of Vulvar Or Vaginal Lesions And Abscesses

g. Dilatation And Curettage, Suction Curettage, Manual Uterine Aspiration; Diagnostic Or Therapeutic, Including Abortions Up To 18 Weeks' Gestation

h. Cervical Cone Biopsy, LEEP Procedure

i. Hysterectomy, Abdominal

j. Hysterectomy, Vaginal

k. Hysterectomy, Laparoscopic-Assisted Or Total Laparoscopic

l. Exploratory Laparotomy

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m. Adnexal Procedures (Open Or Laparoscopic) Such As: Salpingectomy, Salpingostomy, Oophorectomy, Ovarian Detorsion, Ovarian Cystectomy, Ovarian Biopsy, Salpingo-Oophorectomy

n. Myomectomy, Abdominal Or Vaginal

o. Incidental Appendectomy

p. Fistula Repairs (Vesicovaginal Or Rectovaginal)

q. Repair Simple Rent/ Tear Of Bowel Or Bladder

r. Perineoplasty, Labiaplasty

s. Repair Of Cystocoele, Rectocele, Enterocele

t. Tuboplasty

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u. Hernia Repair (Incisional Or Umbilical)

v. Paracentesis

w. Wound Management: I&D, Skin Debridement Wound Dehiscence, Wound Closure

x. Cytoscopy

Provider Name:

Privilege	Requested	Approved
y. Hysteroscopy: Diagnostic Or Operative Including Polypectomy, Myomectomy,Adhesiolysis, Septum Removal, Endometrial Ablation		
z. Laparoscopy, Diagnostic Or Operative Including Adnexal Procedures, Management Of Ectopic, Chromopertubation, Adhesiolysis, Biopsy, Fulgaration Or Excision Of Endometriosis, Myomectomy		
aa. Tubal Sterilization With Cautery, Rings, Or Clips		
bb. Non-Hysteroscopic Endometrial Ablation Techniques: Hta, Thermal Balloon, Nova-		

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cc. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgical privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be for their expertise in gynecologic surgery.

6.06 EMERGENCY GYNECOLOGY AND GYNECOLOGIC SURGERY

Evaluate, diagnose, treat, and provide consultation, inpatient care and pre-and post-operative care necessary to correct or treat female patients of all ages presenting urgently or already hospitalized with injuries and disorders of the female reproductive system and the genitourinary system such as ectopic pregnancy, adnexal torsion, ruptured ovarian cyst, miscarriage, reproductive infections, uterine bleeding and trauma.

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 3 observed operative procedures including at least one laparoscopy.

REAPPOINTMENT: 15 procedures in the previous two years including at least 4 laparoscopies or laparotomies

a. Admission Of Patients With Gynecologic Issues

b. Care Of Admitted Post-Op And Non-Operative Gyn Patients

c. Surgical And Non-Surgical Treatment Of Ectopic Pregnancy And Suspected Ectopic

d. Surgical And Non-Surgical Treatment Of Miscarriage

e. Placement Of Intra-Uterine Balloon Catheter To Manage Bleeding

f. Exam Under Anesthesia

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g. Excision, I&D Or Surgical Management Of Vulvar And Vaginal Lesions And Abscesses

h. Dilatation And Curettage, Suction Curettage, Manual Uterine Aspiration; Diagnostic Or Therapeutic, Including Abortions Up To 18 Weeks' Gestation.

i. Exploratory Laparotomy

j. Diagnostic Laparoscopy, Lysis Of Adhesions

k. Adnexal Procedures (Open Or Laprascopic) Including: Salpingectomy, Salpingostomy, Oophorectomy, Ovarian Cystectomy, Ovarian Drilling, Ovarian Biopsy, Ovarian Detorsion, Oophoropexy

l. Drainage Or Removal Of Pelvic Abscess (Vaginal, Laparoscopic Or Open)

Provider Name:

Privilege	Requested	Approved

m. Repair Of Vaginal, Vulvar Or Cervical Lacerations And Trauma

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n. Myomectomy, Abdominal Or Vaginal

o. Repair Simple Rent/Tear Of Bowel Or Bladder

p. Paracentesis

q. Wound Management: Skin Debridement, Wound Dehiscence, Wound Closure

r. Cystoscopy

s. Emergent Hysteroscopy

t. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgical privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be for their expertise in gynecologic surgery.

III. **24.10 WAIVED TESTING PRIVILEGES**

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

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

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

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

a. Fecal Occult Blood Testing (Hemoccult®)

b. Vaginal Ph Testing (Ph Paper)

c. Urine Chemstrip® Testing

d. Urine Pregnancy Test (Sp® Brand Rapid Test)

IV. SPECIAL PRIVILEGES

1.25 ABORTIONS GREATER THAN 18 WEEKS' GESTATION

(Also Request 24.25 To Practice In Women'S Options Center)

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 3 observed operative procedures. 2 observed operative procedures for UCSF- trained Fellows/Residents.

REAPPOINTMENT: 10 procedures in the previous two years

a. Abortions by dilation and evacuation at greater than 18 weeks' gestation

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Provider Name:

Privilege	Requested	Approved

b. Intra-Fetal Or Intra-Amniotic Injection

2.25 LASER THERAPY

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Appropriate training, complete the laser safety module prepared by the SFGH Laser Safety Committee at http://insidechnsf.chnsf.org/det/HealthStream.htm and baseline eye examination within the previous 1 year.

PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at SFGH. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at SFGH.

a. Laser Therapy Of The Cervix

b. Laser Therapy Of The Vagina, Vulva, And Perineum

c. Laser Conization Of The Cervix

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3.25 HYSTEROSCOPIC STERILIZATION

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

TRAINING AND PROCTORING:

1. Providers must be trained in hysteroscopy and have current gynecologic endoscopy privileges in the SFGH Department of Obstetrics and Gynecology
2. As required by the FDA, the physician must attend a training course sponsored by the manufacturer of the Essure System (Conceptus)
3. After training, the provider must be proctored for two Essure procedures. Proctoring may be performed at SFGH by a provider privileged for this procedure at SFGH or may be proctored at an outside institution by a qualified provider
4. Once proctoring has been completed, certification in the Essure procedure will be issued by Conceptus. This certification is a required prerequisite for approval of this privilege at SFGH.
5. Providers who have been certified by Conceptus at another institution may apply for this privilege at SFGH after being proctored for one procedure by an SFGH physician who currently holds the privilege.

REAPPOINTMENT: 2 operative procedures in the previous two years

a. Essure Tubal Occlusion Procedure

4.25 UROGYNECOLOGY

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 15 operative procedures in the previous two years

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Privilege	Requested	Approved
a. Urodynamics		
b. Intravesical and Intraurethral Injections		
c. Abdominal Bladder Neck Suspension Procedures		
d. Vaginal Bladder Neck Suspension Procedures		
e. Vaginal Vault Suspension Procedures		
f. Urethral Procedures: Dilation Of Urethral Stricture		
g. Colpocleisis		

5.25 PROCEDURAL SEDATION

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Procedural sedation privilege is required for those who will work in Women's Options Center.

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

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

Association PROCTORING: Review of 5 cases. Review of 5 cases for UCSF-

Fellows/Residents.

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

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

1.43 GYNECOLOGIC ONCOLOGY

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

Current certification or active participation in the examination process leading to subspecialty certification in gynecologic oncology by the American Board of Obstetrics and Gynecology

PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 15 operative procedures in the previous two years, at least 5 of which are performed at SFGH

a. Evaluate, Diagnose, Treat, And Provide Consultation And Treatment To Female Patients With Gynecologic Cancer And Complications Resulting There From, Including Carcinomas Of The Cervix, Ovary, Fallopian Tubes, Uterus, Vulva, And Vagina And The Performance Of Procedures On The Bowel, Urethra, And Bladder As Indicated.

b. Radical Hysterectomy For Treatment Of Invasive Carcinoma Of The Cervix

Provider Name:

Privilege	Requested	Approved

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c. Radical Surgery For Treatment Of Gynecologic Malignancy To Include Procedures On Bowel, Ureter, Or Bladder, As Indicated

d. Treatment Of Invasive Carcinoma Of Vulva By Radical Vulvectomy

e. Treatment Of Invasive Carcinoma Of The Vagina By Radical Vaginectomy

2.43 MATERNAL-FETAL MEDICINE

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Successful completion of postgraduate training program in Maternal and Fetal Medicine and current certification or active participation in the examination process leading to subspecialty certification in maternal and fetal medicine by the American Board of Obstetrics and Gynecology.

PROCTORING: Observed care of 3 patients

REAPPOINTMENT: Care of 20 patients in the previous

2 years

a. Evaluate, Diagnose, Treat, And Provide Consultation Regarding Patients With Medical And Surgical Complications Of Pregnancy Such As Maternal Cardiac, Pulmonary, Metabolic, Connective Tissue Disorders, And Fetal Malformations, Conditions, Or Disease

b. Genetic Amniocentesis And Chronic Villus Sampling.

c. Level 2 Obstetrical Ultrasound, Including Doppler

d. Invasive Fetal Procedures, Including Cordocentesis, Intrauterine Fetal Transfusion, Cardiocentesis, And Fetal Injections.

e. Management Of Labor, Operative Deliveries And Postpartum Care For High-

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Risk Obstetric Patients, Including Use Of Pudendal Block And Local Anesthesia, If Indicated.

f. Treatment Of Cervical Insufficiency (Cervical Cerclage)

3.43 ADDICTION MEDICINE

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

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

PROCTORING: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

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

1.51 DUAL DEPARTMENT APPOINTMENT

ONLY FOR THOSE WHO DO NOT HAVE A PRIMARY APPOINTMENT IN OB/GYN
Physicians trained in specialties other than obstetrics and gynecology may apply for dual appointment in the Department of Obstetrics and Gynecology for specified privileges, assuming that training and experience in a residency, fellowship, or clinical practice can be documented.

2.51 Women's Option Center Procedures (Dual Department Appointment Only)

Provider Name:

Privilege	Requested	Approved

PREREQUISITES:
1. Successful completion of an ACGME accredited postgraduate training program in family medicine, internal medicine, or pediatrics
2. Current medical staff appointment to a SFGH clinical department (other than the Department of Obstetrics and Gynecology)
3. Completion of a fellowship program in family planning or documentation of training and experience in performing the requested procedures in residency, fellowship, or clinical practice. If a family planning fellowship has not been completed, clinical experience in the past 5 years of practice must include, at a minimum,
   - Insertion of contraceptive implants (5 procedures)
   - Insertion of intrauterine contraceptives (5 procedures)
   - Abortions up to 18 weeks' gestation (50 procedures)
   - Abortions greater than 18 weeks' gestation (50 procedures)
   - Basic obstetrical ultrasound as an adjunct to abortion (15 procedures)

PROCTORING:
- Insertion of contraceptive implants (2 procedures)

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– Insertion of intrauterine contraceptives (2 procedures)
– Abortions up to 18 weeks' gestation (5 procedures)
– Abortions greater than 18 weeks' gestation (5 procedures)
– Basic obstetrical ultrasound as an adjunct to abortion (5 procedures)

REAPPOINTMENT (procedures in the past 2 years):
– Insertion of contraceptive implants (2 procedures)
– Insertion of intrauterine contraceptives (2 procedures)
– Abortions up to 18 weeks' gestation (10 procedures)
– Abortions greater than 18 weeks' gestation (10 procedures)
– Basic obstetrical ultrasound as an adjunct to abortion (10 procedures)

24.511 Insertion Of Contraceptive Implants (5 procedures)

24.512 Insertion Of Intrauterine Contraceptives (5 procedures)

24.513 Abortions Up To 18 Weeks' Gestation (50 procedures)

1.512 Abortions Greater Than 18 Weeks' Gestation (50 procedures)

2.512 Basic Obstetrical Ultrasound As An Adjunct To Abortion

24.61 LICENSED CLINICAL PSYCHOLOGIST

Provide individual counseling and psychotherapy at the New Generations Health Center

PREREQUISITES: Must hold a doctoral degree in Psychology from an approved APA accredited program and must be licensed by the State of California, Board of Psychology.

PROCTORING: Review of 5 cases by a clinical psychologist on the SFGH Medical

Staff. REAPPOINTMENT: Review of 3 cases by a clinical psychologist on the SFGH

Medical Staff.

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24.65 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

Provider Name:

Privilege	Requested	Approved

CTSI Medical Director _____ Date

I hereby request clinical privileges as indicated above.

Applicant _____ Date

V. **APPROVED BY**

Division Chief _____ Date

Service Chief _____ Date

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~~XIV. APENDIX B. HOUSE STAFF COMPETENCIES~~ XIV. APPENDIX B. HOUSESTAFF

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COMPETENCIES ~~HOUSESTAFF~~ AND SUPERVISON

House Staff providing clinical services shall do so only under the supervision of active or courtesy medical staff who have ultimate responsibility for patient care, are members of the University of California, San Francisco Faculty, and have appropriate clinical privileges.

A. ATTENDING RESPONSIBILITY

Zuckerberg San Francisco General Hospital & Trauma Center Medical Staff Bylaws, JCAHO Standards and California law require that the attending physician oversee and assume ultimate responsibility for the care of each patient. Accordingly, house staff shall be always supervised by and accountable to a member of the ZSFG Medical Staff with a University of California faculty appointment. In order to discharge that responsibility, close supervision and active participation in decision-making is required.

1. Inpatient Attending Rounding/Supervision
   a. The attending physician will discuss the management of the patient with House Staff at least once a day and as necessary in light of material changes or developments in the patient's clinical status.
   b. The attending physician will be available and participate in major decision-making (.e.g., DNR, admission, or discharge orders) at all times.

2. Outpatient Attending Supervision
   a. Attending physicians will oversee the care provided to all outpatients. Attending physicians are assigned to specific outpatient sessions, which may vary from week to week. Attending physicians will be physically present in the outpatient clinics to supervise the care provided by house staff. It is the attending physician's responsibility to arrange coverage for absences.

3. Attending Supervision of Major Procedures/Complex Medical Treatments
   a. The attending physician will provide direct supervision for the main portion of all major operative procedures, including all surgery performed in the main operating room, the Birth Center, and 6G, and all advanced outpatient procedures (e.g. hysteroscopy, cystoscopy, and electro-excisional procedures of the cervix). The attending physician will determine each house staff officer's scope of practice and level of supervision required according to the year of post-graduate training and demonstrated clinical skills.

4. Attending Supervision of Informed Consent Process
   a. All patients with medical decision-making capacity must be given adequate information about the risks, benefits, and alternatives for any treatment, operation, or special diagnostic or therapeutic procedure, which involves significant risk of bodily harm.
   b. The attending physician is responsible for ensuring adequate disclosure is made prior to procedures requiring informed consent, for supervising the informed consent process and ensuring appropriate documentation in the medical record. The attending physician may delegate the task to a licensed physician, but the attending physician should document his or her confirmation that informed consent was obtained in the medical record prior to the procedure.
   c. The patient has a right to know the names and professional relationships of the physicians involved in her medical care. Accordingly, the patient shall be informed which attending physician will be supervising the procedure and, prior to the procedure, when a different attending physician is substituted
   due to scheduling changes, etc.
   d. In the event of a medical emergency, when immediate services are required to alleviate severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required, if delay of such treatment would lead to serious disability or death, the treating physician, preferably the attending, should document the existence and nature of the emergency and the necessity of the proposed or rendered treatment. There is no requirement that the physician seek consultation ("the two attending" rule).

B. HOUSE STAFF RESPONSIBILITES

1. House Staff Compliance
    a. House Staff shall comply with the ZSFG Medical Staff Bylaws, Rules and Regulations, Departmental Rules and Regulations, Hospital Policies and Procedures and the Principles of Medical Ethics of the American Medical Association and participate in the ZSFG PIPS and Risk Management Programs.

2. Responsibilities
    a. House Staff will be able to always identify an available supervising attending physician during patient care. House staff must consult the attending physician, directly or through the chain of command, as appropriate, prior to material changes in the plan of care of a major surgical or obstetrical procedure.
    b. House staff should not proceed with the care or procedure unless and until there is meaningful consultative interaction with the Attending physician, directly or through the chain of command, as appropriate.
    ~~b~~c. House Staff must consult the attending physician, directly or through the chain of command, as appropriate, with questions or concerns regarding patient care and when the plan of care requires that house staff undertake at treatment outside the House Staff member's level of commensurate with his or her level of advancement and responsibility.

C. MEDICAL RECORDS DOCUMENTATION BY ATTENDINGS/HOUSE STAFF

These are delineated in Section XI.B of the OB/GYN Clinical Service Rules and Regulations. Operative reports, discharge summaries, and consultation notes may be written or dictated by House Staff as appropriate but must ultimately be reviewed and signed by the attending physician.

D. HOUSE STAFF EVALUATION AND DISCIPLINARY ACTION

1. Evaluation
    a. House staff are evaluated informally by more senior house staff and by attending physicians as clinical rotations are underway. A formal electronic evaluation is compiled at the end of each rotation, kept on file ~~in the~~by the Residency Program ~~Office~~, and distributed to the resident and his or her faculty advisor. Residents are not advanced to the next postgraduate training year without successful completion of clinical rotations, the annual in-service examination, any delinquent medical records, and their personal house staff experience statistics.

2. Disciplinary Action: ~~Refer to Section VIII.~~ ~~Other~~ disciplinary actions may occur at the direction of the Residency Program.

XV. APPENDIX C- OB/GYN CLINCAL SERVICE ORGANIZATION CHART

~~Interim Chief of Service~~	~~Jody Steinauer, MD, PhD~~
Chief of Service~~, tentatively beginning 11/1/23~~	Rebecca Jackson, MD~~, MAS~~
Medical Director Obstetric Service	Ben Li, M.D.
Medical Director Gynecology Service	~~Abner Korn~~Josie Urbina, M.D.
Medical Director, OMG Clinic	~~Margy Hutchison~~Anna Altshuler, MD
~~Ob-gyn Liaison~~Perinatal Coordinator, OMG Clinic	~~Dilys Walker, M.D~~Savannah Washington, CNM.
Medical Director, Women's Options Center	Eleanor Drey, MD, EdM
Site Director, Resident Education & Training	Biftu Mengesha, M.D., M.A.S.
~~Director of~~Site Director, Medical Student Education	Naomi Stotland, M.D.
~~Medical Director, New Generation Health Center~~	~~Rebecca Jackson, M.D., M.A.S.~~
Medical Director, Reproductive Infections	Nika Seidman, M.D., M.A.S.
Chair of Midwifery Council	~~Margy Hutchison,~~Kara Myers, CNM~~, MSN~~
~~Director Nurse Midwifery Education~~	~~Kim Dau CNM,~~
Director of Quality Improvement	Ana Delgado, CNM

MEDICAL STAFF COMMITTEE ASSIGNMENTS

Ambulatory Care Committee	~~Margy Hutchison~~Anna Altshuler, MD
~~Cancer Committee~~	~~Abner Korn, M.D~~
Credentials Committee	Anna Altshuler, ~~Jennifer Kerns,~~ M.D.~~, MPH~~, Kara Myers, CNM
Interdisciplinary Practice	Kara Myers, CNM
Medical Executive Committee	Rebecca Jackson, M.D.
Operating Room Committee	~~JiaJia Zhang~~Josie Urbina, M.D.
Performance Improvement & Patient Safety (PIPS)	Ana Delgado, CNM.
Perinatal Linkage Committee	Ana Delgado, CNM
Clinical Practice Group	Rebecca Jackson MD~~, MAS~~
Risk Management Committee	Rebecca Jackson, MD~~, MAS~~
Transfusion Committee	Naomi Stotland, MD
Moderate Sedation Committee	Eleanor Drey, MD EdM
Ethics Committee	Yasaswi Kislovskiy, MD and Eleanor Drey, MD, EdM

~~sf~~

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

XVII. APPENDIX D OB/GYN M&M REVIEW FORMS

A.

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Formatted: Indent: Left: 0.08", Space Before: 1.7 pt

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

B.

Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

~~XVII. APPENDIX E- OPPE FORM~~

Medical Executive Committee Annual Report

January 12, 2026

Department of Oral and Maxillofacial Surgery



Changes

Department of Oral and Maxillofacial Surgery

Rules and Regulations

TEMPLATE FOR CHIEF OF SERVICE REPORT TO MEC

Please include the following items in your service report to MEC.

I. Scope of the Clinical Service.
   - A. Clinical services/programs provided
   - B. Hospital-based clinical work
   - C. Ambulatory-based clinical work
   - D. Structure of the Department/Clinical Service and leadership

II. Faculty and Residents
   - A. Faculty – number and roles
   - B. Number and type of trainees participating in clinical programs at ZSFG
   - C. Key training program elements

III. Performance Improvement and Patient Safety initiatives
   - A. Describe at least two PIPS project that are underway or recently completed
     1) Describe the Service's participation in the initiative
     2) Describe the impact on patient care and patient safety
   - B. If available, include patient satisfaction data
   - C. Summarize involvement in Hospital and Medical Staff committees
     1) List the Committees and the members

IV. Research
   - A. Discuss scope of research enterprise
   - B. Highlight key projects and contributions by faculty members and/or trainees

V. Financial Report
   - A. Include revenue and costs related to clinical services, research, and administration

VI. Summary
   - A. Strengths
   - B. Challenges/opportunities for improvement
   - C. Goals – short and long term

Scope of Service

Department of Oral and Maxillofacial Surgery

Hospital Based Oral and Maxillofacial Surgery
Ambulatory Oral and Maxillofacial Surgery

Scope of Service

Department of Oral and Maxillofacial Surgery

Hospital Based Oral and Maxillofacial Surgery
Ambulatory Oral and Maxillofacial Surgery

Laguna Honda Hospital – Dental Department





Scope of Service

Department of Oral and Maxillofacial Surgery

Highland Hospital



Hospital Service

Call Schedule

24/7 Dental

1 in 3 – Facial Trauma (OHNS, OMFS, PRS)

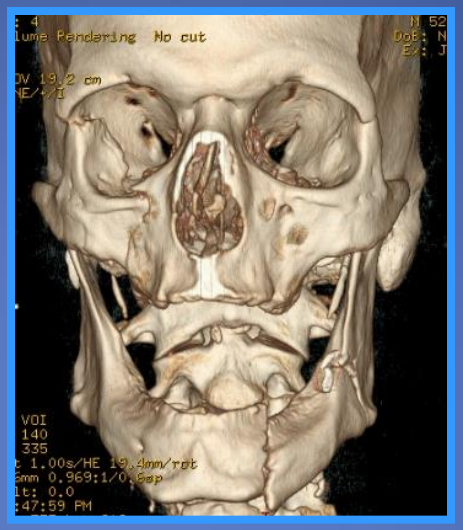
372 Consults

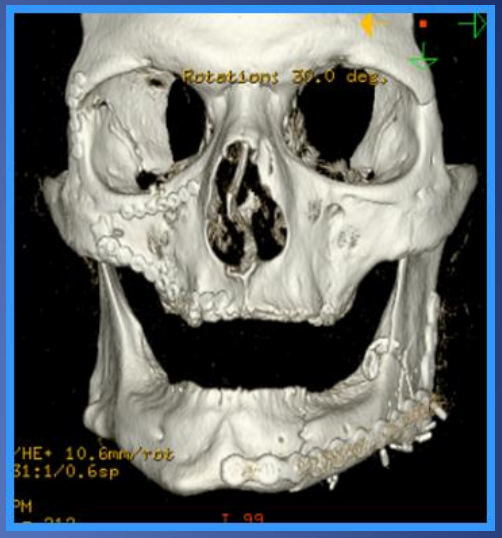
Hospital Service

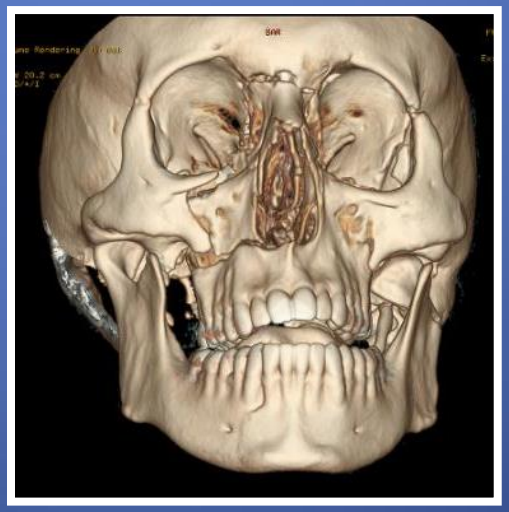
Operating Room

1 Day/Week

111 Case
84 Ambulatory
27 In Patient









Hospital Service

Operating Room

1 Day/Week

111 Case
84 Ambulatory
27 In Patient

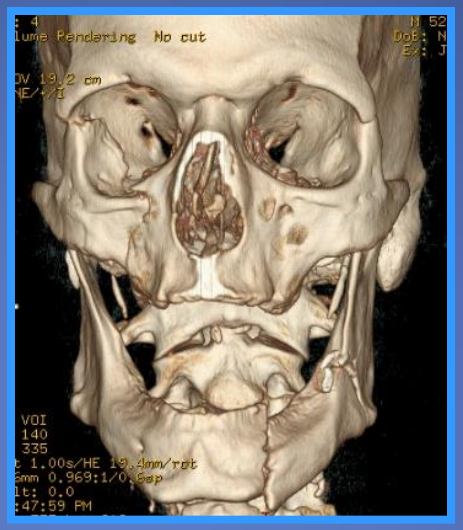
Block Utilization by service

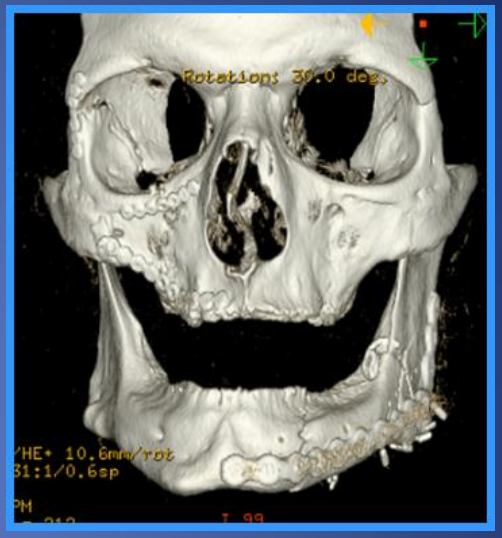
Service	Block Util% May 2025	Block Util% Apr 2025	Block Util% Mar 2025
ENT	76%	61%	89%
General	85%	94%	95%
GYN	87%	82%	82%
Neurosurgery	87%	72%	86%
Ophthalmology	87%	81%	85%
Oral surgery	72%	54%	95%
Orthopedics	81%	77%	78%
Plastics	84%	93%	78%
Urology	86%	81%	72%
Vascular	66%	65%	86%

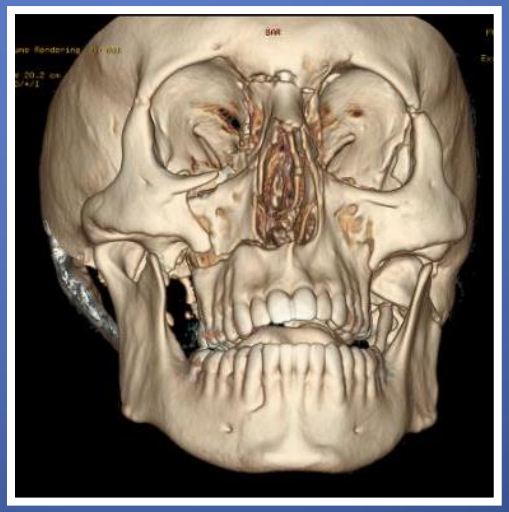
Hospital Service

Admissions

62 Hospital Admissions









Ambulatory Service

1N Clinic

M TuW Th Fr

Dental Alveolar Surgery
Oral Pathology
Oral Medicine

Moderate Sedation

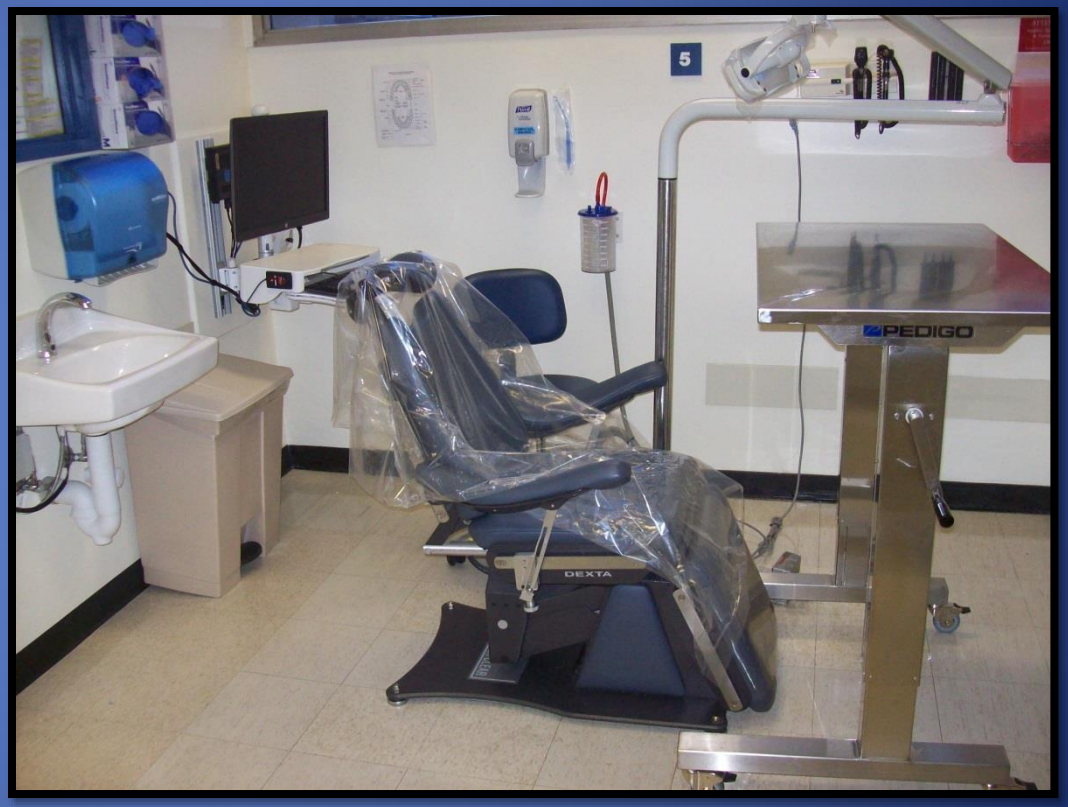


Ambulatory Service

1N Clinic (2022)

5548 Patient Visits
3403 Radiographs
3297 Extractions
251 Infections
202 Emergency Room Consults
81 In-Patients
212 Moderate Sedations

10-15 Walk In Patients



Ambulatory Service

Department of Oral and Maxillofacial Surgery

1N Staff

2 RDA
2 RN
1 Unit Clerk

Nurse Manager

Alena Maunder RN, MSN



Ambulatory Service

Department of Oral and Maxillofacial Surgery



Desiree Roman RN



Ginger Tandoc RN

Ambulatory Service

Department of Oral and Maxillofacial Surgery

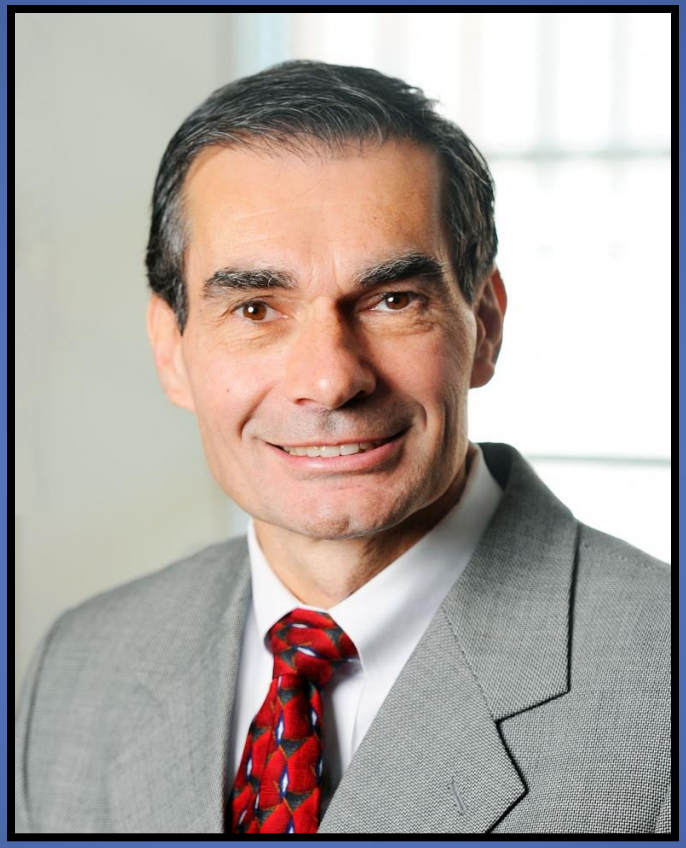


Suman Gir RDA

Faculty and Residents



Faculty



Michael Reddy D.M.D.
Dean, UCSF School of Dentistry

Faculty

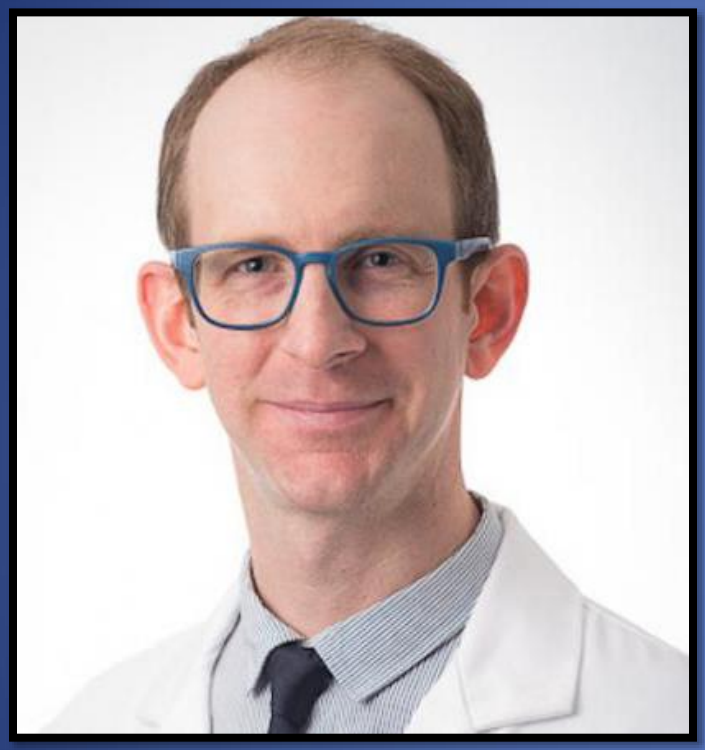


Brian Bast D.M.D., M.D.
Chair, Chief



Sohail Saghezchi D.D.S., M.D.
Residency Program Director

Faculty



Andrew Weeks D.D.S., M.D.



Jennifer Perkins D.D.S., M.D.
Assistant Dean of Education
UCSF School of Dentistry

Faculty



Tara Brantley D.M.D., M.D.



Mark Crane D.D.S. , M.D.

Faculty



Akshay Govind DMD, MD



Ricardo Lugo DDS, MD



Phil Harrison DDS, MD



Janet Sung DMD, MD, MPH

Faculty



Akshay Govind DMD, MD
Teaching Scholars Program



Ricardo Lugo DDS, MD
Coro Faculty Leadership Collaborative



Phil Harrison DDS, MD



Janet Sung DMD, MD, MPH

Trainees

Teaching Programs

Oral and Maxillofacial Surgery Residency

6 Year Program/4 Residents Per Year
Medical School/Anesthesia/General Surgery
40% Fellowship/Academics

Otolaryngology Head and Neck Surgery R1
Plastic and Reconstructive Surgery R1



Nicole Lee, MD, DDS



Morgan Nelson, MD, DDS



Nisarg Patel, MD, DMD, MS



Yunqing (Olivia) Yu, DDS



Sepehr Hashemi, DMD



Matthew Low, DDS



Utsav Rana, DDS



Michael Pedram, MD, DDS



Grant Oshita, MD, DDS



Susan Lee, MD, DDS



Stephen Yang, MD, DDS





Brian Ho, DDS



Kais Larbi, DDS



Brooke Brannon, MD, DDS



Meredith Gomes, MD, DDS



Jymie Graham, MD, DDS



Bryant Lau, DDS



Nathan Tsiperfal, DMD



Sheba Vincent, DDS, MS









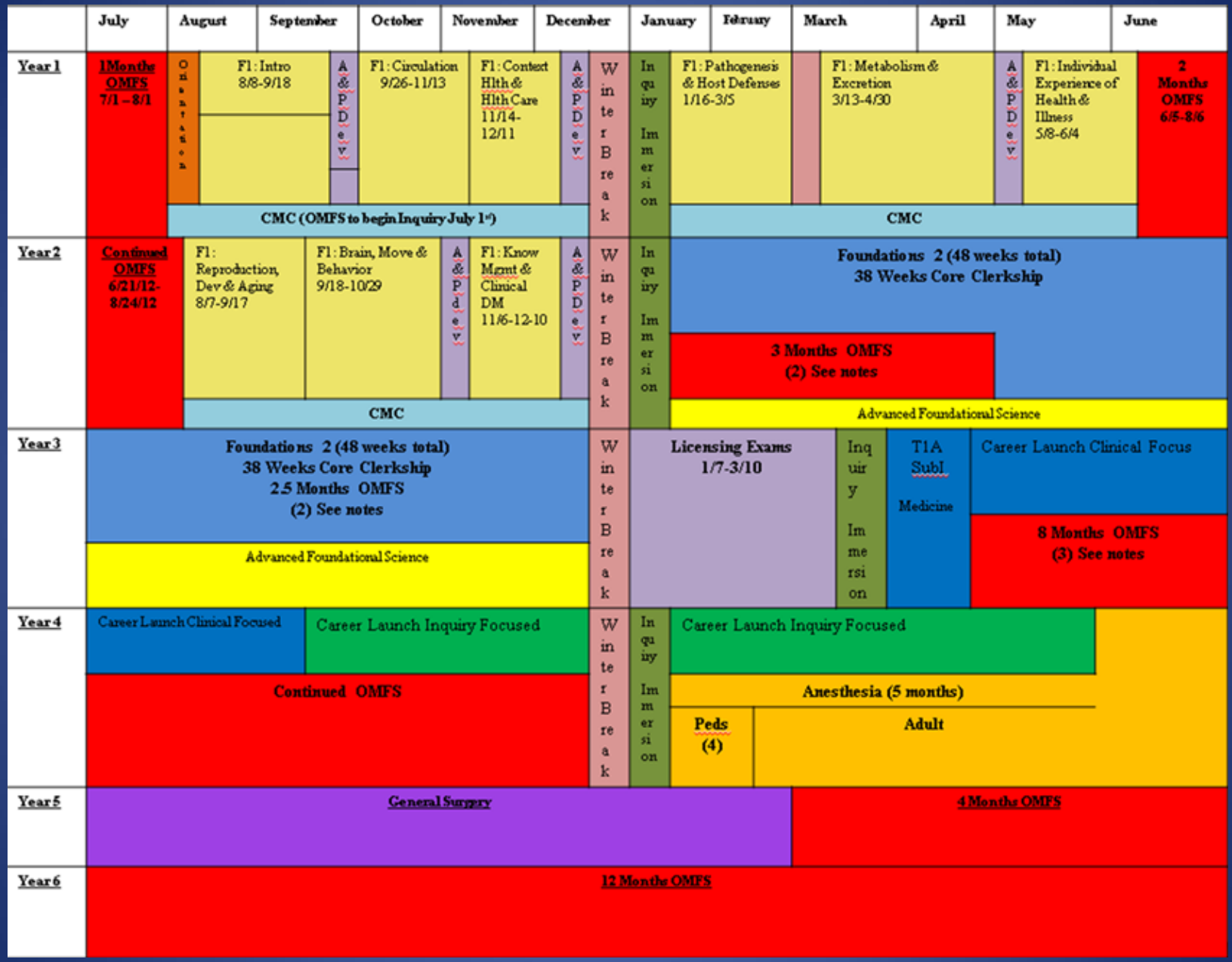
Zachary Dai, DDS



Alireza Hatamifar, DDS



John Killam, DDS


July
August
September
October
November
December
January
February
March
April
May
June
Year 1
1Months OMFS 7/1 – 8/1
Orientation
F1: Intro 8/8-9/18
A & P Dev
F1: Circulation 9/26-11/13
F1: Context Hlth & Hlth Care 11/14-12/11
A & P Dev
Winter Break
Inquiry Immersion
F1: Pathogenesis & Host Defenses 1/16-3/5
F1: Metabolism & Excretion 3/13-4/30
A & P Dev
F1: Individual Experience of Health & Illness 5/8-6/4
2 Months OMFS 6/5-8/6
CMC (OMFS to begin Inquiry July 1st)
CMC
Year 2
Continued OMFS 6/21/12-8/24/12
F1: Reproduction, Dev & Aging 8/7-9/17
F1: Brain, Move & Behavior 9/18-10/29
A & P dev
F1: Know Mgmt & Clinical DM 11/6-12-10
A & P Dev
Winter Break
Inquiry Immersion
Foundations 2 (48 weeks total)
38 Weeks Core Clerkship
3 Months OMFS
(2) See notes
CMC
Advanced Foundational Science
Year 3
Foundations 2 (48 weeks total)
38 Weeks Core Clerkship
2.5 Months OMFS
(2) See notes
Advanced Foundational Science
Winter Break
Licensing Exams 1/7-3/10
Inquiry Immersion
T1A SubI Medicine
Career Launch Clinical Focus
8 Months OMFS
(3) See notes
Year 4
Career Launch Clinical Focused
Career Launch Inquiry Focused
Continued OMFS
Winter Break
Inquiry Immersion
Career Launch Inquiry Focused
Anesthesia (5 months)
Peds (4)
Adult
Year 5
General Surgery
4 Months OMFS
Year 6
12 Months OMFS

Faculty and Residents

Student Programs

Dental Student Clinical Rotation

90 Students/Year

Dentistry for Medical Students

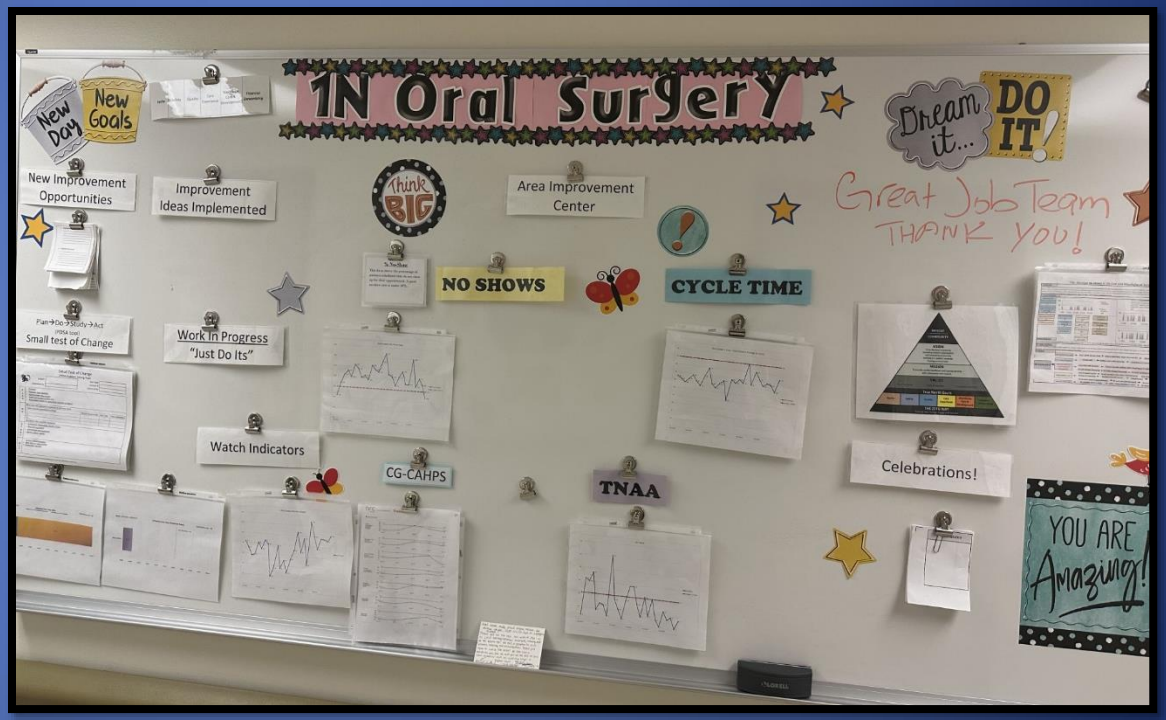
75 Students/Year

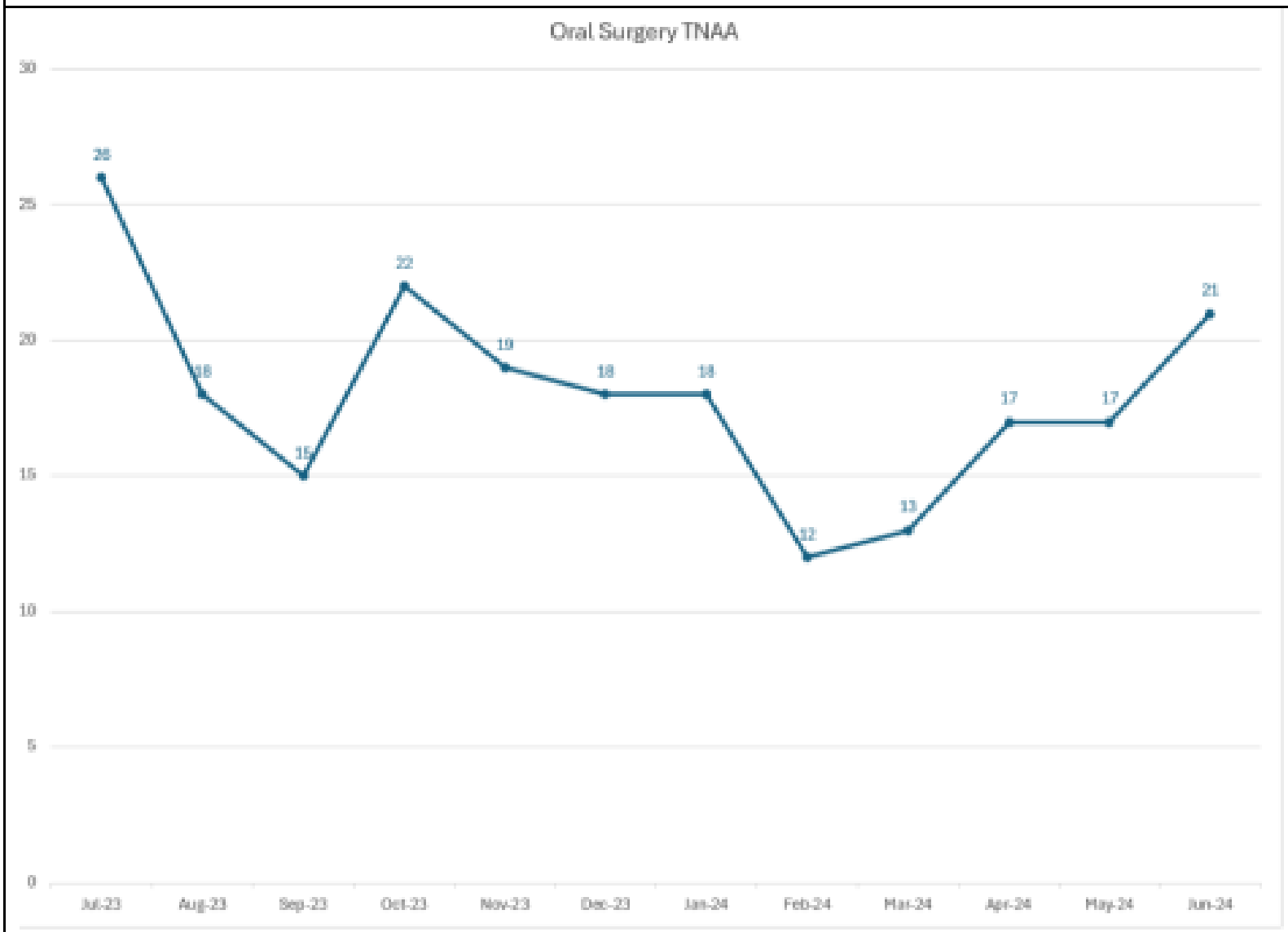
Performance Improvement and Patient Safety Initiatives



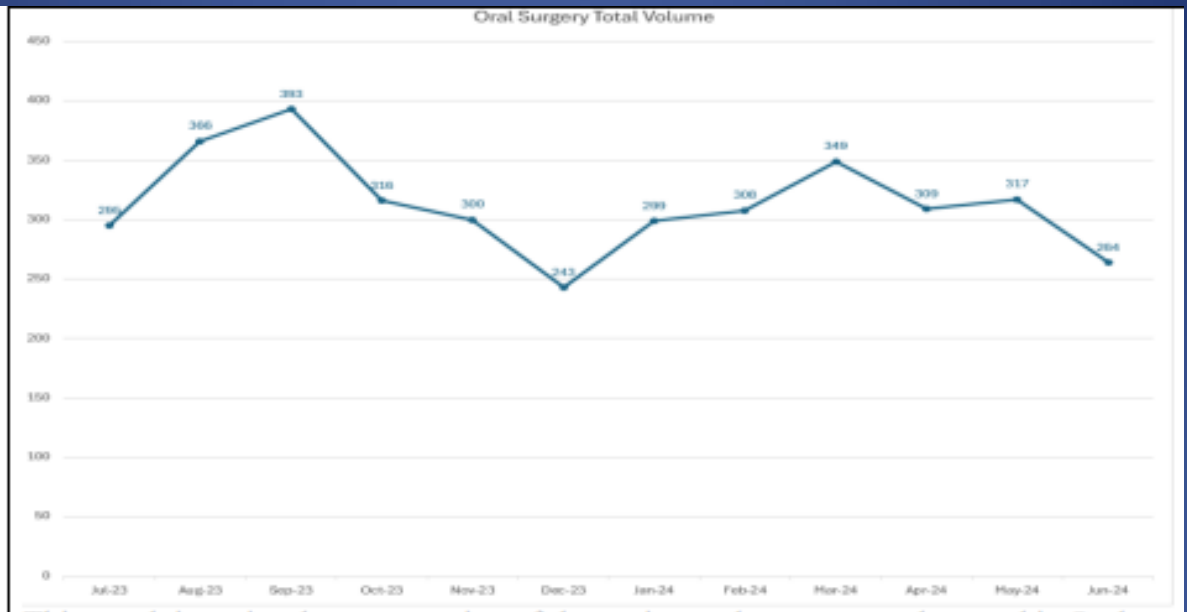
Performance Improvement and Patient Safety

1. TNAA
2. Clinic volume
   Procedural Sedation
3. Clinic Cycle Times

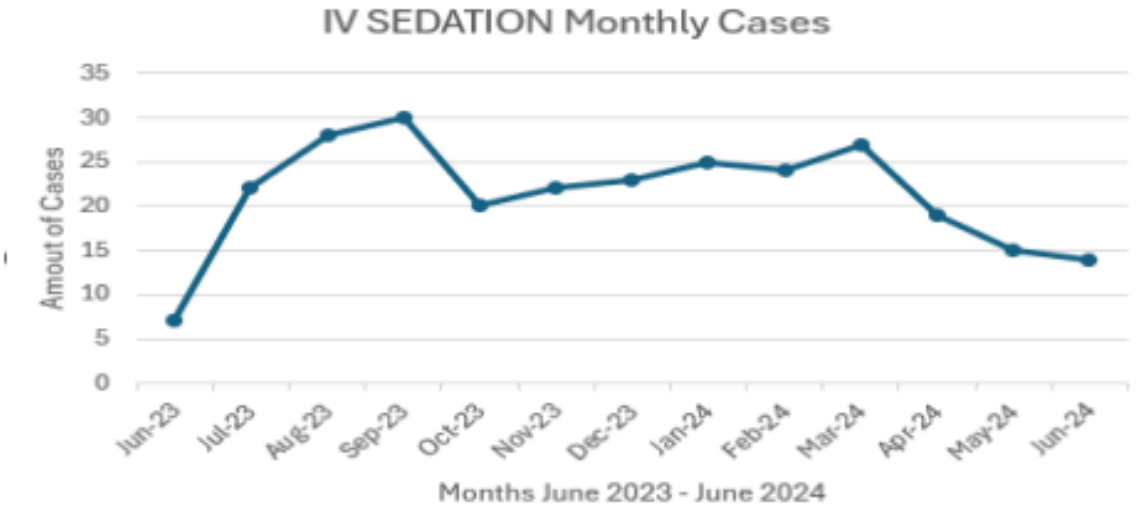




This graph shows TNAA times per month. Let the y-axis show that TNAA trends for the months of June 2023- June 2024 are measured from 0-30 days.



This graph is a visual representation of the patient volume seen and treated in Oral Surgery clinic by month from June 2023 to June 2024. Note that the y-axis is the total number of patients ranging from 0 – 450.



This graph is a visual representation of the monthly amount of IV Sedation cases completed in Oral Surgery clinic by month from June 2023 to June 2024.

Research

UCSF Department of Oral & Maxillofacial Surgery

Search...

Home | Projects | Topics | Locations | People | Resources | Events

Home > Projects

Projects

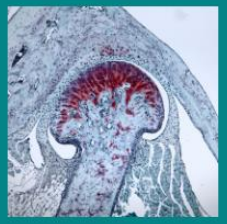
BASIC SCIENCES

Click to jump to section



TRANSLATIONAL RESEARCH

Click to jump to section



CLINICAL RESEARCH

Click to jump to section



Surgical Education

Anesthesia Primer

Site: San Francisco VA Medical Center

Contact information: shelley.miyasaki@va.gov

Faculty/Principal Investigator:

Shelley Miyasaki, DDS, PhD

Temporomandibular Disorders

Biomolecular Characterization of TMJ using single cell Transcriptomics and Advanced Microscopy

Description: Discarded TMJ specimens are analyzed to elucidate expression of multiple genes involved in inflammation and degeneration.

Site: San Francisco VA Medical Center

Contact information: rebeka.silva@va.gov

Faculty/Principal Investigator:

Rebeka Silva, DMD, FACD

Benign Pathology, Temporomandibular Disorders

Calcium pyrophosphate deposition disease of the temporomandibular joint - diagnosis and treatment

Site: Highland Hospital

Contact information: ricardo.lugo@ucsf.edu

Faculty/Principal Investigator:

Ricardo Lugo, DDS, MD

Akshay Govind, DMD, MD

Surgical Education

Anesthesia Primer

Site: San Francisco VA Medical Center

Contact information: shelley.miyasaki@va.gov

Faculty/Principal Investigator:

Shelley Miyasaki, DDS, PhD

Temporomandibular Disorders

Biomolecular Characte
Transcriptomics and A

Description: Discarded TMJ specimens a
degeneration.

Site: San Francisco VA Medical Center

Contact information: rebeka.silva@va.go

Benign Pathology, Temporomandibular D

Calcium pyrophosphat
joint - diagnosis and tr

Site: Highland Hospital

Contact information: ricardo.lugo@ucsf.e

Surgical Education

Complex Airway Management and Decision-Making in Maxillomandibular Fixation Crisis

Site: San Francisco VA Medical Center

Contact information: shelley.miyasaki@va.gov

Faculty/Principal Investigator:

Shelley Miyasaki, DDS, PhD

Craniofacial Surgery

Complications of Subcranial LeFort III and Monobloc Distraction, with and without Facial Bipartition, using Rigid External Distractors

Description: Severe midface hypoplasia associated with syndromic craniosynostosis often requires midface advancement. There is a paucity of literature regarding the incidence of complications associated with midface and frontofacial advancement using rigid external distraction. A 10 year retrospective review was performed for patients with syndromic craniosynostosis who underwent subcranial Le Fort III or monobloc distraction with rigid external distraction, with and without facial bipartition, at Alder Hey Children's Hospital in Liverpool, United Kingdom. A comprehensive review of the demographic information, operative and postoperative course was completed.

Site: Alder Hey Children's Hospital NHS Trust

Contact information: andrew.weeks@ucsf.edu

Faculty/Principal Investigator:

Chris Parks, MBBS

Reconstruction

Delayed Alloplastic Total Joint Replacement for Osteoradionecrosis in Patients with Osseous Vascularized Free Flaps

Description: Case series of patients treated with an interval total joint replacement for osteoradionecrosis in the site of a previous osseous vascularized free flap. There is minimal literature demonstrating the effectiveness and success of alloplastic

Faculty/Principal Investigator:

Ricardo Lugo, DDS, MD

Surgical Education

Anesthesia Primer

Site: San Francisco VA Medical Center

Contact information: shelley.miyasaki@va.gov

Faculty/Principal Investigator:

Shelley Miyasaki, DDS, PhD

Temporomandibular Disorders

Biomolecular Characte
Transcriptomics and A

Description: Discarded TMJ specimens a
degeneration.

Site: San Francisco VA Medical Center

Contact information: rebeka.silva@va.go

Benign Pathology, Temporomandibular D

Calcium pyrophosphat
joint - diagnosis and tr

Site: Highland Hospital

Contact information: ricardo.lugo@ucsf.e

Surgical Education

Complex Airway Management and Decision-Making in Maxillomandibular Fixation Crisis

Site: San Francisco VA Medical Center

Contact information: shelley.miyasaki@va.gov

Faculty/Principal Investigator:

Shelley Miyasaki, DDS, PhD

Craniofacial Surgery

Complications of
with and without

Description: Severe midface hyp
There is a paucity of literature re
using rigid external distraction. A
underwent subcranial Le Fort III
Hey Children's Hospital in Liverp
postoperative course was compl

Site: Alder Hey Children's Hospit

Contact information: andrew.wee

Reconstruction

Delayed Alloplast
Patients with Osse

Description: Case series of patie
previous osseous vascularized fr

Simulation/Medical Emergencies

Evaluating In-Office Emergency Prepardness in Oral & Maxillofacial Surgery Residents Using a Structured Clinical Simulation Curriculum

Description: Oral and maxillofacial surgeons safely perform thousands of in-office procedural sedations per year in the United States. One key aspect of performing safe in-office sedations is appropriate preparation for medical emergencies through clinical simulations. Using the simulation center at Highland Hospital, oral and maxillofacial surgery residents are guided through a structured curriculum with interval assessments of medical knowledge and skills assessments.

Site: Highland Hospital

Contact information: ricardo.lugo@ucsf.edu

Faculty/Principal Investigator:

Ricardo Lugo, DDS, MD

Maxillofacial Trauma

Evaluating Maxillofacial Surgeries incurred during Aquatic Sports

Site: UCSF Medical Center

Contact information: stephen.yang@ucsf.edu

Faculty/Principal Investigator:

Brian Bast, DMD, MD

Craniofacial Surgery, Sleep Surgery

Evaluation Outcomes of MMA Surgery

Site: San Francisco VA Medical Center

Contact information: rjgupta@ucsf.edu

Faculty/Principal Investigator:

Rishi Jay Gupta, DDS, MD, FACS

Surgical Education

Anesthesia Primer

Site: San Francisco VA Medical Center

Contact information: shelley

Faculty/Principal Investigator:

Shelley Miyasaki, DDS, PhD

Surgical Education

Complex Airway Management and Decision-Making in Maxillomandibular Fixation Crisis

Site: San Francisco VA Medical Center

Contact information: shelley.miyasaki@va.gov

Faculty/Principal Investigator:

Shelley Miyasaki, DDS, PhD

Temporomandibular Disorder

Biomolecular C
Transcriptomics

Description: Discarded TMJ s
degeneration.

Site: San Francisco VA Medic

Contact information: rebeka.s

Craniofacial Surgery

Complications of
with and withou

Description: Severe midface h
There is a paucity of literature
using rigid external distraction.
underwent subcranial Le Fort
Hey Children's Hospital in Live
postoperative course was com

Site: Alder Hey Children's Hos

Contact information: andrew.w

Simulation/Medical Emergencies

Evaluating In-Office Emergency Preparedness in Oral & Maxillofacial Surgery Reside

Description: Oral and maxillo
States. One key aspect of pe
clinical simulations. Using th
a structured curriculum with

Site: Highland Hospital

Contact information: ricardo.

Faculty/Principal Investigator:

Benign Pathology, Temporom

Calcium pyroph
joint - diagnosis

Site: Highland Hospital

Contact information: ricardo.

Reconstruction

Delayed Alloplas
Patients with Os

Description: Case series of pa
previous osseous vascularize

Maxillofacial Trauma

Evaluating Max

Site: UCSF Medical Center

Contact information: stephen

Craniofacial Surgery, Sleep S

Evaluation Out

Site: San Francisco VA Medi

Contact information: rjgupta@

Predicting and quantifying nasal changes after Le Fort I surgery

Site: UCSF Medical Center

Contact information: sampeter.odera@ucsf.edu

Sampeter Odera, DMD, MD

Malignant Pathology

Primary squamous cell carcinoma of the submandibular gland

Description: Squmaous cell carcinoma arising within the submandibular gland is an uncommon presentation within the field of head and neck. Although not rare, there is a paucity of contemporary literature that addresses the management of this disease with surgery and recent advancements in adjunctive treatment such as irradiation and chemotherapy. This case report aims centers around a patient who presents with locally advanced squamous cell carcinoma of the submandibular gland.

Site: Highland Hospital

Contact information: ricardo.lugo@ucsf.edu

Faculty/Principal Investigator:

Ricardo Lugo, DDS, MD

Neurosensory

Randomized controlled trial comparing neurosensory defecits using a Sonopet versus reciprocating saw in patients undergoing bilateral sagittal split osteotomies

Description: Split mouth, randomized controlled study comparing postoperative neurosensory deficits of the inferior alveolar nerve distribution when using a reciprocating saw versus a Sonopet for a bilateral sagittal split osteotomy. Patients will be randomized for laterality, type of saw used, and operating surgeon (resident or attending surgeon).

Site: UCSF Medical Center

Contact information: sohail.saghezchi@ucsf.edu

Faculty/Principal Investigator:

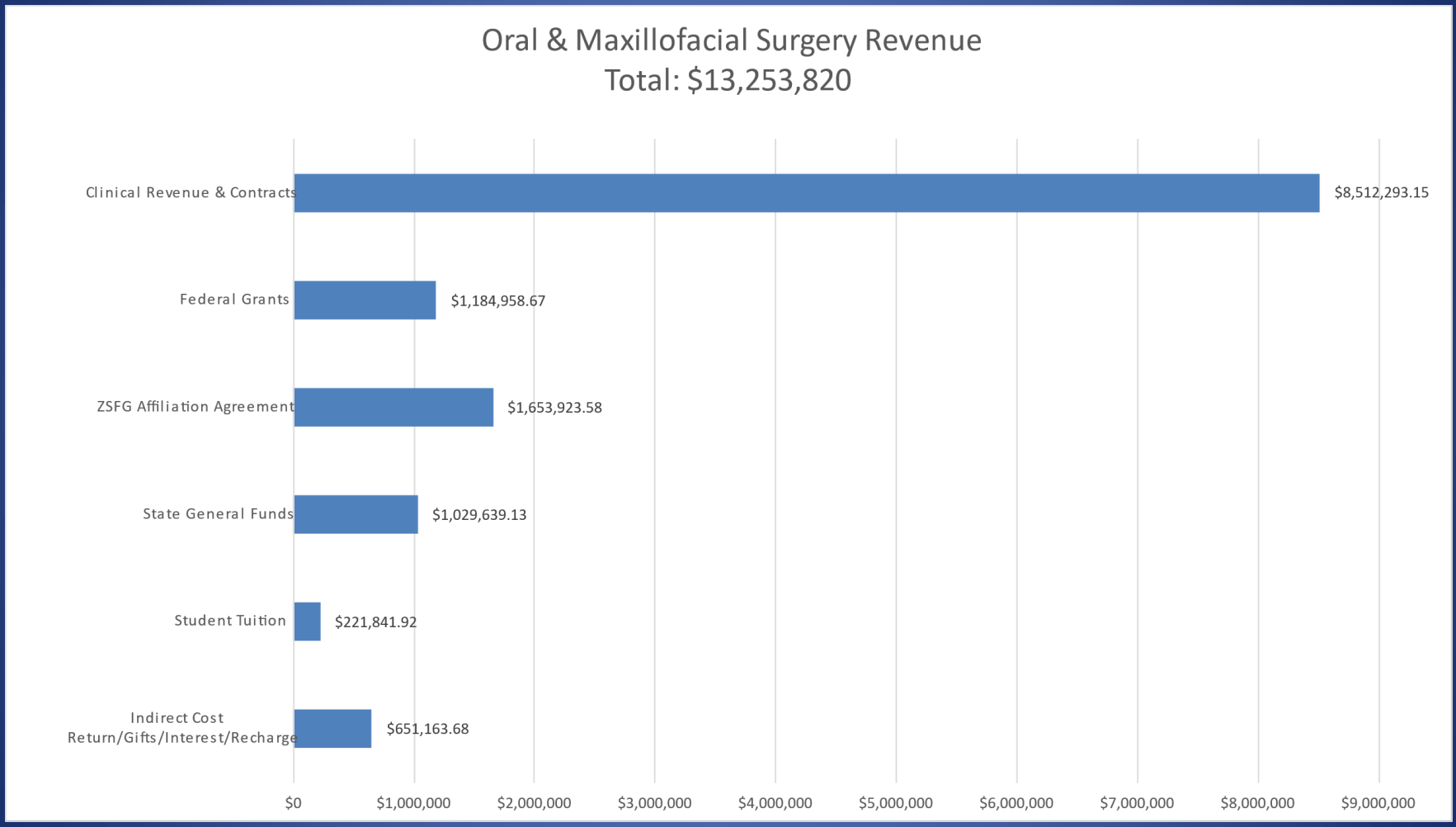
Sohail Saghezchi, DDS, MD

Financial Report



Financial Report

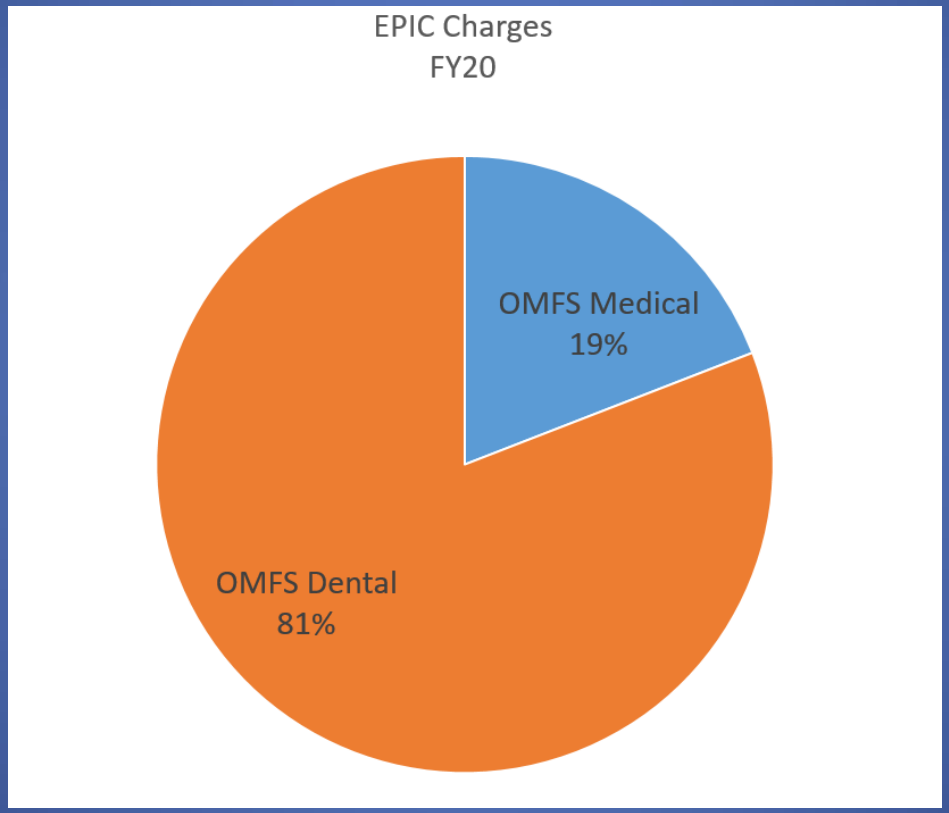
1. Margin supports Mission
2. Small Margins
3. Scale


Oral & Maxillofacial Surgery Revenue
Total: $13,253,820
Clinical Revenue & Contracts
$8,512,293.15
Federal Grants
$1,184,958.67
ZSFG Affiliation Agreement
$1,653,923.58
State General Funds
$1,029,639.13
Student Tuition
$221,841.92
Indirect Cost Return/Gifts/Interest/Recharge
$651,163.68
$0
$1,000,000
$2,000,000
$3,000,000
$4,000,000
$5,000,000
$6,000,000
$7,000,000
$8,000,000
$9,000,000

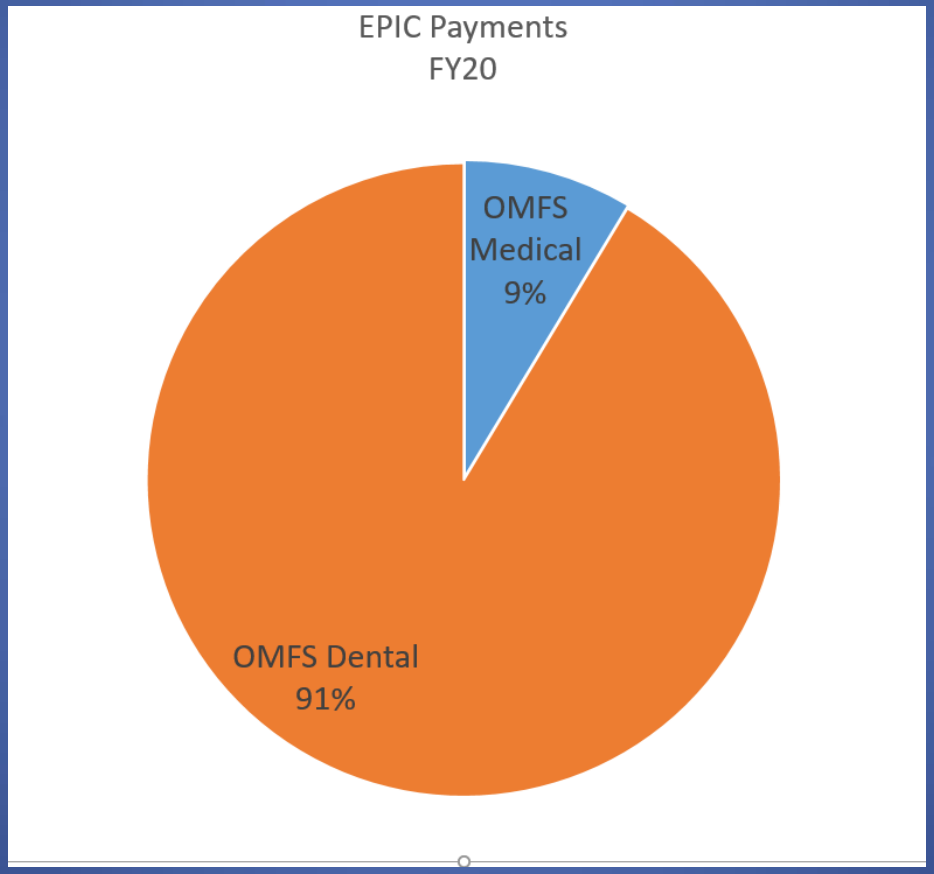
FY2024 ZSFG OMFS Clinical Revenue

Total Charges	1,154,372
Total Collections	655,834 (57%)

Dental Visits 81%, Medical Visits 19% of Charges



Dental Visits 91%, Medical Visits 9% of Collections



Summary

Strengths
Challenges
Goals



Summary

Strengths
Challenges
Goals



City and County of San Francisco

Department of Public Health

Zuckerberg San Francisco General Hospital and Trauma Center

Mary P. Mercer, MD
Chief of Staff

Daniel Lurie
Mayor

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	*ZSFG Clinical Service Rules and Regulations*
Clinical Service :	*Dentistry/Oral and Maxillofacial Surgery Clinical Service*
Date of last approval:	*11/13/2023*
Summary of R&R updates:	*Change 2023 to 2026* *Change Nov 13, 2023 to January 2026* *Added Zuckerberg to San Francisco General Hospital* *Change CHN to SFHN*
Update #1:	
Update #2:	
Update #3:	
Update #4:	
Update #5:	

Medical Staff Services Department
Zuckerberg San Francisco General Hospital and Trauma Center
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DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
CLINICAL SERVICE
RULES AND REGULATIONS
2026

Reviewed/Approved – January 2026 MEC

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

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CLINICAL SERVICE
RULES AND REGULATIONS
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The Pricilla Chan and Mark Zuckerberg
Zuckerberg San Francisco General Hospital
1001 Potrero Ave
San Francisco, CA 94110

DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
CLINICAL SERVICE
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I. DENTISTRY/ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

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

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

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

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

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

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

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth

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

C. ORGANIZATION OF ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

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

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

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

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

C. AFFLIATED PROFESSIONALS

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

D. STAFF CATEGORIES

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

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

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

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

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

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

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

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

D. TEMPORARY PRIVLEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

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

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

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

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

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

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

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

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

The following items require direct attending supervision

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

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

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

VII. ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

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

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

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

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

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

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

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

4. Unplanned return to the Operating Room.

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

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

7. Acquired drug sensitization

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

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

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

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

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

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

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

B. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

See Appendix C – OMS Performance Improvement and Patient Safety Plan

C. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

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

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

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

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

D. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to IX C. Above

X. MEETING REQUIREMENTS

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

The Dentistry/Oral & Maxillofacial Surgery Clinical Services shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XI. ADOPTION AND ADMENDMENT

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

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

APPENDIX A – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PRIVILEGE FORM

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

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

OMFS ORAL & MAXILLOFACIAL SURGERY 2009

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

_____ _____ **8.0 CORE PRIVILEGES**

_____ _____ 8.10 GENERAL DENTISTRY

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

_____ _____ 8.20 ORAL & MAXILLOFACIAL SURGERY

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

_____ _____ **8.30 SPECIAL PRIVILEGES**

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

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

_____ _____ 8.32 MODERATE SEDATION

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

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

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

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

I hereby request clinical privileges as indicated above.

_____ _____
Applicant date

FOR DEPARTMENTAL USE:

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

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

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

APPROVED BY:

_____ _____
Division Chief date

_____ _____
Service Chief date

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

NAME_____

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

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

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

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

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

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

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

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

GROUP I: GENERAL DENTISTRY

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

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

GROUP II: ORAL & MAXILLOFACIAL SURGERY

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

The criteria for oral and maxillofacial surgery are:

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

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

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Appendix B - HOUSE STAFF COMPETENCIES

REFER TO SFHN INTRANET SITE, HOUSE STAFF COMPETENCIES LINK

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APPENDIX C - DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN

Currently Held at Dentistry/OMS Service

APPENDIX D – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY HOUSESTAFF MANUAL

Currently Held at Dentistry/OMS Service

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

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

Chief of Dental/Oral/Maxillofacial Surgery Clinical Service

Position Summary:

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

Reporting Relationships:

The Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service reports directly to the Associate Dean at ZSFG and the Chairperson, UCSF Department of Oral and Maxillofacial Surgery. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service include the following:

Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of ZSFG and the DPH;

In collaboration with the Executive Administrator and other ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;

In collaboration with the Executive Administrator and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and

Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.

Dentistry/Oral & Maxillofacial Surgery Clinical Rules and Regulations
Revised: November 13, 2023, January 2026

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

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

DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
CLINICAL SERVICE
RULES AND REGULATIONS
~~2023~~ 2026

Reviewed/Approved – ~~Nov 13, 2023~~ January 2026 MEC

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RULES AND REGULATIONS
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I. DENTISTRY/ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

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

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

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

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

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

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

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth

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

C. ORGANIZATION OF ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

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

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

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

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

C. AFFLIATED PROFESSIONALS

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

D. STAFF CATEGORIES

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

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

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

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

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

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

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

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

D. TEMPORARY PRIVLEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

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

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

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

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

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

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

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

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

The following items require direct attending supervision

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

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

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

VII. ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

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

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

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

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

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

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

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

4. Unplanned return to the Operating Room.

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

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

7. Acquired drug sensitization

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

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

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

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

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

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

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

B. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

See Appendix C – OMS Performance Improvement and Patient Safety Plan

C. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

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

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

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

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

D. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to IX C. Above

X. MEETING REQUIREMENTS

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

The Dentistry/Oral & Maxillofacial Surgery Clinical Services shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XI. ADOPTION AND ADMENDMENT

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

The Pricilla Chan and Mark Zuckerberg
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1001 Potrero Ave
San Francisco, CA 94110

APPENDIX A – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PRIVILEGE FORM

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

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

OMFS ORAL & MAXILLOFACIAL SURGERY 2009

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

_____ _____ **8.0 CORE PRIVILEGES**

_____ _____ 8.10 GENERAL DENTISTRY

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

_____ _____ 8.20 ORAL & MAXILLOFACIAL SURGERY

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

_____ _____ **8.30 SPECIAL PRIVILEGES**

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

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

_____ _____ 8.32 MODERATE SEDATION

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

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

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

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

I hereby request clinical privileges as indicated above.

_____ _____
Applicant date

FOR DEPARTMENTAL USE:

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

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

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

APPROVED BY:

_____ _____
Division Chief date

_____ _____
Service Chief date

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

NAME_____

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

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

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

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

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

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

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

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

GROUP I: GENERAL DENTISTRY

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

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

GROUP II: ORAL & MAXILLOFACIAL SURGERY

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

The criteria for oral and maxillofacial surgery are:

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

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

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Appendix B - HOUSE STAFF COMPETENCIES

REFER TO ~~CHN~~ SFHN INTRANET SITE, HOUSE STAFF COMPETENCIES LINK

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APPENDIX C - DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN

Currently Held at Dentistry/OMS Service

APPENDIX D – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY HOUSESTAFF MANUAL

Currently Held at Dentistry/OMS Service

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

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

Chief of Dental/Oral/Maxillofacial Surgery Clinical Service

Position Summary:

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

Reporting Relationships:

The Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service reports directly to the Associate Dean at ZSFG and the Chairperson, UCSF Department of Oral and Maxillofacial Surgery. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service include the following:

Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of ZSFG and the DPH;

In collaboration with the Executive Administrator and other ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;

In collaboration with the Executive Administrator and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and

Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.

Dentistry/Oral & Maxillofacial Surgery Clinical Rules and Regulations
Revised: November 13, 2023, January 2026

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

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

UCSF Department of Anesthesia and Perioperative Care

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

Anesthesia & Perioperative Care Biennial Report

January 13, 2026

Romain Pirracchio, MD, MPH, PhD

Mission & Vision

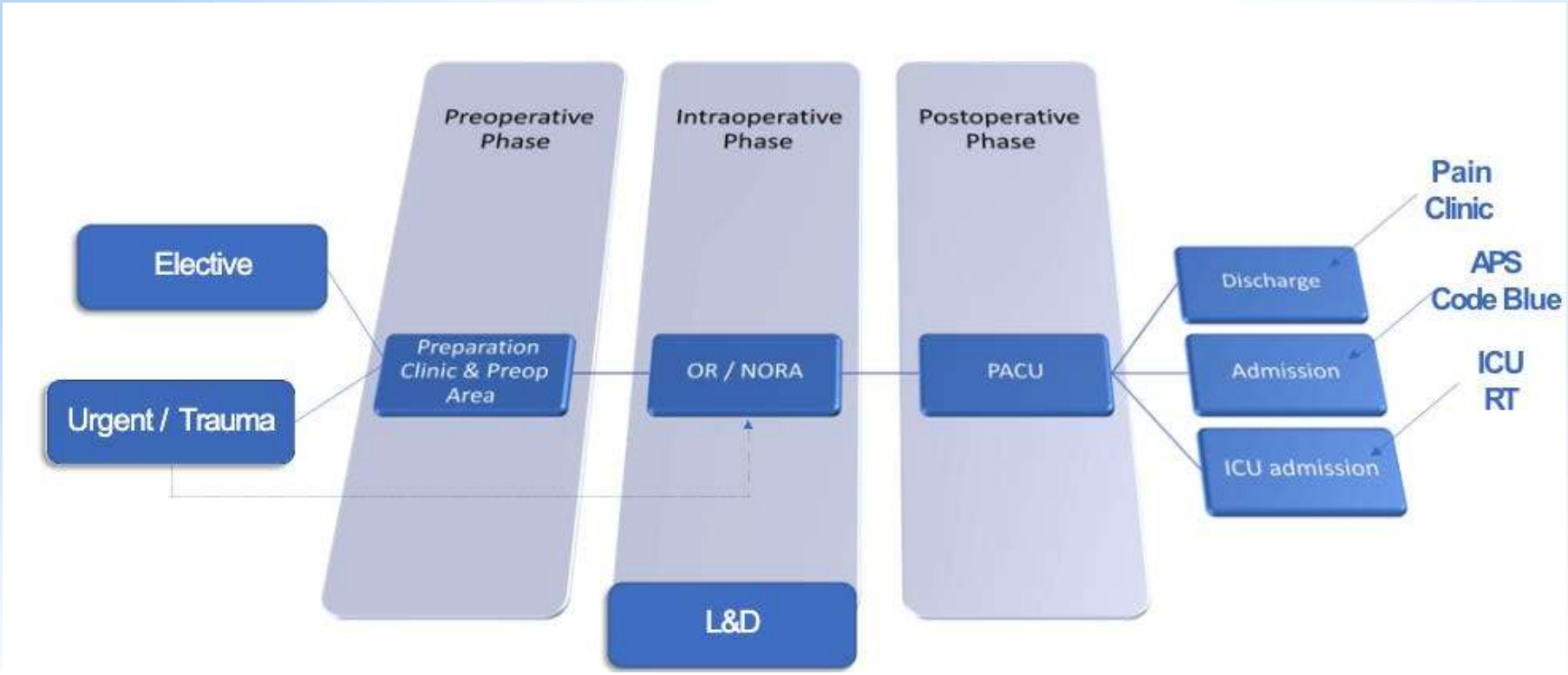
Our mission is excellence in patient-centered perioperative care that is guided by innovative research, education, and our commitment to health equity.

Our vision is to advance perioperative care by cultivating the next generation of leaders in our field.

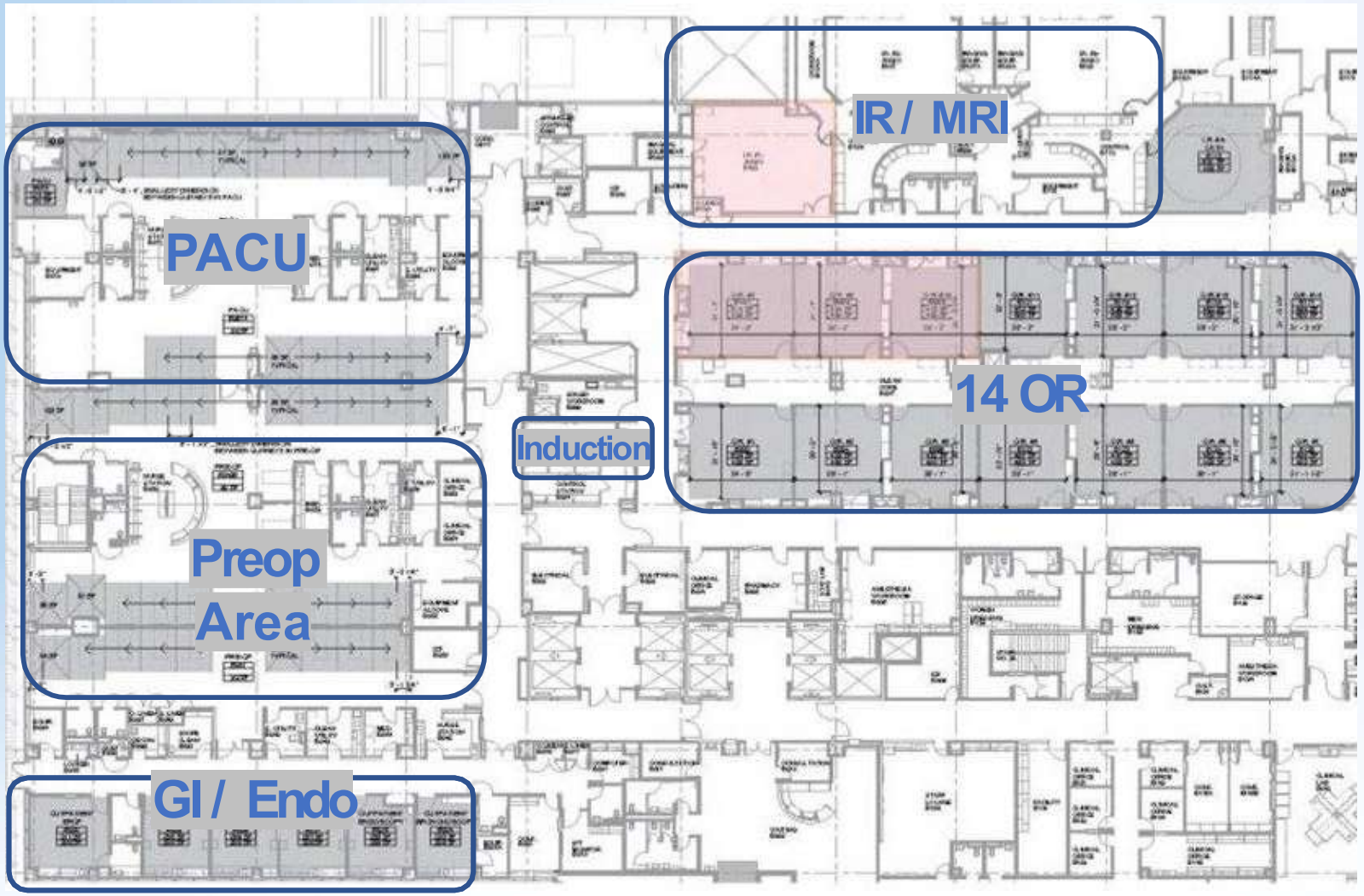
Who are we?

Scope of Services and Clinical Activities

The Department of Anesthesia and Perioperative Care provides **comprehensive perioperative care.**

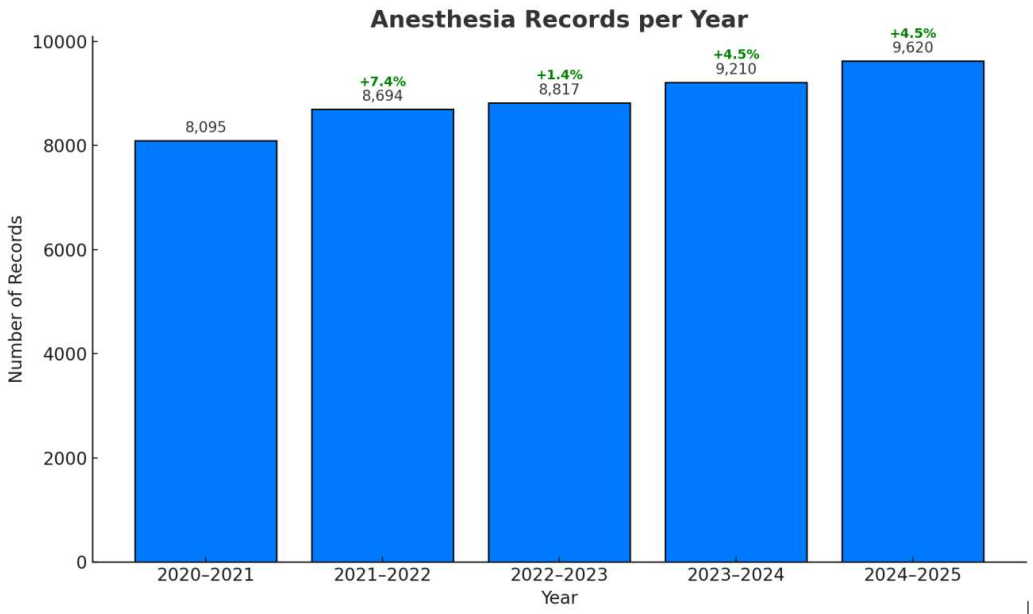


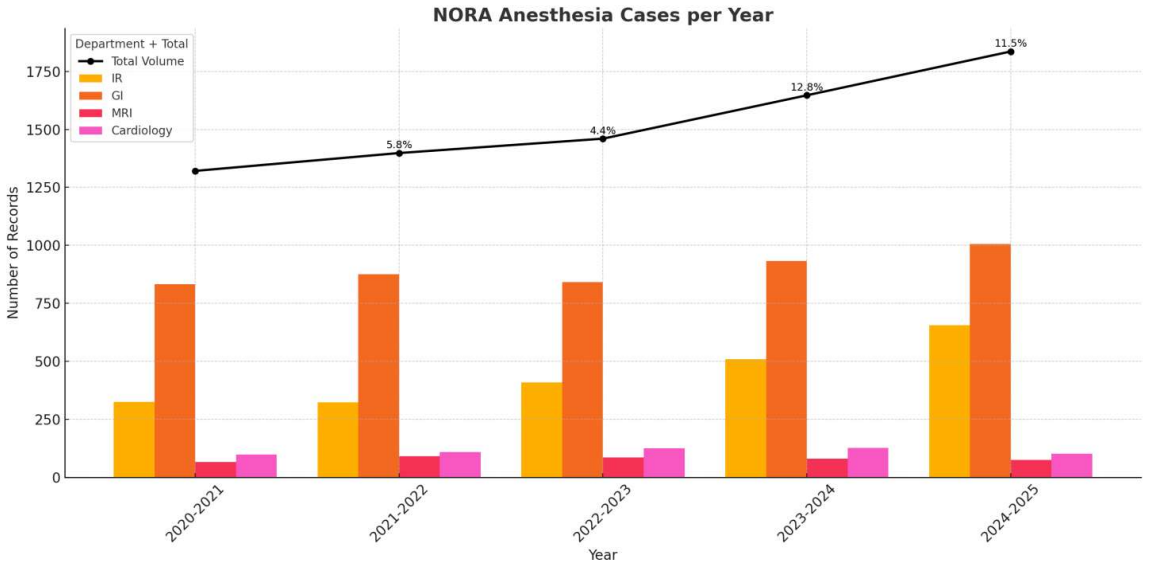
Procedural Area Bldg 25 Ground Level



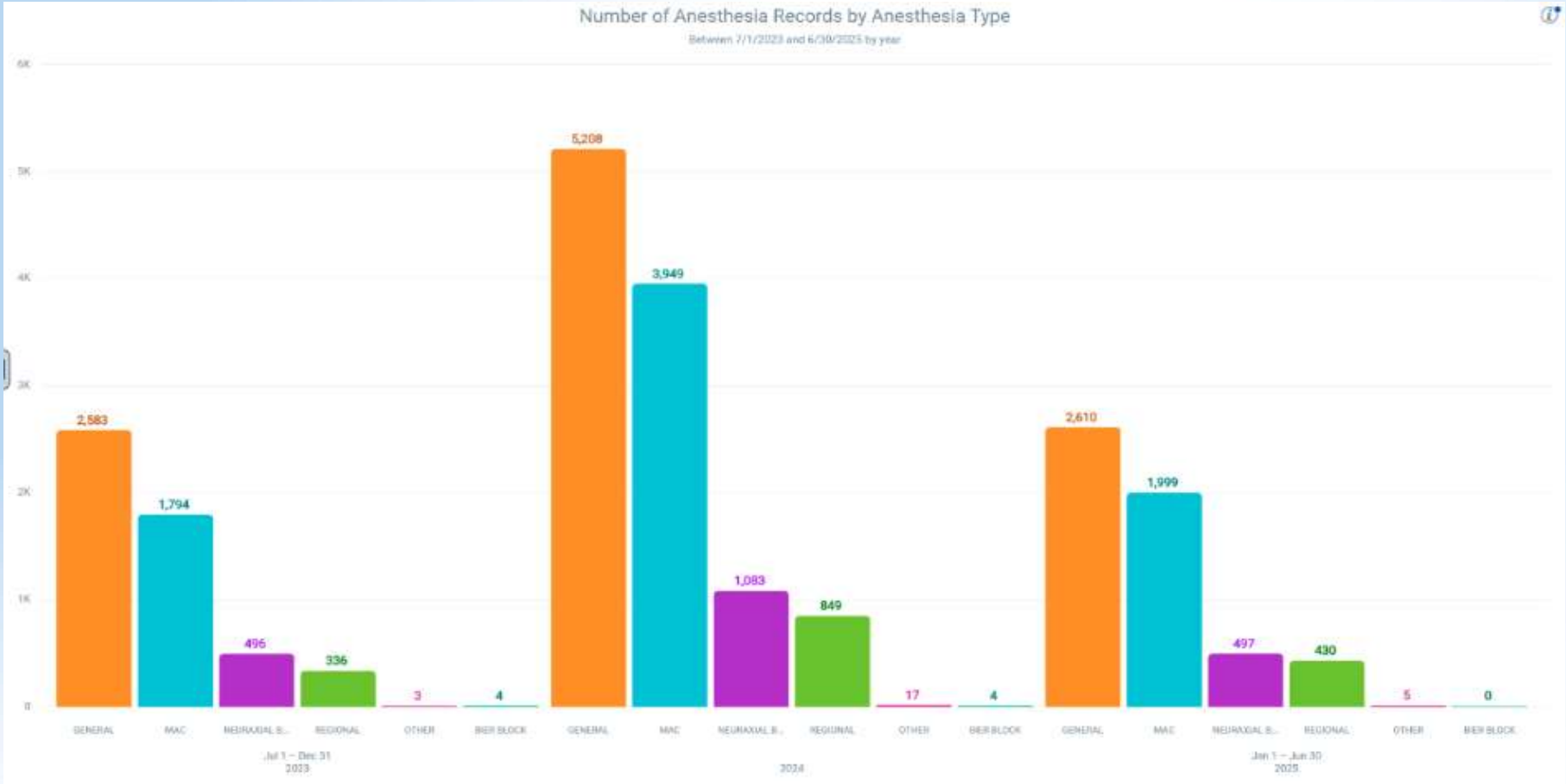
OR Staffing

Weekdays	Nights	Weekends & Holidays
• D1	• D1	• Sat :
• D2	• 3 Residents	• D1 / D2 / (D3)
• D3		• 1 CRNA
• D4 / D5 / D6		
• S1 / (S2-3)		• Sun :
• 6-9 CRNAs		• D1
• 0-3 residents		• 3 Residents


Anesthesia Records per Year
Number of Records
Year
2020–2021
2021–2022
2022–2023
2023–2024
2024–2025
8,095
+7.4%
8,694
+1.4%
8,817
+4.5%
9,210
+4.5%
9,620


NORA Anesthesia Cases per Year
Department + Total
Total Volume
IR
GI
MRI
Cardiology
Number of Records
Year
2020-2021
2021-2022
2022-2023
2023-2024
2024-2025
5.8%
4.4%
12.8%
11.5%

Volume by Anesthesia Type
FY24-25



OR/NORA Highlights

Clinical Pathways

✓Coordination and provision of subspeciality pediatric anesthesia attending staffing with Mission Bay

✓Acute spine injury patient flow pathway in progress

✓Preoperative neuraxial catheter placement guideline

✓NORA Block with new Epic build

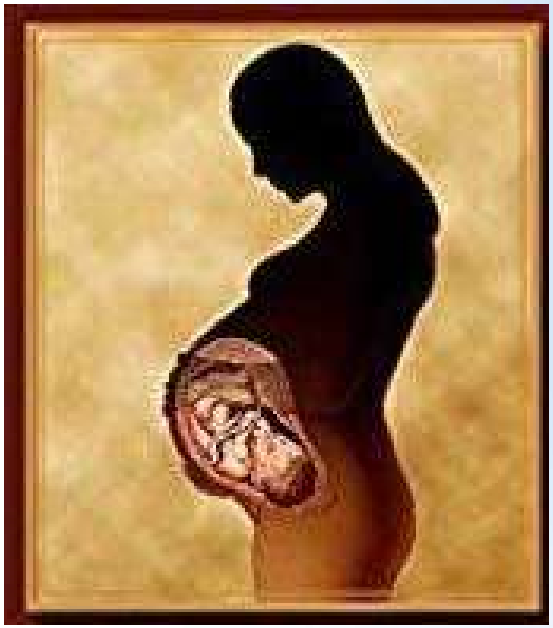
Trauma and Acute Care

✓ ACS Trauma Survey: Reviewers highlighted the Anesthesia Department's critical role in trauma care

Obstetric Anesthesia & WOC

OB anesthesia staffing

- Weekdays :
  - OB anesthesia : 1 attending / 1 resident (or CRNA)
  - 6G (WOC) : 1 attending (Wed / Fri)
- Nights : 1 attending / 1 resident
- Weekends, Holidays :
  - Saturdays: 1 attending
  - Sundays/Holidays: 1 attending / 1 resident



ZSFG Obstetric Anesthesia

Procedure	7/1/2023 - 6/30/24	7/1/24 - 6/30/25
Cesarean delivery	286	291
Labor epidural analgesia	642	695
Post-partum tubal ligation	56	40
Cervical cerclage	8	5
Dilation and curettage	20	22
Other procedure with anesthesia	19	16

Highlights

- Reduce general anesthesia for operative delivery rates
- Tracking ERAS compliance (neuraxial long-acting opioid dose, multi-modal analgesia)
- Intraoperative temperature management during C-sections

ZSFG Women's Options Clinic Anesthesia

Women's Options Center	7/1/2023 - 6/30/24	7/1/24 - 6/30/25
Dilation and evacuation	370	385
Other procedure with anesthesia	77	92

Highlights

- ✓ Streamlining emergent admission workflow to main OR/IR
- ✓ Hovermat recycling program
- ✓ Remimazolam & Ketamine for moderate sedation
- ✓ Development of anesthesia resident curriculum
- ✓ National Abortion Federation Board of Directors representation
- ✓ National Abortion Federation CEO Selection Committee
- ✓ Organization of a pre-conference workshop on anesthesia for abortion at NAF annual meeting

ZSFG Preoperative Anesthesia Clinic

- **Mission**

✓ Streamlined workflows for efficiency & patient experience

- **Staffing**

✓ 1 faculty

✓ NP 2 FT NP, 2 PD NP

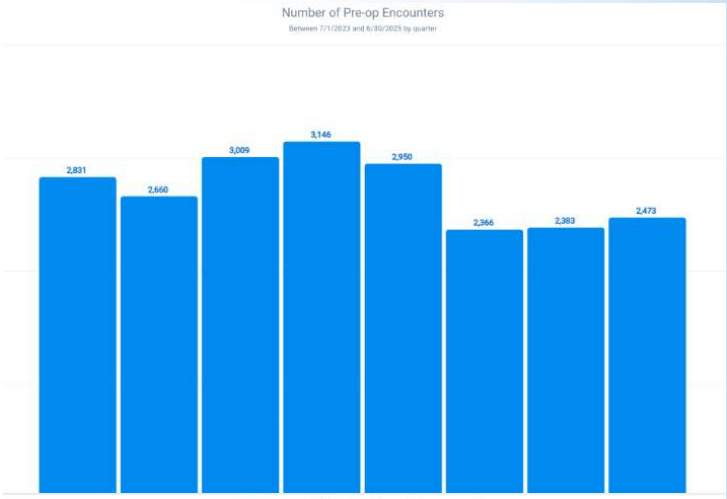
✓ TNAA Median < 7 days

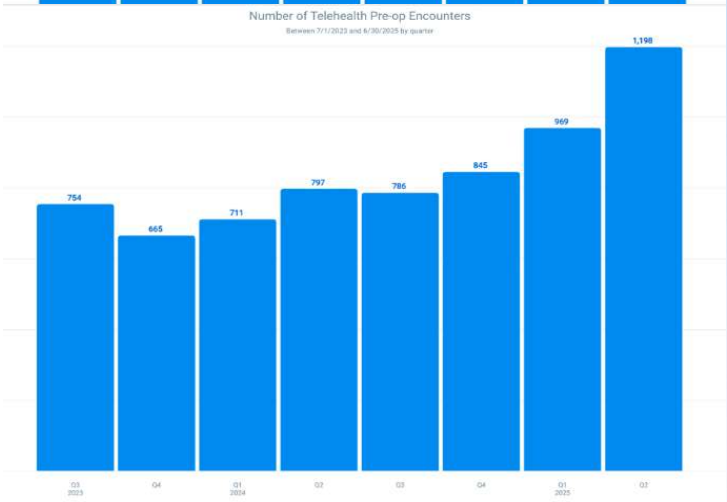
- **Pathways**

✓ Colorectal ERAS Pathway (8/2023)

✓ OSA Pathway (9/2023)

✓ Lyft Free RideShare for Visits (ongoing)





Anesthesia Pain Management Group



Anesthesia Pain Service (APS)

- **Mission**: provide advanced pain management techniques to REDUCE RELIANCE on OPIOIDS for hospitalized patients

- **Volume** (FY 24-25)
  - ✓ 300 interventional pain procedures (epidurals/nerve catheters) per year

- **Highlights**
  - ✓ The service is working on introducing low dose Ketamine IV infusion to the Med/Surgical units as an adjunct to pain management

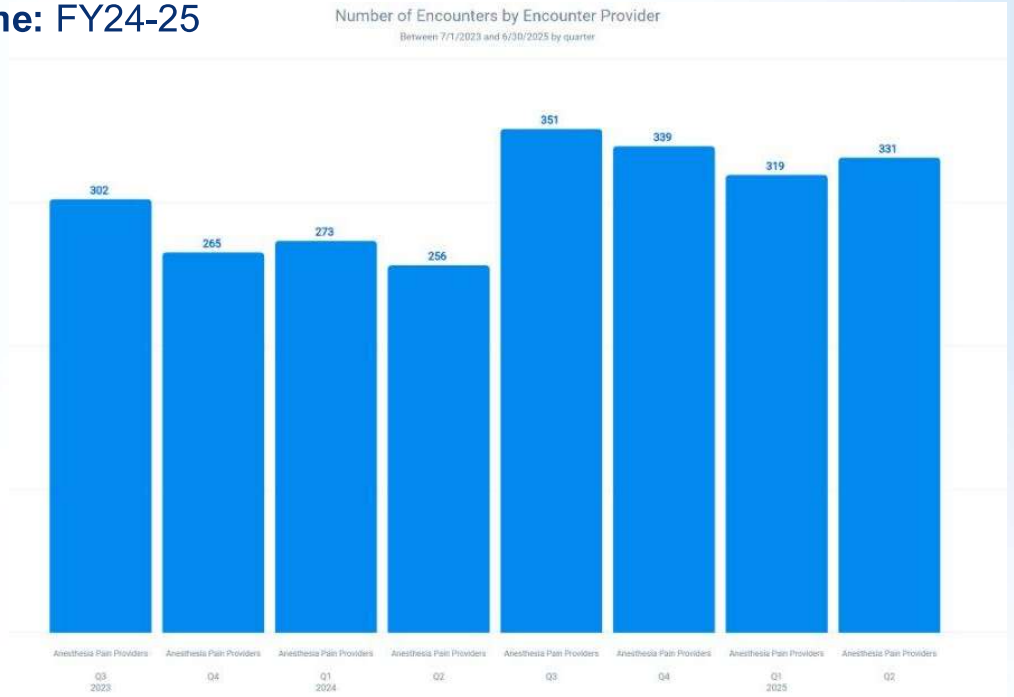
Anesthesia Pain Management Group



Anesthesia Pain Clinic

Mission: provide NON-OPIOID alternatives for network patients with chronic pain

Volume: FY24-25



Intensive Care Unit
Anesthesia Critical Care

- 12 ICU-trained faculty

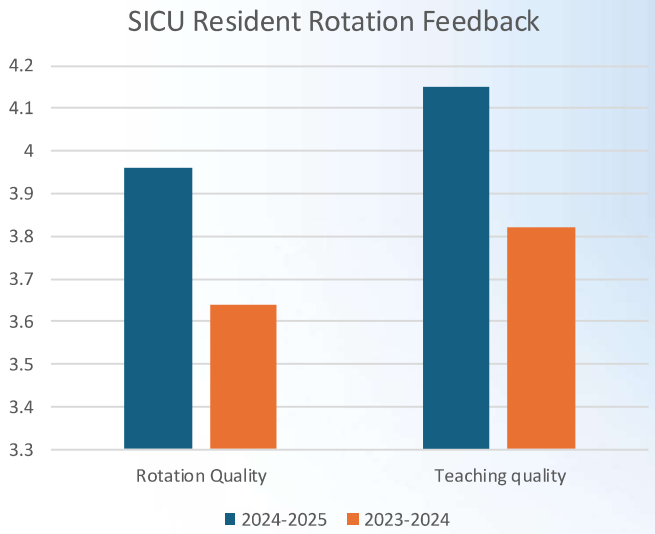
- SICU Co-Medical Director: Dr. Susan Yoo
- Anesthesia Critical Care Director: Dr. Ashish Agrawal

- 23 SICU wks staffed by anesthesia intensivists
  - Night coverage for SICU/MICU
- Critical Care Trainees:
  - 23 anesthesia residents/yr
  - 8 anesthesia critical care fellows (22 multidisciplinary fellows total)



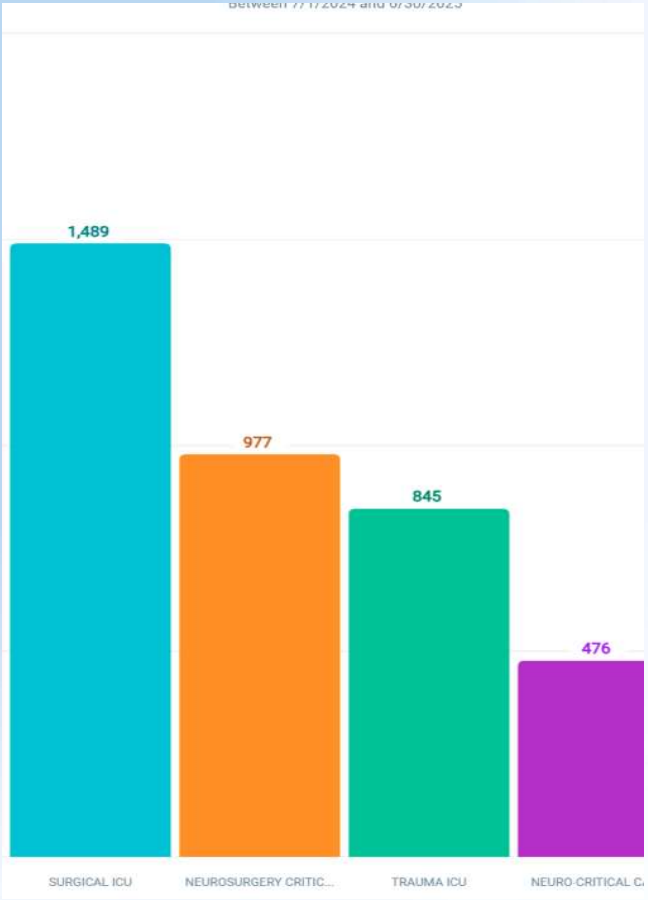
Anesthesia Critical Care
Highlights

- New SICU Staffing Model:
  - Collaborative high-intensity model for emergency general surgery patients
  - Consistent overnight fellow/attending coverage
- Ped:
  - Improved workflows for consult (BCH), management, and transfer of pediatric patients
- Education:
  - New SICU resident simulation session
  - SICU pigtail and surgical airway workshops
  - Robust monthly interdisciplinary M&M
  - Improvement in SICU Resident Rotation Feedback



Anesthesia Critical Care

Number of ICU Stays FY25



Highlights

- ✓ **New Extubation huddle**: Multidisciplinary huddle prior to extubation with review of risk assessment, reintubation plan, resource review
- ✓ **New respiratory care pathways** for atelectasis and secretion prevention/management
- ✓ **New chest tube/surgical airway sim workshop SICU Shock Sim launch:** Simulation-based education for SICU residents, monthly

Pathways in Progress

- ✓ Peripheral IV Vasopressors
- ✓ Spinal Cord Injury (Protocol done, Epic order set pending build)
- ✓ Rib fracture care/pain mgmt
- ✓ Percutaneous tracheostomy in ICU : Multidisciplinary workflow

New SICU Staffing Model: Transition to collaborative centralized high-intensity model in progress

Trauma Anesthesia

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

- **Director: Sherry Liou, MD**
- **Updates/Highlights**
  - New transfer guidelines for pediatric trauma patients in coordination with the Pediatric Anesthesia team at UCSF/CHO
  - Improved access to in-person Pediatric Anesthesiologist for emergent/urgent cases
  - Incoming Trauma Anesthesia Fellow in AY 2025-2026
  - New Trauma Anesthesia resident curriculum
- **Ongoing Projects**
  - Multidisciplinary IR in 60 minutes trauma QI project
  - Pharmacy roll out of new fibrinogen concentrate (Riastap -> Fibryga)
    - Stored at room temp and FDA approved for acquired hypofibrinogenemia

	2023	2024
<1 years old	**13**	**11**
MOI = Blunt	13	10
MOI = Penetrating	0	1
MOI = other	0	0
1-5 years old	**29**	**37**
MOI = Blunt	29	36
MOI = Penetrating	0	0
MOI = other	0	1
6-17 years old	**102**	**117**
MOI = Blunt	78	94
MOI = Penetrating	23	22
MOI = other	1	1
18+ years old	**3112**	**3249**
MOI = Blunt	2677	2846
MOI = Penetrating	421	390
MOI = other	14	13
Total Trauma Patients	**3256**	**3414**

ZSFG Anesthesia Workroom

Mission and Highlights

- Anesthesia workspace improvement

✓ Standardized the Anesthesia workspace in all OR suites and satellite areas

✓ Championed the considerate usage of very limited Anesthesia space/footprint in the OR suites and modeling this for other departments

➓ Quality of care and patient safety improvement

✓ Hospital wide implementation of the full barrier Arterial Catheterization Kit under Anesthesia leadership

✓ Created and implemented a custom Spinal Kit for spinal anesthesia cases and a custom Combined Spinal/Epidural Kit

✓ Reviewed and revised Anesthesia Policy 10.0: Malignant Hyperthermia Response

Staffing

✓ New Anesthesia Tech Supervisors roles

✓ Contract labor employees to mitigate short staffing challenges and implemented a on call policy

✓ Daily huddle, weekly Lead Tech and Supervisor meetings, monthly Anesthesia Tech Leadership meetings and monthly All Staff Workroom meetings

Financial stewardship and controlling

✓ Negotiated equipment and supplies pricing and contracts with various vendors and distributors to ensure the best price and quality and generated savings for ZSFG

✓ RCA for missing equipment

✓ Implemented close monitoring and tracking workflows for other high-priced equipment and supplies

Respiratory Care Services



Team Structure

~ 50 Respiratory therapists

- 1 Medical director (Dr Ashish Agrawal)
- 7 Leadership and Admin RTs
  - Data-driven management
  - Education for RCS, nurses, and resident/fellow trainees
  - Staffing and support for all RCS equipment

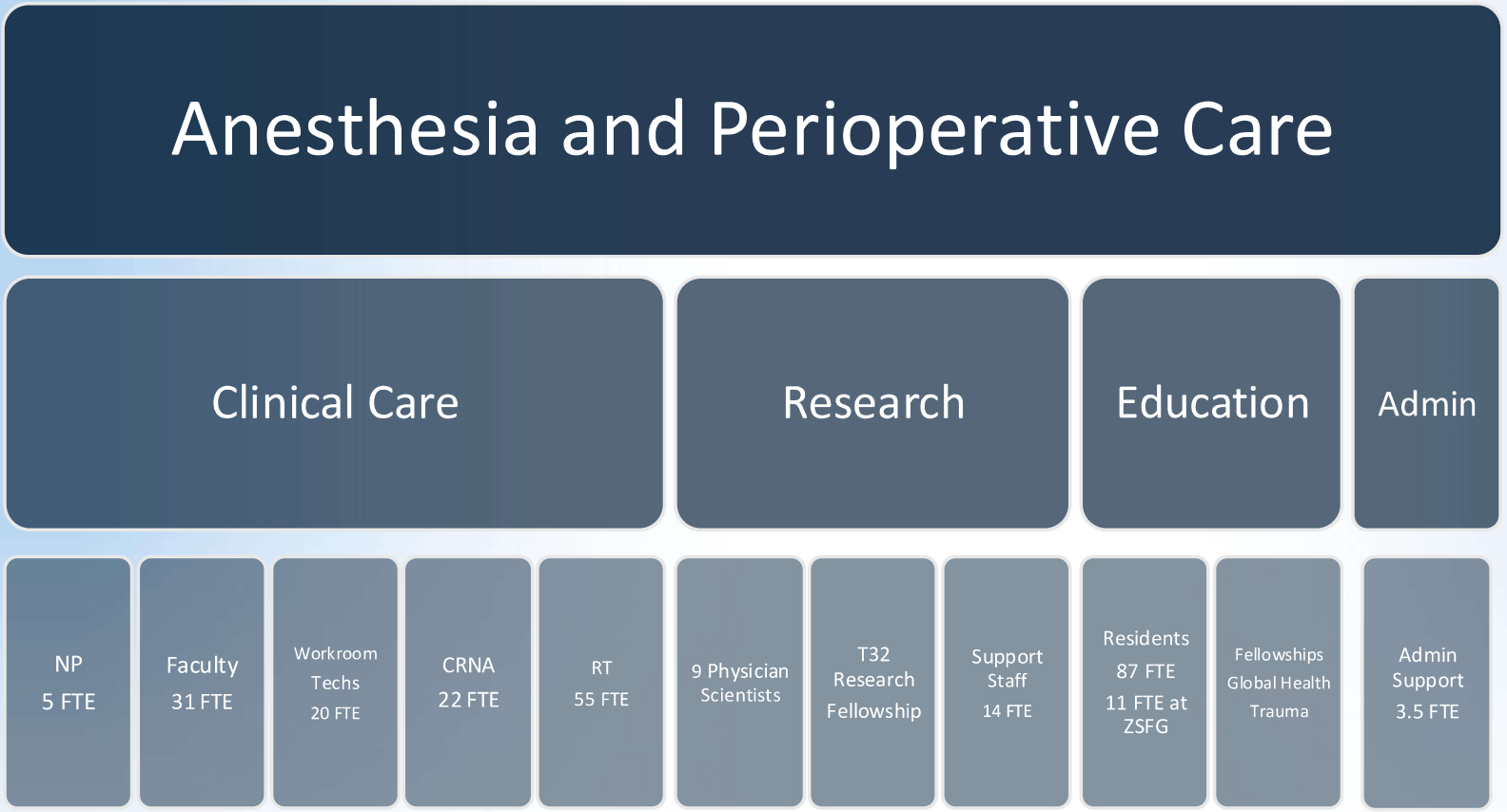
Clinical Footprint

- 1 RCS provider in each ICU
- Neonatal ICU
- Emergency Department
- MERT/Code Blue
- Floor Support
- Hospital Transports (all intubated patients)
- Last year scheduled extra RCS provider on 200+ days to meet increased clinical volume

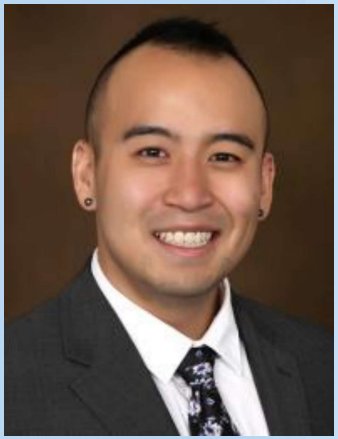
People:
Academic Specialized Periop Experts



Our People


Anesthesia and Perioperative Care
Clinical Care
Research
Education
Admin
NP
5 FTE
Faculty
31 FTE
Workroom
Techs
20 FTE
CRNA
22 FTE
RT
55 FTE
9 Physician
Scientists
T32
Research
Fellowship
Support
Staff
14 FTE
Residents
87 FTE
11 FTE at
ZSFG
Fellowships
Global Health
Trauma
Admin
Support
3.5 FTE

New Faculty



Thien Le, MD



MacGregor Hodgson, MD



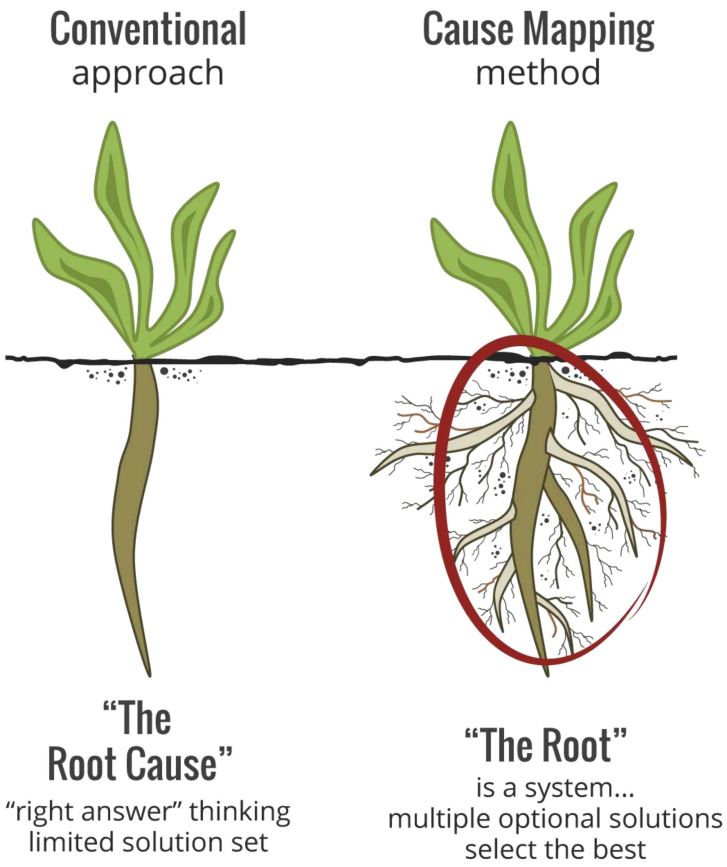
Laura McClung, MD



Margot Pierlussi, MD



Elodie Lang, MD



Retention

- **Exit interviews**
- Faculty Survey / Faculty Retreat
- Cause identified :
  - Salary (vs. National / Local benchmark)
  - Cost of living / childcare / schools
  - QOL at work
  - Academic mission
  - **Career opportunites**

Foster the Diversity of our Clinical Mission

- Anesthesia and Perioperative Medicine
- Trauma Anesthesia
- Critical Care Medicine
- Regional Anesthesia
- OB anesthesia
- Acute and Chronic Pain
- US-guided anesthesia



Leadership Positions

Romain Pirracchio
- Executive Vice Chair of Adult Anesthesia, Department of Anesthesia and Perioperative Care

Renee Navarro
- Vice Chancellor Opportunity and Outreach

Nandini Palaniappa
- Medical Director of Perioperative and Procedural Services

Susan Yoo
- Co-Director SICU

Marc Steurer
- Associate Chair for Finance, Department of Anesthesia and Perioperative Care

Ashish Agrawal
- RCS medical director
- Chair Sedation Committee

Greg Chinn
- CRNA medical director

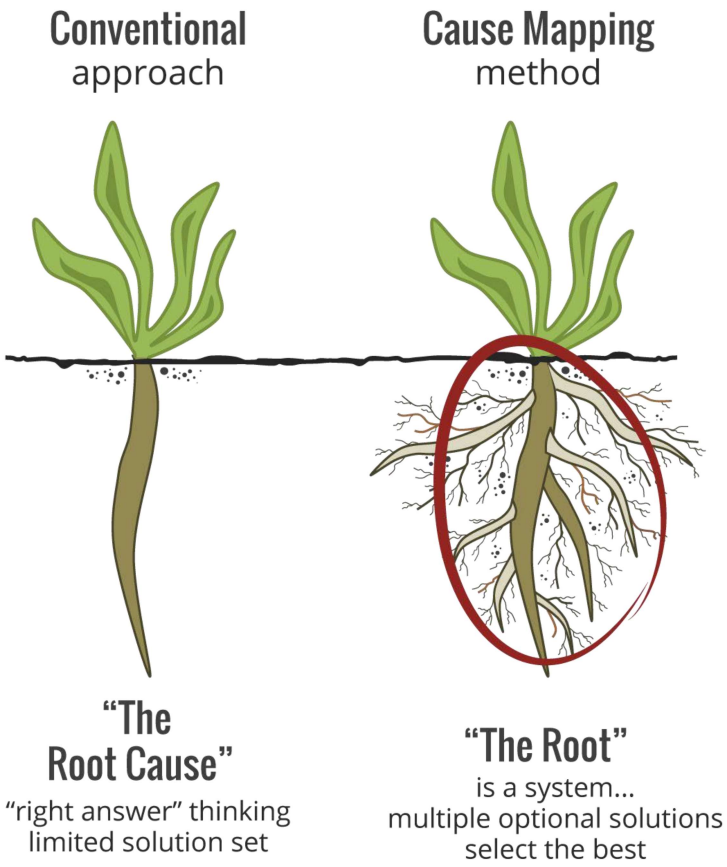
Tyler Law
- Chair Code Blue committee

Arthur Wood
- Chair Pain Committee

Polina Ward
- Director of Clinical Staff

Yvonne Stanek
- Anesthesia Workroom Manager

Kirsten Barash / Ryan Stevenson
- Lead CRNAs

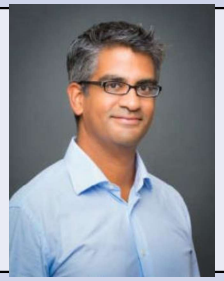


Retention

- **Exit interviews**
- Faculty Survey / Faculty Retreat
- Cause identified :
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  - QOL at work
  - Academic mission
  - **Career opportunites**

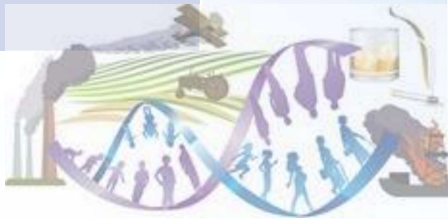
ZSFG Anesthesia and Periop Research

Basic Science

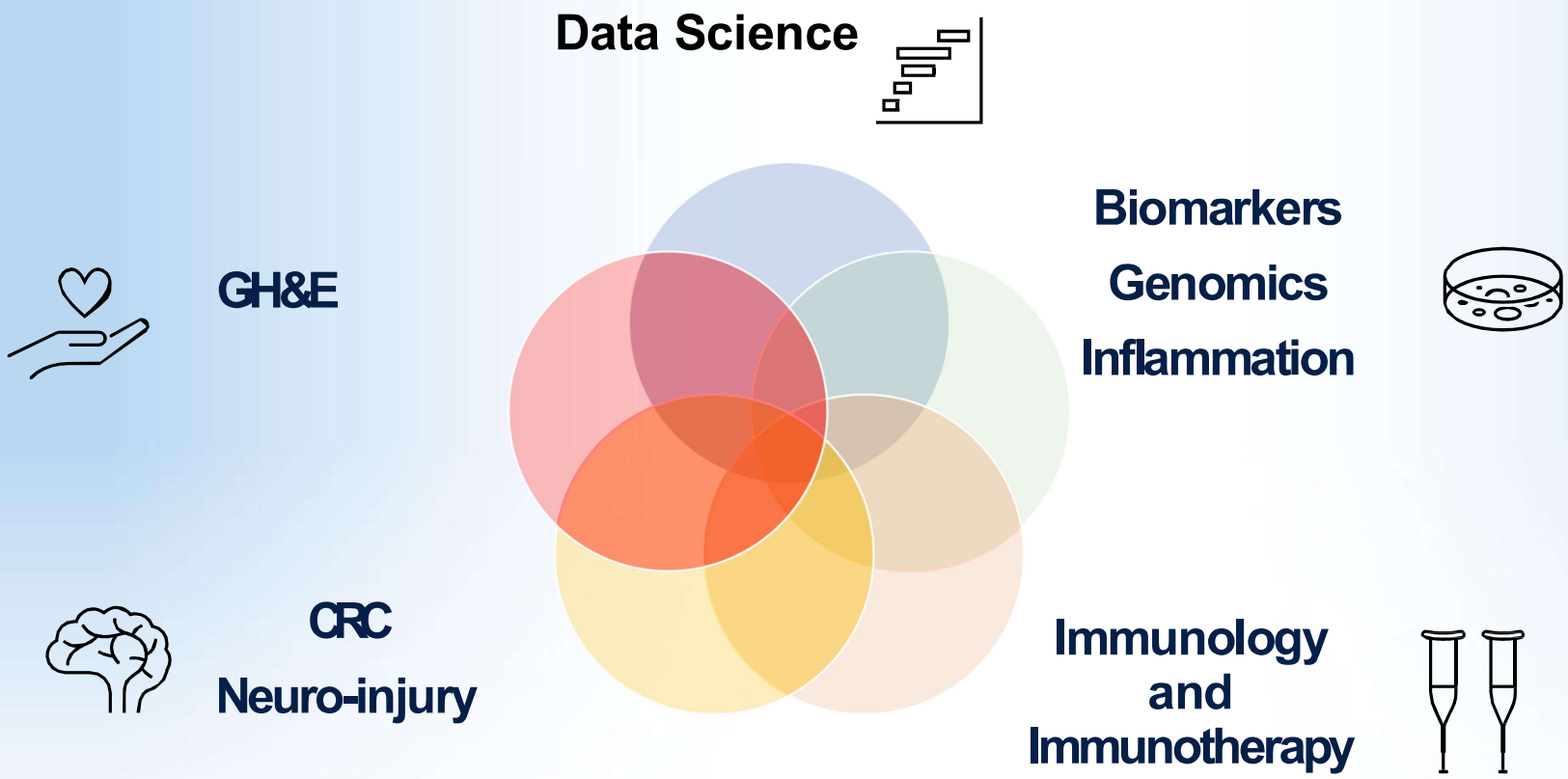
					
Roland Bainton	Bin Liu	Helen Kim	Jim Marks	Romain Pirracchio	Erica Langnas
					
Phil Kurien	Arun Prakash	Jonathan Pan	Mervyn Maze	Michael Lipnick	Tyler Law







Anesthesia Research Map



Active Grants

Over $33,000,000 in active grants awarded to ZSFG Anesthesia Researchers

- Multiple Funding Sources
  - NIH
    - NINDS
    - NIBIB
    - NCI
    - NHLBI
  - DOD
  - AHA
  - PHI
  - FDA
  - PCORI

- FAER
- UCSF – PATH
- UCSF – RAP
- Foundation
  - Gordon and Betty Moore
  - Robert Wood Johnson
  - Dates
- CA Dept of Public Health
- UCSF Anesthesia Department
- ZSFG – Deans Office
- SURF
- Industry
  - Hemosonics
  - Vena Vitals
  - AOP Health
- CA Department of Cannabis Control

Publications

- Over 130 Publications from this group in the 2023-2025 cycle
- Reflective of collaborations
- Reflective of work being done on campus
- High-impact journals


CLINICAL AND TRANSLATIONAL MEDICINE
Open Access

Clin Transl Med. 2024 Apr 22;14(4):e1650. doi: 10.1002/ctm2.1650

ATF3 is a neuron-specific biomarker for spinal cord injury and ischaemic stroke

Jonathan Z Pan [1], Zhanqiang Wang [1,2,3], Wei Sun [1,4], Peipei Pan [1,2], Wei Li [1,4], Yongtao Sun [1,5], Shoulin Chen [1,6], Amity Lin [1], Wulin Tan [1,7], Liangliang He [1,8], Jacob Greene [9], Virginia Yao [1], Lijun An [1,10], Rich Liang [1,2], Qifeng Li [1,2,11], Jessica Yu [1], Lingyi Zhang [1], Nikolaos Kyritsis [12,13], Xuan Duong Fernandez [12,13], Sara Moncivais [12,13], Esmeralda Mendoza [12,13], Pamela Fung [1], Gongming Wang [1,4], Xinhuan Niu [1,4], Qihang Du [1,4], Zhaoyang Xiao [1,14], Yuwen Chang [1], Peiyuan Lv [14,15], J Russell Huie [12,13], Abel Torres-Espin [12,13], Adam R Ferguson [12,13], Debra D Hemmerle [12,13], Jason F Talbott [16], Philip R Weinstein [12,13], Lisa U Pascual [17], Vineeta Singh [18], Anthony M DiGiorgio [12,13], Rajiv Saigal [12,13], William D Whetstone [19], Geoffrey T Manley [12,13], Sanjay S Dhall [20], Jacqueline C Bresnahan [12,13], Mervyn Maze [1,2], Xiangning Jiang [18], Neel S Singhal [18], Michael S Beattie [12,13], Hua Su [1,2,✉], Zhonghui Guan [1,✉]


JAMA

Optimal Vasopressin Initiation in Septic Shock
The OVISS Reinforcement Learning Study

Alexandre Kalimouttou, MD[1,2,3]; Jason N. Kennedy, MS[4,5]; Jean Feng, PhD[6]; Harvineet Singh, PhD[6]; Suchi Saria, PhD[7,8,9,10,11]; Derek C. Angus, MD, MPH[4,5]; Christopher W. Seymour, MD, MSc[4,5]; Romain Pirracchio, MD, MPH, PhD[1,2,6]


Increasing Endoglin Deletion in Endothelial Cells Exacerbates the Severity of Brain Arteriovenous Malformation in Mouse

by Zahra Shabani [1,2], Leandro Barbosa Do Prado [1,2], Rui Zhang [1,2], Wan Zhu [1,2], Sonali S. Shaligram [1,2], Alka Yadav [1,2], Calvin Wang [1,2] and Hua Su [1,2,*]


Clinical Investigation

A comparison of large language model-generated and published perioperative neurocognitive disorder recommendations: a cross-sectional web-based analysis

Sarah Saxena [1,2], Odmara L. Barreto Chang [3], Melanie Suppan [4], Basak Ceyda Meco [5,6], Susana Vacas [7], Finn Radtke [8], Idit Matot [9], Arnout Devos [10], Mervyn Maze [3], Mia Gisselbaek [4,11], Joana Berger-Estilita [12,13]


ANESTHESIOLOGY

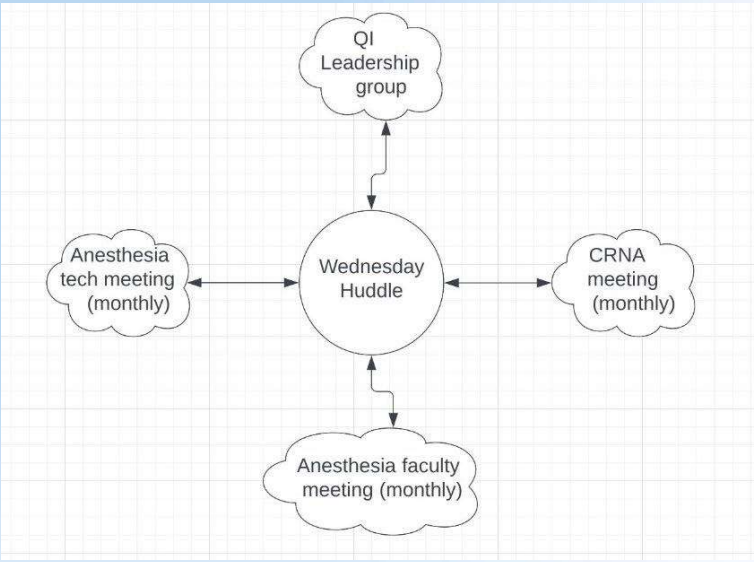
Global Survey of Anesthesia Breathing Circuit Reuse: A Neglected Opportunity for U.S. Health Care to Reduce Climate Impact

Gandhi, Seema M.D., M.B.B.S.[1,*]; Wang, Kaiyi M.S.[1]; Young, Charlotte M.D.[1]; Clarke, Alexander L. M.B.B.S.[2,3]; Gropper, Michael A. M.D., Ph.D.[1]; Lakatos, Kyle M.D., M.P.P., M.S.[4]; Lipnick, Michael S. M.D.[1]; Sasaki Russell, Jennifer Ph.D.[1]; Prakash, Arun M.D., Ph.D.[1]; Gelb, Adrian W. M.D.[1]

Author Information

Anesthesiology 143(1):p 206-208, July 2025. | DOI: 10.1097/ALN.0000000000005462

Quality Improvement work





Driver 1: Perioperative hyperglycemia

Improve monitoring and treatment of hyperglycemia

- Baseline (FY 21-22): fewer than 65% eligible patients* who had hyperglycemia (BG >200) had glucose measurement re-checked or treated with insulin within 90 minutes.
- Target: 75%
- August 2023: 82%

*All inpatients receiving surgery and outpatient (come-and-go) patients with cases longer than 4 hours

Driver 2: Anesthesia for Cesarean Delivery

Decrease avoidable use of general anesthesia during C-sections

- SOAP Center of Excellence criteria:
  - <2% elective cesarean deliveries
  - <10% urgent/emergent cesarean deliveries receive general anesthesia
  - Target: <5%

Baseline (FY 21-22): 14.9% (all deliveries) received general anesthesia

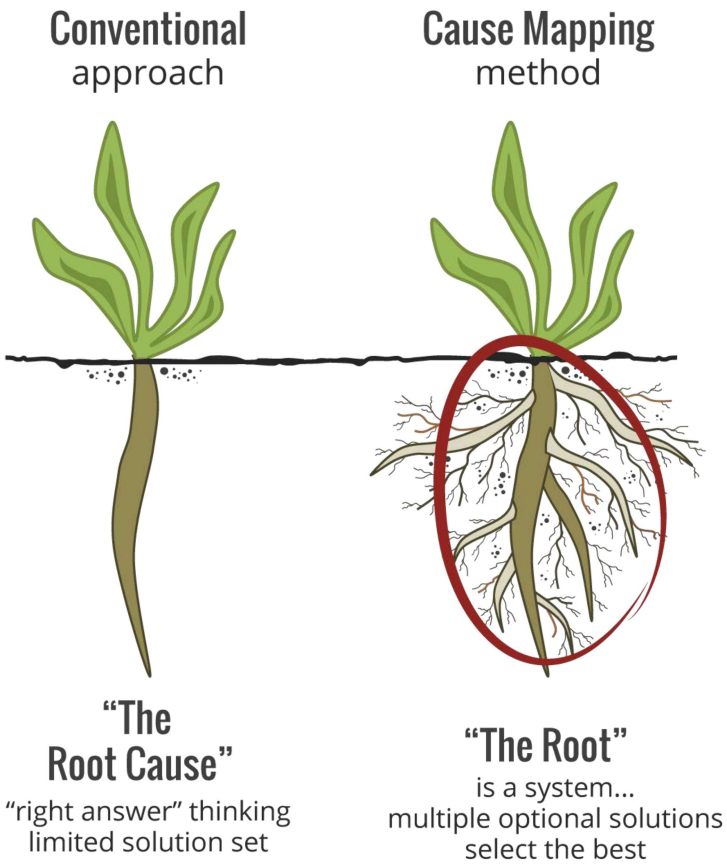
FY 22-23: 11.7%

Driver 3: Anesthesia Greenhouse Gas Emissions

Decrease the carbon footprint of anesthesia delivery

- Reducing fresh gas flow decreases anesthesia waste when using sevoflurane (a potent greenhouse gas)
  - Increase the percent of cases with mean FGF <=2L/min between intubation and extubation

- Baseline (FY 22/23): 25%
- Target: 40%
- August 2023: 51%



Retention

- **Exit interviews**
- Faculty Survey / Faculty Retreat
- Cause identified :
  - Salary (vs. National / Local benchmark)
  - Cost of living / childcare / schools
  - QOL at work
  - Academic mission
  - **Career opportunites**

Faculty Wellbeing



Wellbeing group: Dr Erica Langnas, Dr Phil Kurien



Wellbeing initiatives

In collaboration with UCSF and with ZSFG partners

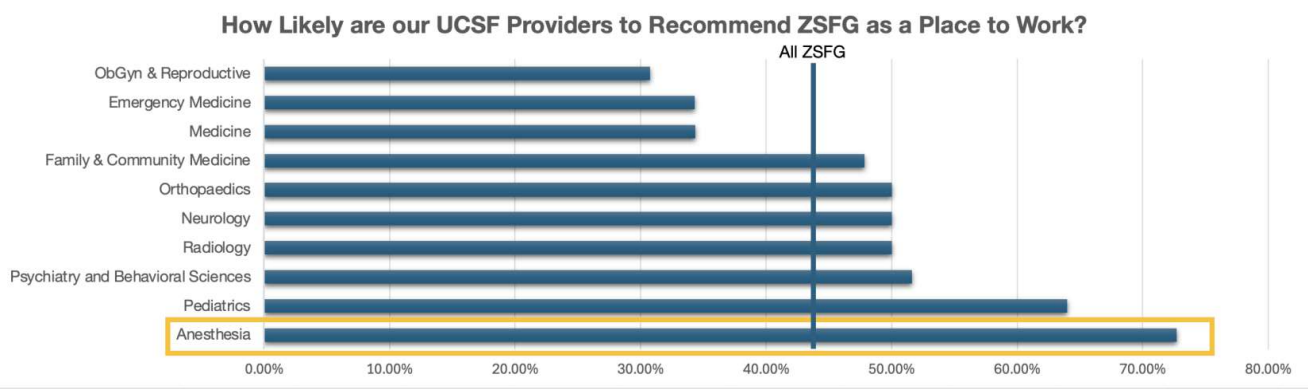
ZSFG Well-Being Initiatives



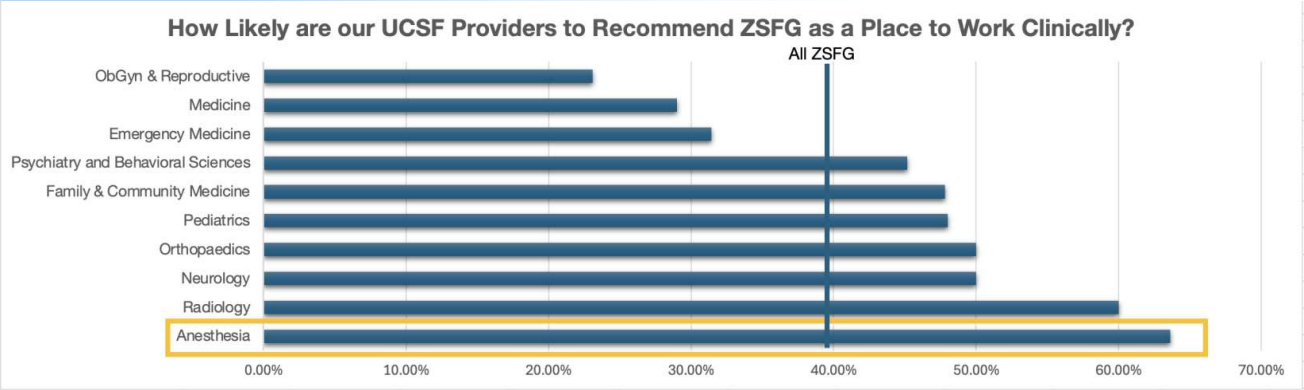
- Faculty Retreats: Spring 2024
  - Focus on Well-Being, Work-Life Balance, Perioperative Pathways, Community Building, Actionable Solutions
- Morale Events/Celebrations/Farewell Gatherings
  - Strengthen Existing Community Build New Community, Show Appreciation
- Professional Portraits
  - Faculty, CRNAs, NPs, Staff, Anesthesia Techs
- Language and Equity
  - Learning how to “break the ice” with patients in top 3 non-english languages
- Improving Staffing
  - Faculty, CRNAs, NPs, Staff, Anesthesia Techs
- Inter and Cross Campus Collaboration
  - ZSFG Faculty Experience Council, UCSF Anesthesia Well-Being, and UCSF Committee on Faculty Welfare

ZSFG Anesthesia NPS Data

All ZSFG FY24 Responses



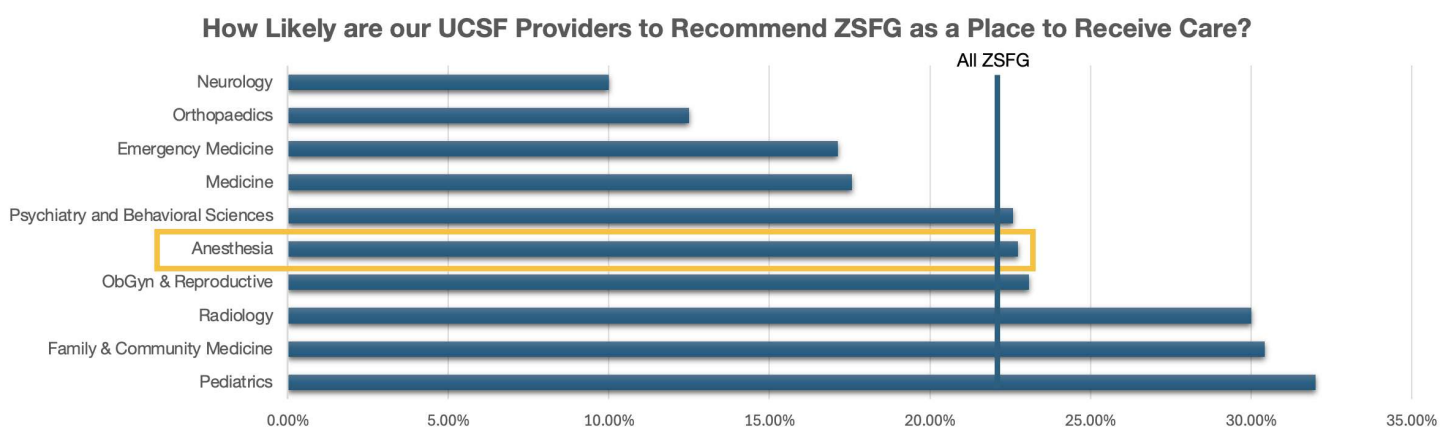
Place to Work



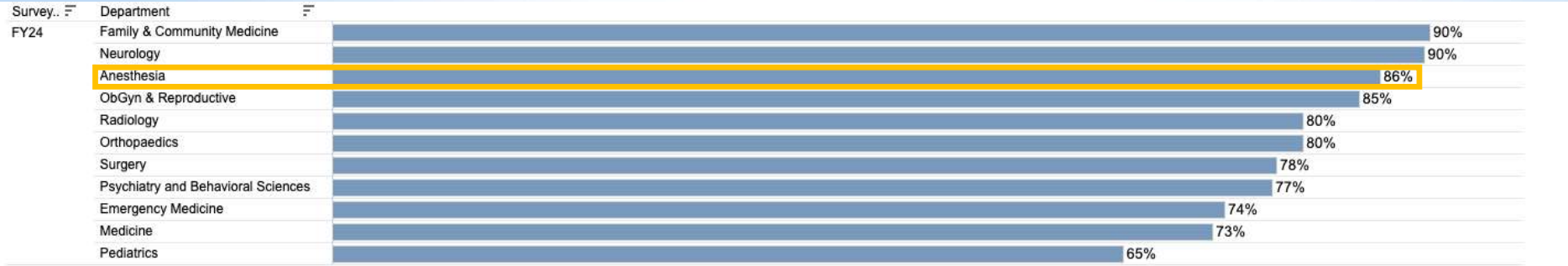
Place to Work Clinically

ZSFG Anesthesia NPS Data

All ZSFG FY24 Responses



UCSF ZSFG
FY 24 Leadership Support
Divisional/Department Leadership
"Agree/Strongly Agree"



Constructing Our Future

Thrive in our Missions, Develop our People



Anesthesia – Learner Education



- Numbers at-a-glance at ZSFG Anesthesia:
  - 31 medical students (Anesthesia 110 at ZSFG)
  - 27 Anesthesia CA-1 residents
  - 50 Anesthesia CA-2 & CA-3 residents
  - 53 Medicine R3 residents (Code Blue Simulation)
  - 16 Emergency Medicine residents (OR Anesthesia Rotation)
  - 7 Pulmonary Medicine fellows (OR Anesthesia Rotation)
  - 2 ACLS instructor, 1 ATLS instructors
  - 6 MOCA Simulation courses

- **Ranked #1 Anesthesia Residency Program:**

ZSFG Anesthesia rotation consistently highly ranked in residency program

UCSF
University of California
San Francisco

Anesthesia – Simulation

Anesthesia Simulation lab moved to Pride Hall in July 2023

- Residency Crisis simulation 2-3 times per month
- Anesthesia 110 simulation 2 times per month
- Faculty MOCA simulation 7 sessions yearly
- Anesthesia Residency remediation using simulation pathway
- Hosting Medical student simulation session as part of ASA 2023
- Intensive simulation for new CA-1 residents in July



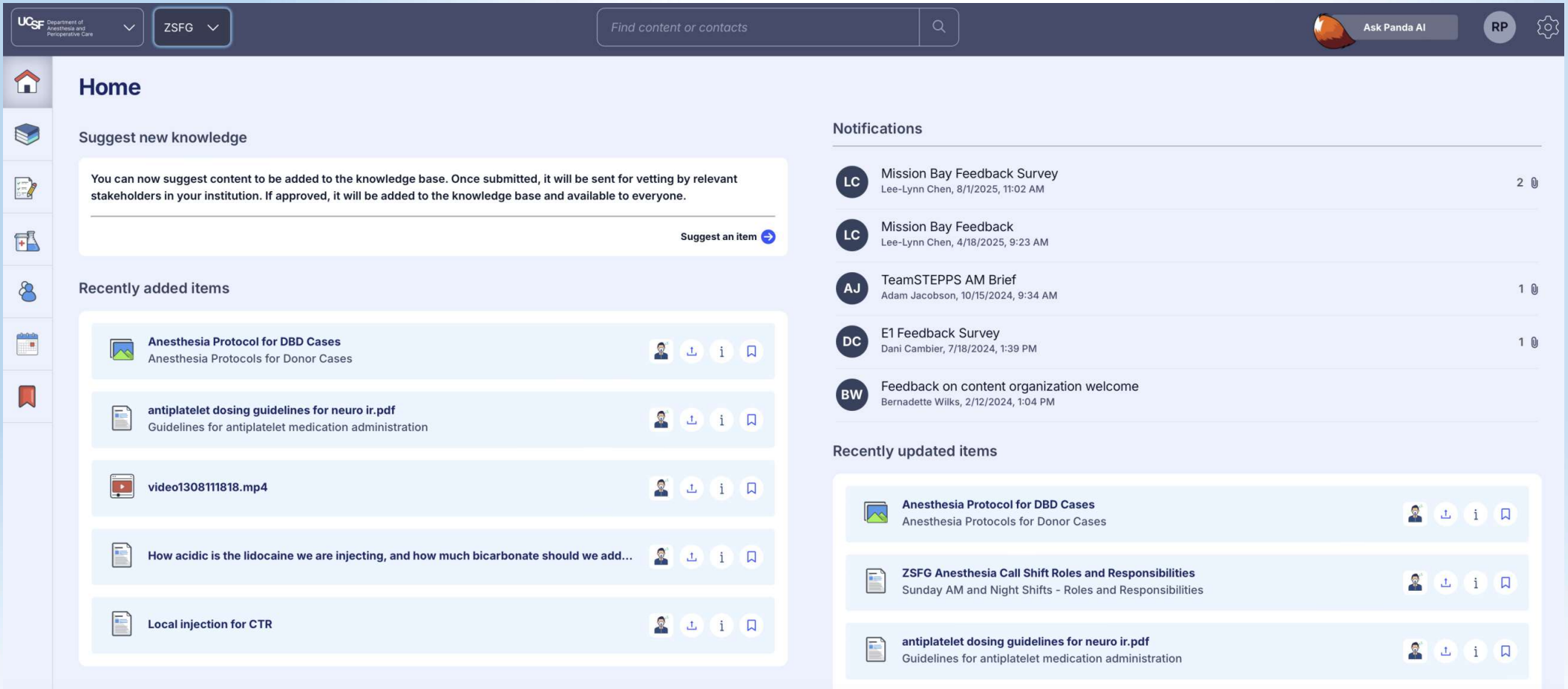
Continuing Education at ZSFG Anesthesia

- Ongoing monthly CME-accredited Faculty Education Series
  - Has drawn speakers from all over the United States
  - Estimated 90% attendance from all faculty, CRNAs, and residents

- ZSFG-Paris Program:
  - Joint case-conference between Anesthesia departments at ZSFG and HEGP hospital in Paris
  - Exchange Program



Unified Anesthesia Portal



Anesthesia Clinical Adverse Event

Clinical Adverse Event* Occurs

Complete REPORTING **AND** DISCLOSURE Pathways

Take care of the patient

- Refer to checklists
- Call in backup if needed
- Consults/specialists
- Anesthesia follow- up (if unable to follow-up yourself): Call pain service x30018.
- Notify primary care physician if appropriate

Take care of yourself

- Can you focus on subsequent tasks/patients?
- Consider backup or relief, especially after severe adverse outcomes
- Consider a team debrief (not a venue for blame)

REPORTING *Required*

Unexpected death or serious physical or psych injury

YES

SENTINEL EVENT
Call risk mgmt (6-6052, 415-327-1013 pgr)
AND contact Marc Steurer (415-307-5052)
AND complete UO and M&M entries

NO

UNUSUAL OCCURRENCE
Report on UO form
AND enter into M&M Database

Risk mgmt coordinates follow-up analysis

DISCLOSURE *Required*

Clinical team arrives at consensus of events to ensure consistent information for disclosure

Disclosure to patient/surrogate: Attending physician; have a witness present. If possible, contact risk mgmt beforehand

**May decide not to disclose if would place patient at risk of physical or psychological harm. Consider ethics/risk mgmt. consult.

DISCLOSE & DOCUMENT DISCLOSURE

- ❑ Interpreter services as necessary
- ❑ Factual explanation
- ❑ Expression of empathy & apology
- ❑ No conjecture of cause/attribution of fault until investigation complete
- ❑ Explanation of impact on treatment & steps to mitigate any injury
- ❑ Assurance that health team will be available for questions
- ❑ Investigation findings as available

MEDICAL RECORD

***Use .anesdisclosure in post-op note or progress note**

- ❑ Factual description
- ❑ Note outlining patient discussion
- ❑ Personnel present (including interpreter)
- ❑ Note describing follow-up discussions
- ❑ Reasons for withholding disclosure**

*Adverse Event: Negative result stemming from a diagnostic test, medical treatment, or surgical intervention. It *may or may not* be the result of a clinical error (act or failure to act).

*Please send any feedback on this flowsheet to Ashish.Agrawal@ucsf.edu

This cognitive aid is to be used to aid decision-making after a possible adverse event. It is not a formal guideline or policy, and individual patient concerns may justify or require deviations from these suggestions.

Corneal Abrasion

Patient reports painful or itchy eyes, blurry vision, or foreign object sensation

Is the patient high risk?

Yes

High Risk Factors include:
Monocular vision
Contact Lens Use
(Contact lens wearers are at risk for pseudomonas infection and will need broader antibiotic coverage.)

No

Apply topical anesthetic to eye. Does the eye pain persist?

Yes

Common topical anesthetics include **Proparacaine 0.5% 1 drop per eye.** Should work within minutes. If eye pain does NOT disappear, this is not a corneal abrasion.

No

Fluorescein strip, cobalt blue light. Any corneal defects noted?

No

If a defect is seen, corneal abrasion is diagnosed. If no defect is seen, consult ophthalmology to consider other diagnoses.

Yes

Rx: Erythromycin 0.5% ophthalmic ointment every 6 hours.

Consult: Ophthalmology

Outpatient Follow-up prn

Ophthalmology clinic (628-206-8025 or 628-206-7319, ask for Judy Cayabyab) if symptoms not significantly improved after first 12-24 hours. (Patient can call to schedule drop in same-day visit.)

Did You Know?

- Eye irritation or pain can be due to topical injury (corneal abrasion, exposure keratopathy) generally expected to heal quickly or due to deeper issues within the eye (acute angle closure glaucoma, uveitis, optic neuropathy) which require urgent ophthalmology evaluation.
- Corneal abrasions may cause some loss of visual acuity, especially if moderate or severely injured. Vision changes alone do not necessitate an ophthalmology consult.
- Corneal abrasions or topical injury to the eye should improve with topical anesthetic. Ongoing eye pain after a topical anesthetic should be concerning for another emergent process, such as acute angle closure glaucoma.
- Corneal abrasions should improve dramatically within the first 24 hours after injury, especially after prolonged eye closure (sleeping). Eye symptoms which do not improve rapidly within 24 hours should be seen in ophthalmology clinic, where patients can get a same-day appointment.

References:

Please send feedback/comments to: Ashish.Agrawal@ucsf.edu

Special thanks to Dr. Sri Padmanabhan. V. 1

This cognitive aid is to be used to aid decision-making after a possible adverse event. It is not a formal guideline or policy, and individual patient concerns may justify or require deviations from these suggestions.

PIV Extravasation

Did You Know?

- Peripheral IV (PIV) extravasations are among the most common complications seen during anesthesia care.
- While most PIV extravasations resolve with conservative management, severe cases can result in compartment syndrome, tissue necrosis, and a need for skin grafts.
- Severity can be related to the volume of solution infused, the characteristics of medications infused (pH, osmolarity, vasoconstriction, and cytotoxicity), and the location or depth of peripheral IV used.
- **The choice of appropriate antidotes may be confusing or unclear, and best practice is to refer to a reference or aid as provided here.**

References:

Credit: Melissa Nguyen. V.1

Suspected Peripheral IV Extravasation

IMMEDIATELY: STEP 1 – Limit ongoing damage

- Stop infusion
- Obtain alternative access at unaffected site to continue important medication administration
  - Avoid sites distal to the site of extravasation.

STEP 2 – Treat Extravasation

Tiny.ucsf.edu/sfghanesrisk

- Attempt to aspirate any residual drug from catheter, then remove catheter.
  - **Exception:** Aspiration of contrast media is NOT recommended.
  - Avoid friction or pressure to the affected area.
  - Do NOT flush the line to dilute drug solution.
- Order and administer antidote (See complete reference at link)
  - Prep skin with 10% povidone-iodine (1 min scrub, then dry, preferred for skin breaks) or 2% chlorhexidine gluconate (30 sec scrub, then dry). Use aseptic technique.
  - Apply loose gauze dressing and assess every 2 hours to monitor for improvement or worsening.
- Elevate limb, apply recommended thermal compresses.
  - Compresses for 15-20 min q4 hours for 24-48 hours or until inflammation/symptoms resolve.
  - No clear benefit between cold vs. warm. Cold may reduce inflammation and pain, while warm may improve drug clearance from tissue.

Step 3 – Documentation

- Outline extravasation area with marking pen, date and time.
- Document skin and neurologic exam as appropriate
- Submit Unusual Occurrence (UO) and follow reporting/disclosure pathways

Step 4 - Follow-up

- Monitor extravasated site at least each nursing shift x 48 hours.
- If any skin breakdown, necrosis, concern for compartment syndrome, or other surgical concerns, call surgical consult:
  - Hand (ortho/plastics) for below the elbow
  - General surgery for other sites

Please send feedback/comments to: Ashish.Agrawal@ucsf.edu

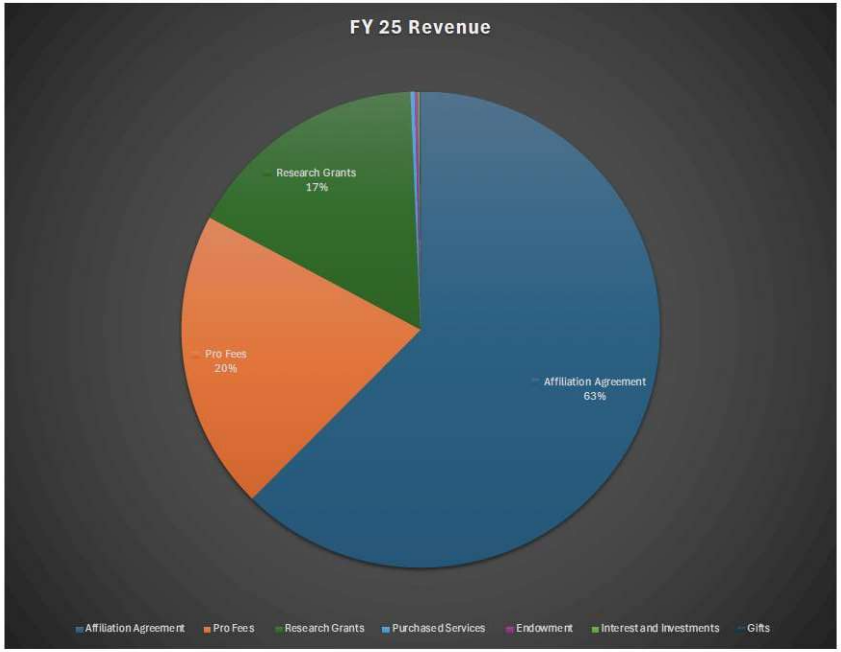
Sustainability



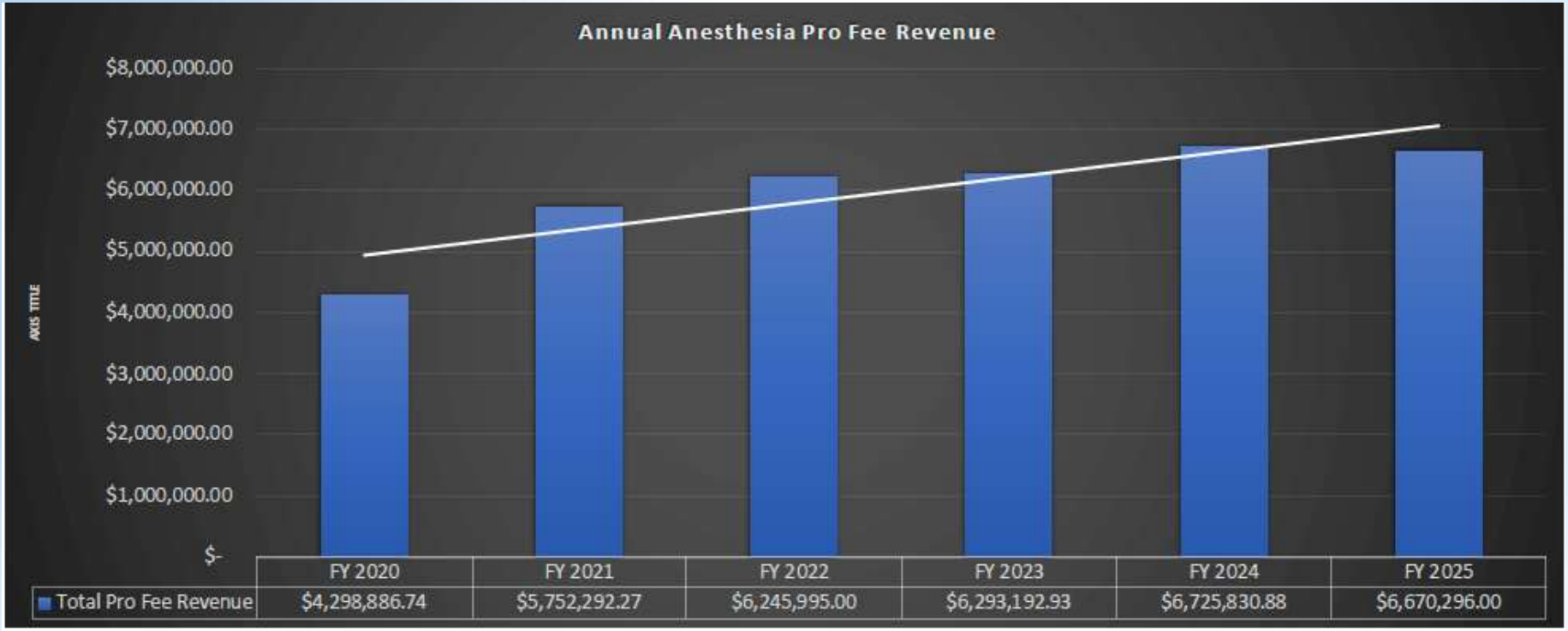
VISION : Sustainability & Investment in Department Missions

FY25 Revenue

Revenue Source	FY 25 Revenue	% of FY 25 Revenue
Affiliation Agreement	$ 20,460,675	62.44%
Pro Fees	$ 6,670,296	20.36%
Research Grants	$ 5,411,771	16.52%
Purchased Services	$ 90,809	0.28%
Endowment	$ 75,838	0.23%
Interest and Investments	$ 34,852	0.11%
Gifts	$ 22,158	0.07%
	$ 32,766,399	100.00%

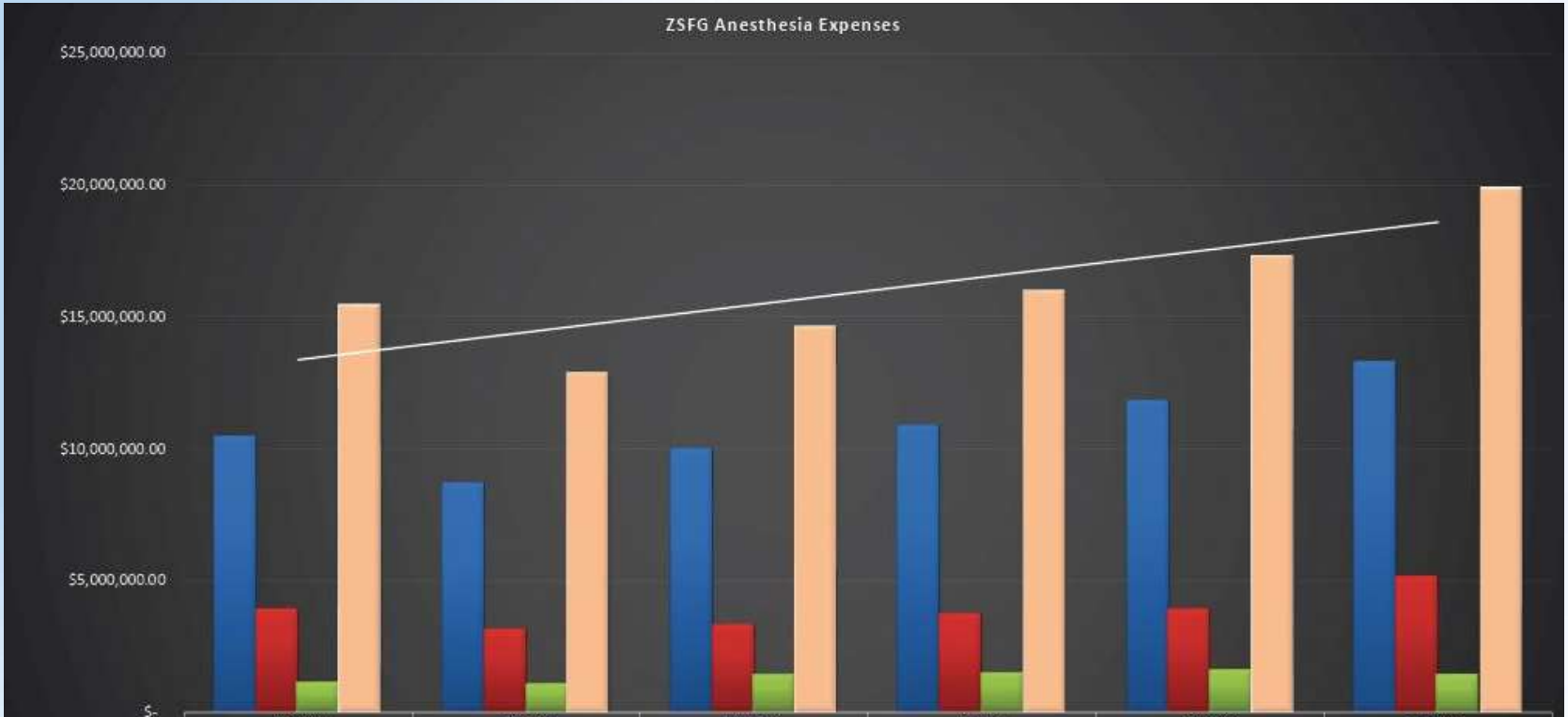


Pro-Fee Revenue:
FY20-25



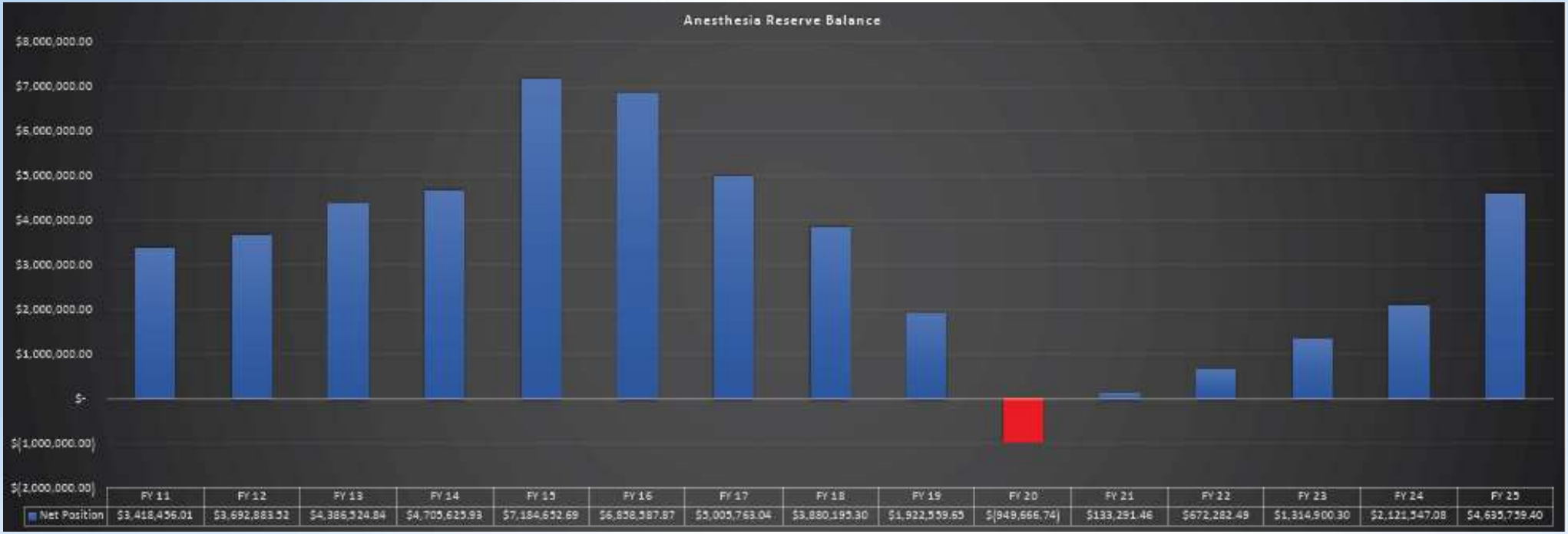
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Total Pro Fee Revenue	$4,298,886.74	$5,752,292.27	$6,245,995.00	$6,293,192.93	$6,725,830.88	$6,670,296.00

Expenses:
FY 20-25



	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Faculty Expenses	$10,455,658.85	$8,665,885.00	$9,997,539.00	$10,819,761.00	$11,788,123.00	$13,287,667.00
Staff Salaries	$3,879,254.23	$3,109,675.87	$3,255,568.00	$3,675,062.00	$3,880,530.00	$5,133,481.35
Non-Salary Expenses	$1,097,242.18	$1,057,838.56	$1,366,764.00	$1,477,032.00	$1,579,322.00	$1,400,592.00
Total	$15,432,155.26	$12,833,399.43	$14,619,871.00	$15,971,855.00	$17,247,975.00	$19,821,740.35

Reserve Balances:
FY11-25



	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
Net Position	$3,418,456.01	$3,692,883.52	$4,386,524.84	$4,705,625.93	$7,184,652.69	$6,838,387.87	$5,005,763.04	$3,880,195.30	$1,922,559.65	$(949,666.74)	$133,291.46	$672,282.49	$1,314,900.30	$2,121,347.08	$4,635,759.40

Challenges

Staffing:
- Retention: Maintaining a competent and engaged faculty to deliver both clinical care and mission
  - Compensation gap
  - Location pressure
- **CRNA shortage**
- **Anesthesia Tech shortage**

URM:
- Insufficient diversity

Finances:
- Building stronger reserves, while reinvesting in institution, mission and people

Pain:
- APS: Limited coverage on nights and weekends due to challenges funding additional pain NP staff – long wait times for acute pain treatment
- Wait times for procedures are on average 8-10 months - Wait times predicted to increase due to challenges funding additional Pain Anesthesia MD staff

Strengths

- People: Dedication and Mission-driven
- Diversity of our Clinical Mission
- Strength of our Academic Program
- Our trainees
- GH&E Focus

PERIOPERATIVE MEDICINE

THE PATHWAY TO BETTER SURGICAL CARE





Department of
Anesthesia and
Perioperative Care

Summary of changes to Anesthesia Rules and Regulations

- Minor grammatical and phrasing changes throughout which do not substantially alter the structure or meaning of the sentences. (See track changes document.)
- Minor changes throughout to reflect updated equipment used and updated checklists, such as new self-test on the anesthesia machines, moved to Epic documentation instead of paper documentation for some tasks, etc. (See track changes document.)
- I.A. Added pre-op clinic, Chronic pain service, and Acute pain service to list of anesthesia services.
- I.B. List of anesthesia clinical leaders updated to reflect current positions
- I.B. Paragraph on Jehovah's witnesses combined with section below also about Jehovah's witnesses (VII.A.1).
- I.C.5 Current anesthesia machine has internal self-test which replaces previous manual machine checks.
- I.C.5 Reference to ZSFG Perioperative Fire Policy (#36) and removed Appendix L which is duplicative.
- II.E. Added Nurse Practitioner Job Description.
- Appendix B: New organizational chart
- Appendix D: Updated reference to handoff checklist available to reflect current practice.
- Appendix D.1 deleted because checklist is now available in Epic. D2 and D3 renumbered to D1 and D2.
- D.2 and D.3 checklists updated to modern versions.
- Appendix F: Deleted the duplicative requirement for controlled substances to be drawn up and labeled appropriately because this requirement is not different than the same requirement for ALL medications which is stated in this document already.
- Appendix F.1: Updated to new statement from the ASA.
- Appendix G deleted because anesthesia machines now have internal self-check per manufacturer recommendations.
- Appendix H: Updated Malignant Hyperthermia resources to reflect updates in 2023 including new formulation of Dantrolene.
    - Appendices H.1 to H6 updated to reflect new MH resources available to staff.
- Appendix I.1 and I.2: Code Bag inventory updated
- Appendix J.1: Updated OR1 checklist
- Appendix K.1-2: Updated L&D Checklists

- Appendix L deleted, duplicative policy with ZSFG Perioperative Fire Policy (#36).
- Appendix M1: Updated Clinical Service Privilege form
- Appendix N: Updated Anesthesia OPPE metrics

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ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE

RULES AND REGULATIONS
2026

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE
RULES AND REGULATIONS
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Commented [AA1]: Make sake sure page numbers are correct.

I. ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE POLICIES

A. SCOPE OF SERVICE

1. OVERSIGHT - The Chief of the Anesthesia Service (Refer to Appendix A for detailed job description) is responsible for oversight of all anesthetic care at Zuckerberg San Francisco General Hospital (ZSFG) including pre-op clinic, all functions of the Post-Anesthesia Care Unit (PACU) related to the Anesthesia and Perioperative Care Clinical Services, administration of anesthesia faculty attending in the Medical-Surgical ICU, administration of anesthesia faculty attending in the Chronic Pain Clinic and Acute Pain Service, and administration of the Respiratory Care Service.

Commented [AA2]: Pain clinic? Pre-op clinic? Acute pain service? Would some of these be part of "anesthetic care"?

B. ORGANIZATION/STAFFING OF THE ANESTHESIA AND PERIOPERATIVE CARE SERVICE

1. CHIEF OF SERVICE - The Chief of the Anesthesia Service, or his/her designee, is responsible for ensuring the quality of anesthesia care. As necessary, assistance is invited from other services/departments, the Performance Improvement and Patient Safety Committee, or the appropriate ZSFG administrative committee or organization (example: Executive Committee, OR Committee, Engineering, etc.).

   To facilitate the administrative oversight of the varied clinical activities in the Department, the Chief has appointed the following clinical leaders (see Appendix B for Department of Anesthesia Organizational Chart):

   Associate Chief of Research

   Associate Chief of Education

   Associate Chief of Strategy

   Associate Chief of Clinical Operations
   Director of Obstetrical Anesthesia
   Director of Quality Improvement
   Director of Regional Anesthesia
   Medical Director Post-Anesthesia Care Unit (PACU)
   Medical Director Anesthesia Workroom
   Medical Director of Respiratory Therapy
   Medical Director of the Anesthesia Pre-Operative Clinic
   Medical Director Trauma Anesthesia
   Medical Director Anesthesia Pain Clinic
   Medical Co-Director of the Surgical ICU
   Anesthesia ICU Director
   Director of Medical Student Education
   Director of ZSFG Resident Rotation

2. REGULAR SERVICE PROVISION – Anesthesia services at ZSFG Medical Center are administered by a combination of fully credentialed, qualified anesthesiologists who are board certified or actively pursuing board certification, or the equivalent, as

determined by the Chief of Anesthesia and Perioperative Care, or certified registered nurse anesthetists **(**CRNAs**),** and trainees in the training program of the Department of Anesthesia and Perioperative Care, UCSF.

The scope of anesthesia services is determined by a continuing process of needs assessment and negotiation with ZSFG and other clinical departments. The Chief of the Anesthesia Service, or his/her designee, is responsible to oversee and provide adequate coverage. The Department of Anesthesia and Perioperative Care will always provide qualified anesthesia personnel to meet the obligations of these agreements. Residents, fellows and CRNAs may administer anesthesia when under the supervision of an attending anesthesiologist who is immediately available if needed. This supervising attending anesthesiologist will be prepared to immediately conduct hands-on intervention if needed.

3. ON-CALL COVERAGE - A minimum of three physicians or two physicians and one nurse anesthetist will be in the hospital at all times. Of these, one physician will be available for immediate emergencies and will coordinate the activities of the other two. One of the physicians will be available for obstetrical anesthesia.

4. ON-CALL FACULTY ANESTHESIOLOGIST - At all times, one member of the attending staff is in the hospital and takes responsibility for all anesthetics administered. A second attending anesthesiologist is on-call for backup and will be called in to ensure adequate in-house coverage if the coordinating anesthesia attending is confronted with or anticipates a workload that cannot be handled safely with the regular staff.

5. ANESTHESIA SERVICE IN THE EVENT OF A DISASTER – The Anesthesia Service functions within the scope of the overall hospital disaster plan. In the event of a mass casualty event, the on-call attending anesthesiologist will initiate backup attending activation and contact the Clinical Director or Departmental Administrator on call. Additional faculty, CRNAs, and Anesthesia technicians will be activated as determined by the Clinical Director and D1 attending using the Disaster Phone Tree (posted at OR front desk).

   In the event of a disaster that inactivates the telephone system, it is the responsibility of all personnel (who are able to do so) to come to the hospital immediately when they become aware of the disaster.

6. EMERGENCY PROCEDURES - In any emergency that requires resuscitation or handling of any airway problem, the Anesthesia Service may be contacted through the on-call physician on 30000 or 30001, or a “Code Blue” or airway stat may be called via the operator. When a replacement pager/phone is in use, the telephone operator, the Emergency Department, the Family Birth Center, and the OR front desk will be notified by the on-call anesthesia resident or faculty.

Commented [AA3]: Do we want a caveat that would allow the coordinating anesthesiologist to reassign providers in an emergency? As currently written this mandates us keeping OB availability even if there are no laboring patients and multiple OR emergencies. I realize there may be regulatory reasons why we need to state we always have OB availability so not sure if we can really change this.

7. NURSE ANESTHETIST JOB DESCRIPTION (CRNA)

   See Section II.E. Affiliated Professionals

8. NURSE PRACTITIONER JOB DESCRIPTION (NP)

   See Section II.E. Affiliated Professionals

C. DELIVERY OF ANESTHETIC CARE

1. OVERVIEW - Anesthesia providers (as described above) will routinely administer anesthesia to all patients brought to surgery, except in those cases where the surgeon desires to administer local or topical anesthesia, or where no anesthesia is required.
   The Anesthesia Service will also provide anesthesia in other sections of the hospital (Labor & Delivery floor, radiology suite, emergency department, etc.) when appropriate. A uniform standard of anesthesia care will be followed wherever anesthesia services are delivered to patients.

2. PRE-OPERATIVE ANESTHESIA EVALUATION - Each patient will be evaluated either by clinic visit, in-hospital visit, or chart review by a member of the anesthesia care team within the 48 hours prior to surgery. Pre-anesthesia evaluation and documentation shall be performed according to the guidelines (Basic Standards for Pre-Anesthesia Care described by the American Society of Anesthesiologists) and shall consider the patient's medical condition and surgical urgency (Appendix C). If, in his/her opinion, additional diagnostic or therapeutic measures are necessary prior to surgery, he/she will discuss these measures with the responsible surgeon/proceduralist and with an anesthesia attending. These concerns will also be discussed with the anesthesia care team assigned to the case as soon as possible.

   The preoperative note shall be reviewed, verified, and signed by the anesthesia care team on the day of surgery. It will include a notation of the patient's diagnosis, surgical or obstetrical procedure anticipated; pertinent history and physical; assessment of anesthetic problems; and choice of anesthesia type (general, MAC, neuraxial block, peripheral regional anesthesia, or a combination of these). On the day of surgery, the anesthesia care team shall verify the identification of the patient, site and side of surgery, presence of consent, and any changes to the previously obtained history and physical. All questions from the patient and/or family shall be answered, the preferred type of anesthesia explained, and any alternatives discussed. In the case of an emergency where the urgency of the situation precludes a complete preoperative evaluation, specific documentation of the emergent nature of the procedure should be made by the attending anesthesiologist.

3. CHOICE OF ANESTHESIA - Under most circumstances, the responsibility for the choice of anesthetic technique belongs to the anesthesiologist. When unusual circumstances cause the surgeon to have a special preference, this should be handled by prior consultation.

4. ADMINISTRATION OF ANESTHESIA - Immediately prior to the induction of anesthesia or intravenous sedation, with the patient in the OR, procedure room, or induction room, the patient's condition will be reviewed by the anesthesia provider including measurement of vital signs, assessment of airway status, and response to pre-procedure medications. This physician or his/her assigned replacement will continue to be responsible for the safety of the patient throughout the anesthetic period.

   It is expected that the attending anesthesiologist will be present for induction and emergence from anesthesia and any other critical parts of the procedure.

   A record will be kept of all events taking place during the induction of, maintenance of, and emergence from anesthesia. This record will include vital signs, the amounts and duration of all drugs, anesthetic agents, intravenous fluids, and blood products given, placement of invasive catheters, and description of anesthetic technique including methods of body warming. In addition, the anesthesia record will document the estimated blood loss and urinary output when measured, any unusual events during the anesthesia period, and the status of the patient at the conclusion of surgery in the PACU.

   Whenever there is a change of anesthesia care provider, for example at morning break, lunch break, or at shift changes, a formal handoff of patient care information will occur between the outgoing and incoming care provider as required by The Joint Commission (TJC) and in conformance with the Departmental Transition of Care Policy (Appendix D).

   Standards for Basic Intra-operative Monitoring established by the American Society of Anesthesiologists will be adhered to in all cases (Appendix E). The anesthesia record shall document the monitors utilized and the results of such monitoring.

   It is department policy that all syringes or intravenous fluids containing medication for patient administration be appropriately labeled. Medications should be prepared daily and discarded at the end of the work period.

   a. All syringes will be labeled with drug name, concentration or total dose, the date and time of preparation and the initials of the anesthesia provider.
   b. All syringes containing medications outdate 24 hours after they are drawn up, except for propofol, which outdates after 6 hours.
   c. Labeling of the syringe is not required if the drug is drawn up and administered immediately by the individual who prepared the medication with no intervening tasks.

Commented [AA4]: 12 hours in vial, 6 hours in syringe.

d. In all operating rooms or procedural areas when the anesthesia provider is not present, unused medications will reside inside the lockable anesthesia cart. Anesthesia carts may be left unlocked and non-controlled medications may be left in, or on, the top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the immediate vicinity (see appendix F for detailed Policy and Procedure).

e. Anesthesia providers may carry medications on their person under the following circumstances:
    i. When taking those drugs directly for administration at the patient's bedside. These drugs may include but are not limited to analgesics, anxiolytics, sedatives, vasopressors, anti-emetics, beta-blockers, bronchodilators. Only drug sufficient for the anticipated patient need should be carried on the provider's person.
    ii. When transporting a patient to or from an acute care unit.

f. Controlled drugs must at all times be either under the direct control of the anesthesia provider or in an approved locked box or drawer in a secure area. Controlled drugs (narcotics/sedatives and ketamine) are obtained from Pharmacy or the operating room charge nurse using a locked box method. Dispensed drugs are entered in a Pharmacy Log sheet. Any unused medications in the syringes should be disposed of, with a witness, prior to the initiation of care of another patient. The waste must be documented on the controlled substance administration record and initialed by the provider and witness.

g. All used medications will be disposed of between cases. At the conclusion of the work period, all used and unused medications will be disposed of.

h. ZSFG high-alert medications (heparin and insulin) must be drawn up and the dose checked by two providers.

i. Anesthesia care providers will be familiar with, and adhere to, the Operating Room Universal Protocol Policy and Procedure and will actively participate in the Rolling Timeout, Final Timeout and end of case debriefing.

5. ANESTHESIA EQUIPMENT

a. The anesthesia work place consists of an anesthetic machine, monitoring, and an anesthesia cart.

b. The anesthesia provider shall inspect and test the anesthetic apparatus prior to use. This should be done in accordance with the anesthesia machine's built in machine checklist per manufacturer guidelines. In general, this will include checking:
    i. Reserve supply of oxygen

ii. Connected pipeline inlets
iii. Functioning, filled vaporizers
iv. Calibrated, functioning oxygen analyzers and respiratory gas and anesthetic analyzers
v. That the Anesthesia machine is free of leaks
vi. That there are functioning inspiratory and expiratory valves (if a circle system is to be used)
vii. That there is non-exhausted CO_2 absorbent (if a circle system is to be used)
viii That there is a functioning leak-free mechanical ventilator, where appropriate

c. If leaks or other faults are detected, the equipment must not be used until the fault is repaired.

d. The anesthesia provider shall also check the availability, readiness, cleanliness (sterility where appropriate) and working order of all other equipment used in the administration of anesthetic agents. This includes resuscitative equipment.

e. All reusable anesthesia equipment in direct contact with the patient shall be cleaned after each use (See Infection Control).

f. Regular anesthesia carts are standardized according to the Anesthesia Cart Policy and are provided for every OR. Additionally, the following specially equipped carts are available:

- Three Trauma Carts, one located in the Trauma OR (in addition to a regular cart); a second Trauma cart is available in the designated Trauma Backup OR when the primary trauma OR is in use; a third Trauma cart is available in an obstetric OR.
- Obstetrical OR carts are available in each of the Labor & Delivery operating rooms.
- One epidural cart is maintained on Labor and Delivery.
- Two fiberoptic/difficult airway carts.
- One regional anesthesia cart.
- Three Pediatric Carts.
- Two Malignant Hyperthermia (MH) cart.
- Two ICU difficult airway carts.

Except for the MH cart, carts will be stocked with drugs and supplies by OR workroom and pharmacy personnel according to established policy (See OR Workroom Policy and Procedures).
Responsibilities for stocking and checking the contents of the MH cart are defined in the MH cart Policy & Procedure (Appendix H).

g. Four Anesthesia Intubation Bags will be maintained for emergency airway procedures within the hospital. The contents and procedures for stocking and checking these bags are described in the Anesthesia Intubation Bags Policy and Procedure (Appendix I).

h. To ensure proper care of any surgical emergency case, designated Trauma and L&D ORs are prepared and checked at least once per day. Details of preparing and checking these areas are described in the Trauma Operating Room Preparedness Policy and Procedure (Appendix J) and Labor and Delivery Operating Room Preparedness Policy and Procedure (Appendix K).

i. The presence of flammable materials and oxidizing agents makes the operating room a location for potential fires. In order to minimize the probability of fire, the ZSFG Fire Safety in the Perioperative Environment will be followed (Operating Room Departmental Policy 36).

Commented [AA5]: Is this anesthesia specific?

Commented [AA6R5]: Changing this to refer to the OR policy and not a separate anesthesia policy in the Appendix.

6. OTHER SPECIAL ANESTHESIA EQUIPMENT - Disposable anesthesia hoses and breathing bags are available and will be discarded after each use. Disposable anesthesia hoses, adapters, connectors, Y-pieces and other removable parts are to be replaced with clean or sterile equipment for each case. Plastic or rubber goods may be sterilized by either ethylene oxide or sterilized in perchloric acid. These items need not be sterile at the time of use as long as they are disinfected and stored in a clean manner.

Ventilators and canisters in daily use should be cleaned at monthly intervals.
Disposable endotracheal tubes are to be discarded after use.
Disposable suction catheters are to be discarded after each use.
All medication vials are single use and will be disposed of at the end of the case.
Anesthesia circuits will contain a filter to prevent contamination of those parts not replaced after each case (CO2 absorber, etc).

7. POST-ANESTHESIA CARE UNIT (PACU)

a. All patients who have had surgery and/or anesthesia who are not directly admitted to an intensive care unit should be admitted to the Post-Anesthesia Care Unit (PACU) for observation until fully recovered from anesthesia and until vital signs are stable. Patients with infections requiring respiratory isolation will require special arrangements per Infection Control policies.

b. Non-post-operative patients requiring special care and/or procedures may be admitted at the discretion of the responsible anesthesiologist after consultation with the PACU charge nurse. This will be considered if all other special care units of the hospital are at capacity. The PACU is thus the unit of last resort for critical care patients.

c. Medical Orders for Postanesthesia care, including pain medication, are provided by the anesthesia care team who admits a patient to the PACU.

d. It is the responsibility of the anesthesia provider to give a verbal report to the PACU nurse on each patient admitted.

e. The anesthesia provider should not leave the patient until completely satisfied that the patient can be safely attended by the nurse receiving the patient, whether this be in the PACU, or intensive care unit.

f. The anesthesia attending or his/her designee will follow the progress of each patient under his/her care in the PACU. He/she will be available for consultation concerning any complications in the post-operative period. The anesthesiologist or his/her designee must evaluate the patient for anesthetic complications following surgery. The responsible physician or dentist who discharges the patient from the hospital must inform Anesthesia of any unusual anesthetic-related events that may occur post discharge.

g. In general, visitors are not allowed in the PACU. Exceptions will be made, for example, when the patient is very young, or when the patient must spend an unusual amount of time in the PACU, or at the discretion of the anesthesia attending and PACU charge RN. Under these circumstances, visitors will be allowed~~,~~ when the Charge Nurse approves.

h. In the case of an emergency in the PACU, the anesthesia resident or CRNA, attending on-call, and the surgeon involved will be notified.

i. An anesthesia attending must evaluate each patient who has received anesthesia services and document readiness for discharge before the patient can leave the PACU. The patient must meet PACU discharge criteria (see PACU Nursing Policy and Procedures).

II. CREDENTIALING

A. MEMBERSHIP REQUIREMENTS

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

Commented [AA7]: Is this referring to hospital R&R?

B. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Anesthesia and Perioperative Care Clinical Service Department is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

1. Attending staff appointed to the Medical Staff will be proctored at the beginning of service. This will include:

    a. Observation of the appointee discharging his/her usual clinical responsibilities, and
    b. Observation of the appointee in his/her discussion of clinical problems with housestaff or CRNAs.
    c. A sufficient number of times will be used to reach a conclusion as to competence.

2. By the end of three (3) months, the proctor will submit a report to the Chief of Anesthesia Service. This report will include:

    a. The nature of observations made
    b. The time period of observations,
    c. A recommendation may be made for a further period of proctoring if this is thought to be necessary.

3. When intensive care privileges are to be included, proctoring will include observations of care given by the appointee by a member of the Anesthesia ICU attending staff.

4. Proctoring reports will form a part of the Chief of Anesthesia Service's recommendation for appointment to the staff.

5. Quality of care issues in regard to faculty are discussed in several ways (See Section IX.D. Clinical Indicators). This information is used for reappointment.

6. Attending staff are evaluated on an ongoing basis in various ways.

    a. Initially, the proctoring protocol is followed.
    b. Through Faculty Reappointment every two years.
    c. Through twice yearly Ongoing Professional Performance Evaluation. (See Appendix N, Anesthesia OPPE)

C. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Anesthesia and Perioperative Care Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

1. REAPPOINTMENT CRITERIA

The criteria for faculty reappointment shall include review of his or her clinical care, licensure status, professional judgment and performance, and review of health status as indicated. The reappointment process will include review of case management by the Department's Director of Quality Improvement, the Clinical Director of Anesthesia, or the Vice Chief of Anesthesia as reflected in the twice yearly OPPE. The following information will be collected and reviewed.

a. A review of the number and type of cases done by each faculty will be generated from the operating room records to allow the Chief of Anesthesia Service (or designee) to review the work performed by each faculty member and adequacy of clinical experience.

b. Further, a review of the postoperative complications will be summarized as part of the OPPE process and the appropriate faculty member's cases with problems will be noted (physician specific). These will be based on Joint Commission-mandated clinical indicators.

c. A file will be generated for each faculty member to allow a review by the Chief of Anesthesia Service (or designee). Documentation of licensure will include current state license, and DEA license.

d. There will also be an ongoing review of cases listed for possible M & M discussion. This will be discussed at regular monthly conferences and as needed at faculty meetings. These will be kept on file and available for review at the time of reappointment. Finally, the Chief of Anesthesia Service shall file individual memos, comments, or other documentation relating to an individual physician's clinical care and competence, so that he will be able to document and re-certify the individual at reappointment time.

D. PRACTIONER PERFORMANCE PROFILES

The Anesthesia and Perioperative Care Clinical Service Practitioner Performance Profiles are maintained by the Chief of Anesthesia Service. This includes items C.1. (a – d) above.

E. AFFILIATED PROFESSIONALS

The process of appointment and reappointment to the Affiliated Professionals through the Anesthesia and Perioperative Care Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

1. NURSE ANESTHETIST JOB DESCRIPTION (CRNA)

    a. Characteristics of Job - Under the supervision of physician anesthesiologists, CRNAs administer anesthesia, other central nervous system depressants, and necessary additional medications in the operating suite, delivery rooms, and other diagnostic and treatment areas. They may respond to trauma patients and any other types of emergencies in the Emergency Department and other patient care areas. They maintain records of anesthesia and other drugs administered, of resuscitations carried out, and of each patient's responses to these measures.

    b. Responsibilities of Job – CRNAs are responsible for: 1) carrying out established methods and procedures in administering anesthetics, including both elective and emergency operations and procedures; 2) monitoring patient's physiological status, using current electronic and other equipment; 3) preparing detailed medical and technical records relative to anesthetics administered and patient's reactions. The nature of work involves sustained physical effort and manual dexterity with some exposure to health and accident hazards. Rotation on night and weekend call may be required.

    c. Minimum Qualifications:

        i. Training and experience: requires completion of high school, supplemented by graduation from an accredited school of nursing, and two years of special certified training in anesthesia, or an equivalent combination of training and experience. Current ongoing experience with a broad range of anesthetist's duties is essential.

        ii. Knowledge, abilities and skills: requires thorough knowledge of various types and methods of administering anesthesia; standard operating room methods, equipment, and procedures; anesthesia equipment, instruments, and drugs used in various types of surgery.

        iii. Requires ability and skill to detect unfavorable patient reactions and apply prompt remedial measures.

        iv. License: requires possession of current valid license as a registered nurse issued by the State Board of Nursing Examiners, and current certification by the American Association of Nurse Anesthesiology (or evidence of eligibility for the first six months' employment.)

Commented [AA8]: Do we need to include their updated name here?

2. NURSE PRACTITIONER JOB DESCRIPTION (NP)

a. Characteristics of Job - Under the supervision of physician anesthesiologists, NPs conduct physical exams, diagnose and treat illness, order and interpret tests, counsel on preventative health care, assist in surgery, perform invasive procedures, and furnish medications/issue drug orders as established by state law.

b. Responsibilities of Job – NPs are responsible for some or all of the following tasks: 1) Health Care Management and Coordination: Primary Care/Specialty Clinics/Inpatient Units; 2) Pre-Op Screening of Adults; 3) Pre-Op Screening of Children; 4) Furnishing Medications and Drug Orders; 5) Electronic Consult (eConsult) Review; 6) Management of Neuraxial/Nerve Catheters for Pain Control; 7) Trigger Point Injections

c. Minimum Qualifications:

i. Training and experience: Successful completion of a program which conforms to the Board of Registered Nurses (BRN) standards, and possession of an Adult Nurse Practitioner (ANP), Family Nurse Practitioner (FNP), or Pediatric Nurse Practitioner (PNP) degree. Ongoing maintenance of Board Certification.

ii. Knowledge, abilities and skills: requires preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness as relevant to perioperative coordination for anesthesia care.

iii. License: Active California Registered Nurse License.

iv. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.

v. Possession of a National Provider Identifier or must have submitted an application.

F. STAFF CATEGORIES

Anesthesia and Perioperative Care Clinical Service attending staff fall into the same staff categories that are described in Article III of the ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF STAFF PRIVILEGE CRITERIA

Anesthesia privileges are developed in accordance with ZSFG Medical Staff. All requests for clinical privileges will be evaluated and approved by the Chief of Anesthesia.

B. PRIVILEGE CATEGORIES: See Appendix M

C. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Anesthesia and Perioperative Care Clinical Service Privilege Request Form shall be reviewed annually.

D. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

The process for modification/change to the privileges for members of the Anesthesia Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, and accompanying manuals.

IV. PROCTORING AND MONITORING – See Section II A and B, and IX

A. REQUIREMENTS

Monitoring (Proctoring) requirements for the Anesthesia and Perioperative Care Clinical Service shall be the responsibility of the Chief of the Anesthesia Service.

B. ADDITIONAL PRIVILEGES

Request for additional privileges for the Anesthesia and Perioperative Care Clinical Service shall be in accordance with the ZSFG Bylaws, Rules and Regulations, accompanying manuals, as well as these Clinical Service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Request for removal of privileges for the Anesthesia and Perioperative Care Clinical Service shall be in accordance with the ZSFG Bylaws, Rules and Regulations, accompanying manuals, as well as these Clinical Service Rules and Regulations.

V. EDUCATION

The Anesthesia and Perioperative Care Service offers an extensive lecture series for 1st, 2nd, and 3rd year residents. A well-organized course structure is provided for medical student rotations. Faculty education is provided on a regular basis based on high-yield identified topics selected internally. In addition, all members of the staff can attend UCSF department courses for CME credits.

VI. ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE HOUSESTAFF TRAINING

PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience.

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF:

1. The resident physician shall be responsible for preoperative evaluation, planning and administration of an anesthetic, and postoperative care of assigned patients. This will be done under the supervision of an attending faculty member. It is expected that all cases will be discussed with the attending anesthesiologist prior to the induction of anesthesia.

2. Decisions regarding the progressive involvement and independence of the resident in the above-mentioned patient care activities are made following close observation of the skills and knowledge base of the resident.

B. RESIDENT EVALUATION PROCESS:

1. Each of the staff completes a written evaluation which is entered into an electronic departmental database. General recommendations are then passed on to a faculty advisor. The UCSF Anesthesia Department reports on resident clinical competence to the American Board of Anesthesiology on a regular basis. The period of time at ZSFG is closely scrutinized for quality of care. Clinical comments are made to the house staff on a daily basis when needed.

2. Didactic Educational Activities

    a. Thursday afternoon conferences are directed at topics of clinical relevance to the practice of anesthesia at ZSFG, as well as reviews of recent journal articles relevant to the clinical cases seen at ZSFG and are run by faculty members.

    b. Monthly Wednesday morning M&M Conference includes evaluation and discussion of all department-wide deaths, as well as significant complications, near misses, and appropriate cases with an emphasis on specific problems and/or possible changes in practice and improved care.

    c. All residents are required to attend weekly didactic sessions and grand rounds.

3. Ability to write patient care orders:
House staff members may write patient care orders following management discussions with an attending.

VII. ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE CONSULTATION CRITERIA

A. In cases in which the patient has a significant systemic disease or an unusual surgical problem, consultation is required. All consultations must be in writing and signed by the consultant. This consultation may be accomplished by a visit to the preoperative clinic or by an individual consultation regarding an inpatient or a patient in clinic.

1. **Jehovah's Witnesses** – Surgery that may involve any blood loss in a Jehovah's Witness may only be scheduled following prior arrangement with the Department of Anesthesia by obtaining an Anesthesia consultation. This is to ensure that the patient and anesthesia provider understand the types of blood and fluid products available, that there is a clear understanding of the patient's wishes regarding the type of products they will accept, and to ensure the availability of an anesthesiologist prepared to enter into an agreement not to transfuse blood, if that is what the patient desires.

B. Consultation is not required in the case of extreme emergency when, in the opinion of the attending physician, the life of the patient would be jeopardized by the delay necessary to obtain qualified consultation. In such emergency cases, the physician shall record the emergency situation which required this action.

C. When a member of the medical staff has discussed a case preoperatively, or given advice about the patient, or where consultation is the result of a clinical conference, this should be so stated in the chart.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations, and accompanying manuals will govern all disciplinary action involving members of the ZSFG Anesthesia and Perioperative Care Clinical Service.

IX. PERFORMANCE IMPROVEMENT/PATIENT SATETY (PIPS) and UTILIZATION MANAGEMENT

The overall responsibility for Performance Improvement/Patient Safety and Utilization Management rests with the Chief of the Anesthesia and Perioperative Care Clinical Service. Design and implementation and other portions of the programs will be delegated to members of the department, recognizing that this is a department-wide responsibility.

Commented [AA9]: Would move the Jehovah's witness paragraph from above as a sub-point here.

A. GOALS AND OBJECTIVES

The Chief of the Anesthesia Service, or his/her designee, is responsible for ensuring resolution of quality care issues. As necessary, assistance is invited from other departments, the Performance/Improvement Patient Safety (PIPS) Committee, or the appropriate ZSFG administrative committee or organization (example: Executive Committee, OR Committee, Engineering, etc.).

1. To ensure appropriate care of all patients receiving anesthetic care or intervention. It is understood that this care is provided chiefly in the OR and PACU, but includes other areas such as the Emergency Room, intensive care units, obstetrical suite, GI suite, and Radiology.

2. To minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care. Efficiency in delivery of service is also a prime objective.

B. RESPONSIBILITY

1. Anesthetic morbidity and mortality is identified by postoperative visits, reports submitted into the division's M&M database, and SAFE reports. A record of this is kept for individual anesthetists and major problems are highlighted. This is maintained within the Anesthesia and Perioperative Care Clinical Service. These are reviewed regularly to determine the adequacy of care. Specific problems are tabulated for the faculty reappointment database. The Chief and his/her designees also review near-miss reports made by CRNAs, residents, and faculty contemporaneously, and appropriate follow-up and/or corrective actions are taken.

2. Monthly staff meetings address organizational as well as performance improvement and patient safety issues. Minutes are submitted to the Medical Staff Office. The minutes outline topics covered and track ongoing problems. Performance improvement and patient safety issues are discussed at most meetings.

3. A member of the attending staff undertakes further evaluation of any issues identified at M&M or from other departments, patients, or administration. This may take the form of a broad review or specific attention to a clinical problem.

   Follow-up on the above might include:

   a. Inservice (or departmental education/training). (Example: A follow-up on the review of epidural narcotics or lecture to the nursing staff on these modalities and means to decrease side effects.)

   b. Revision of policy or procedures.

c. Potential staff changes/proctoring, dismissal, etc.

d. Purchase of equipment. (Example: The O.R. monitoring equipment has expanded dramatically in recent years and exceeds the American Society of Anesthesiology standards).

C. REPORTING

Performance Improvement/Patient Safety (PIPS) and Utilization Management activity records will be maintained by the department. Further, minutes will be sent to the Medical Staff Office and will include PIPS and Utilization Management information/follow-up, etc.

D. CLINICAL INDICATORS

The Department of Anesthesia and Perioperative Care believes in the consistent delivery of quality patient care, as defined by the Institute of Medicine, i.e. that it is safe, timely, effective, efficient, equitable, and patient-centered. The Anesthesia and Perioperative Care Clinical Service reviews and evaluates the quality and appropriateness of the care delivered on a continuous basis. This is a multi-faceted program with data collection from numerous sources. These include:

1. Direct supervision of the performance of residents and CRNA's by members of the attending staff. Monthly evaluation of each resident includes direct comment on patient care issues. Performance evaluations of CRNA's are done on an annual basis.
2. All anesthesia-related deaths and complications are reviewed at monthly Morbidity and Mortality meetings. Cases are reviewed for deaths, myocardial infarction, neurologic injury, aspiration, and other adverse events occurring within 48 hours of anesthesia care. These indicators are reviewed at the monthly M&M conference and are included as part of OPPE. All members of the Anesthesia Service, including faculty, CRNA's, residents, and students are expected to attend these meetings. They are accredited for Continuing Medical Education. An attempt is made to determine ways to improve patient outcomes and avoid future problems. This is an open forum for frank discussion and educational opportunities. Records are kept in the departmental office. M&M conference is protected and confidential (California Evidence Code section 1157).

   Cases are also reviewed at routine ZSFG departmental faculty meetings with an emphasis on specific problems on possible changes in practice. Some cases are also presented and discussed at UCSF departmental Grand Rounds.

3. STARS conferences (ZSFG Thursday Afternoon Resident Seminars) are for primarily residents and are directed to topics relevant to the care of patients at ZSFG. These meetings are to discuss cases, recent and topical journal articles, special techniques and ideas to improve anesthesia management, especially as pertains to trauma and indigent care, and avoidance of future problems.

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Section IX.D.

F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

It is understood that regular review by the Performance Improvement/Patient Safety Committee will occur as reports and problems arise from our department or others within ZSFG. Further, there shall be an annual review of our program and Performance Improvement and Patient Safety Issues from the previous year. Refer to Section IX.D.

G. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

See Attending, Resident, and CRNA staff. Refer to Section IX.D.

H. CLINICAL INDICATORS

Refer to Section IX.D, Clinical Indicators

X. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws 7.2.I, All Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, and the annual Medical Staff Meeting.

The Anesthesia and Perioperative Care Clinical Service shall meet as frequently as necessary, but at least quarterly, to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. Monthly orientation sessions are held to inform house staff of ZSFG-specific rules and regulations, patient care issues, schedules, etc.

B. Ongoing educational sessions are held for faculty and CRNAs regarding hospital and department policies and procedures, equipment, performance improvement and patient safety, etc.

C. Scheduling of house staff is done in accordance with the UCSF resident work hour requirements and the UCSF GME Office.

D. Risk Management: the department adheres to all hospital policies. Any untoward events are reported promptly to risk management.

E. Well Being: The ZSFG Medical Staff Office has an active Physician Well Being Committee which accepts self-referrals as well as referrals of other medical staff. Any evidence of impairment is referred to the committee where a prompt and thorough investigation is carried out. If impairment is identified, recommendations are made for ongoing treatment and monitoring. Whenever possible, the Physician Well Being Committee aims to provide a supportive and non-punitive approach to allow medical staff to return to work while prioritizing safe patient care.

XII. ADOPTION AND AMENDMENT

The Anesthesia and Perioperative Care Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Anesthesia and Perioperative Care Clinical Service every two years at an Anesthesia and Perioperative Care Clinical Service meeting.

APPENDIX A: Clinical Service Chief of Anesthesia and Perioperative Care Service Job Description

Title: Clinical Service Chief of Anesthesia and Perioperative Care Service Job Description

Chief of Anesthesia and Peri-Operative Care Clinical Service Position Summary:

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

Reporting Relationships:

The Chief of Anesthesia and Peri-Operative Care Clinical Service reports directly to the Vice Dean and the University of California, San Francisco (UCSF) Anesthesia Department Chair. A committee appointed by the Chief of Staff reviews the Chief not less than every four years. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Vice Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of Anesthesia and Peri-Operative Care Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Anesthesia and Peri-Operative Care Clinical Service include the following:

Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of ZSFG and the DPH;

In collaboration with the Executive Administrator and other ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;

In collaboration with the Executive Administrator and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs,

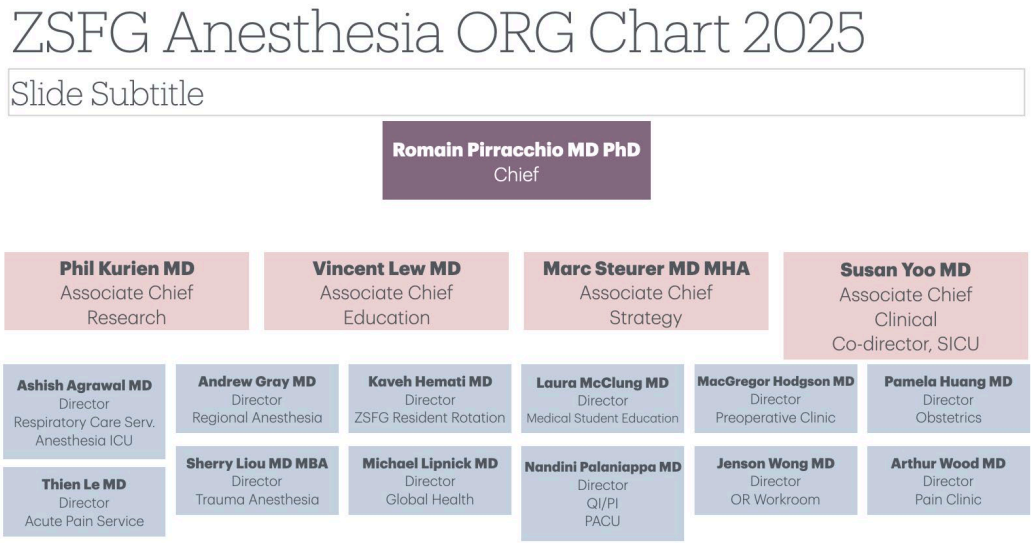
selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.

Zuckerberg San Francisco General Hospital
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APPENDIX B: UCSF Department of Anesthesia and Perioperative Care Zuckerberg San Francisco General Hospital Division Organization

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APPENDIX C: Basic Standards for Preanesthesia Care

Commented [AA11]: Note: No newer version. Most recently updated in 2020.

(Approved by the American Society of Anesthesiologists House of Delegates on October 14, 1987, and last affirmed on December 13, 2020)

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
    a. Discuss the medical history, including previous anesthetic experiences and medical therapy.
    b. Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

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APPENDIX D: ZSFG Anesthesia Department Transition of Care Policy

Title: **ZSFG Anesthesia Department Transition of Care Policy**

Purpose: To establish Policy and Procedure defining the purpose and procedure concerning perioperative transition of care. This Policy is compliant with the Joint Commission Standard PC.02.02.01 (Coordinating the patient's care, treatment, and services based on the patient's needs).

Policy: An anesthesia team consisting of a faculty member and an anesthesia trainee or CRNA, or an anesthesia faculty member alone, provides Perioperative anesthesia care at ZSFG. Transition of anesthesia care ("hand-off") to a different provider may become necessary at the end of the caregiver's regular working shift, or during the regular working hours for a short time to ensure adequate breaks. This Policy formalizes and standardizes the process of any transition of care, which becomes necessary during the intraoperative period.

Oversight for establishing this Policy & Procedure is the responsibility of the Chief of Anesthesia or his/her designee.

Background: Adequate transfer of patient care is a crucial part of a safe medical practice. TJC recognizes this in implementing a National Patient Safety Goal in 2007 to ensure standardization when patient care is transferred to another caregiver. This P&P defines a safe and standardized process to transfer accurate information about the patient including medical history, surgical procedure, current conditions and anticipated intraoperative course.

Procedures:

1. For shift-related transfers of care, providers will follow departmental handover checklists.
    a. These handovers occur at 7AM and 6PM between incoming and departing anesthesia faculty managing the OR, Obstetrical Suites, and Anesthesia Pain Service to ensure appropriate transfer of patient information and management duties.
    b. This Handover will follow the ZSFG Anesthesia Shift Handover Checklist and the ZSFG Anesthesia OB/Pain Service Shift Handover Checklist
2. For the intraoperative transfer of care, standardized checklists are available in Epic under the intraoperative care tab. This includes pre-op history, pre-op meds, lines, drains, airways, intraop medications, ins and outs, major intraop events, requests from surgeons, and postprocedure care plan.
3. Handover procedures are performed whenever care or responsibilities are transferred between caregivers. This includes:
    a. Any permanent transfers of care between faculty and/or between residents and CRNA's.
    b. Intermittent transfers of care (e.g. as occurs for morning, lunch, and preoperative breaks)

D.1 ZSFG Anesthesia OB/Pain Service Shift Handover Checklist

D.2 ZSFG Anesthesia Shift Handover Checklist

Commented [AA12]: D.1 deleted because checklist is now in Epic.

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D.1 ZSFG Anesthesia OB/Pain Service Shift Handover Checklist

OB SHIFT HANDOFF

- **Laboring Patients with or w/o Epidural**
- **Active/New Viable Antepartum Patients**
- **Postpartum Issues**
- Completed OB Records Needing Closure
- OB Anesthesia Follow Up Notes
- Grease Board Notes Update
- **OB-A/B Ready & Epidural Cart**
- **Phones/Pagers/Keys Handoff**
- **Resident & Attending Staff Attestation**

PAIN SHIFT HANDOFF

- **Current Pain Patients - Update Hand-Off**
- New Pts: Check Multimodal Analg. Orders
- Duramorph Checks
- **Pain Service To-Dos**
- **Pain Phone (Forward/Unforward) & Pager**

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D.2 ZSFG Anesthesia Shift Handover Checklist

ZSFG ANESTHESIA SHIFT HANDOFF

- **Current Procedures**
- **Add-On Cases**
- **Active Consults/900s/Consent issues**
- **PACU Issues**
- **OR 1 & OB-A & B Readiness**
- **4 Anesthesia Bags & Pedi Pack**
- **AM: Sick Calls? STARS (Thu @5pm)?**
- **PM: CRNA breaks/Late Stays?**
- **PM: Preop status**
- **Phone & Pager Handoff**
- **New M&M cases?**
- **OB/Pain Handoff**

M&M submission requires UCSFwpa or VPN

APPENDIX E: Standards for Basic Anesthetic Monitoring

Commented [AA13]: This is the latest version of this.

STANDARDS FOR BASIC ANESTHETIC MONITORING

(Approved by the ASA House of Delegates on October 21, 1986, last amended on October 20, 2010, and reaffirmed on December 13, 2020)

These standards apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. They apply to all general anesthetics, regional anesthetics and monitored anesthesia care. This set of standards addresses only the issue of basic anesthetic monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, 1) some of these methods of monitoring may be clinically impractical, and 2) appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual† monitoring may be unavoidable. These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

STANDARD I

Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

Objective

Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, e.g., radiation, to the anesthesia personnel which might require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgment of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

STANDARD II

During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

Oxygenation

Objective

To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.

Methods

1. Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.*

2. Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed.* When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.* Adequate illumination and exposure of the patient are necessary to assess color.*

Ventilation

Objective

To ensure adequate ventilation of the patient during all anesthetics.

Methods

1. Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.*

2. When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.* When capnography or capnometry is utilized, the end tidal CO2 alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.*

3. When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

4. During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

Circulation

Objective

To ensure the adequacy of the patient's circulatory function during all anesthetics.

Methods

1. Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.*

2. Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.*

3. Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra- arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry**.**

Body Temperature

Objective

To aid in the maintenance of appropriate body temperature during all anesthetics.

Methods

1. Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.

† Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."

* Under extenuating circumstances, the responsible anesthesiologist may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record.

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APPENDIX F: Anesthesia Cart Locking, Medication Safety and Controlled Substance Policy and Procedure

Title: Anesthesia Cart Locking, Medication Safety and Controlled Substance Policy and Procedure

Purpose: To establish Policy and Procedure for the locking of anesthesia carts and handling of controlled substances. Oversight for establishing and updating this Policy & Procedure is the responsibility of the Chief of Anesthesia or his/her designee.

Background: Anesthesia carts contain various equipment and drugs needed for induction and maintenance of anesthesia and the support of additional anesthesia-related tasks e.g. difficult airway management, central line placement, etc. To avoid illegitimate access to the carts, all carts are generally kept locked. At the beginning and end of cases, however, it is necessary for the anesthesia provider to have immediate access to drugs and equipment. As stated in the attached Security of Medications in the Operating Room position statement drafted by the American Society of Anesthesiologists (ASA), "At the end of anesthesia cases, when patients are particularly vulnerable, anesthesia professionals dedicate full attention to their patients. This vulnerable period extends from the time the patient emerges from anesthesia until the anesthesia professional transports the patient to a recovery area. If drugs are locked up during this vulnerable period, provider access to drugs required for emergency patient care is obstructed. Furthermore, requiring anesthesia professionals to divert attention from patients in order to lock non-controlled medications in anesthesia carts during the period between emergence from anesthesia and transport of patients out of the operating room jeopardizes patient safety. Therefore, locking non-controlled medications at this point in the anesthetic should not be required." (Appendix F1) Similarly, anesthesia providers bring premedicated patients from the preoperative holding area into the operating room. Immediate access to anesthesia drugs and equipment may be required. For these reasons the ASA states in the position statement "Anesthesia carts may be left unlocked and non-controlled medications may be left in or on the top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the OR suite."
The position of the regulatory authorities on this issue is in flux. While the State Operations Manual require that carts containing anesthesia medications be locked whenever they are not directly monitored by an individual with legal access to the medications, even within a secure operation room suite CMS published a proposed revision on March 25, 2005 requiring now that "all drugs and biologicals be kept in a secure area, and locked ***when appropriate***" [§482.25(b)(2)]. The California Department of Health Services issued a memorandum stating that "anesthesia carts and anesthetic machines may remain unlocked during and in between surgical cases in a given operation room, as long as there are surgical service personnel in the immediate vicinity." This statement follows American Society of Anesthesiologists (ASA) policy.
The Anesthesia Locked Cart Policy follows the final CMS rule as well as the ASA position statement on this issue.

Policies:

- Anesthesia carts are generally to be kept locked at all times. However, in certain situations Anesthesia professionals must have immediate access to drugs required for emergency patient care. Procedures designed to prevent unauthorized access to such drugs must be consistent with this imperative for patient safety. Therefore, the following exemptions apply to the locked cart policy:
    - Anesthesia carts may be left unlocked and non-controlled medications may be left in, or on, the top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the immediate vicinity.
    - Anesthesia carts may also remain unlocked whenever the anesthesia provider is able to directly monitor access to the anesthesia cart.

- All medications (including controlled substances) and solutions will be labeled with the medication name, concentration, date, time drawn up, and initials of the care provider whenever transferred from their original container.
    - Medications transferred from their original container will expire 24 hours after they are drawn up, except for propofol, which expires after 6 hours.
    - All labels are to be verified verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.
    - Any medications found unlabeled or incompletely labeled are to be immediately discarded.
    - At shift change or break relief, all medications and their labels will be reviewed by entering and exiting personnel.
- Drug boxes containing controlled substances are picked up from pharmacy prior to starting work and must be returned immediately to pharmacy after the shift ends. Proper hospital ID is required when obtaining controlled substance boxes. The controlled substance box must be brought directly to the providers assigned location and kept locked to the top of the anesthesia cart. **Drug box keys are always to be kept with the provider. Keys may not be stored in the anesthesia cart, even if the cart is locked.**

  Exemptions:
    - Open and/or unlocked controlled substance boxes are acceptable whenever the anesthesia provider is in the immediate vicinity and able to directly monitor access to the drug box.
- Controlled substances in syringes must remain in the OR at all times.
    - Exemption: To obtain adequate pre- or postoperative sedation and pain management the anesthesia provider is allowed to carry a reasonable amount of controlled substances on his/her body in syringes if directly heading to the pre-operative area to premedicate a patient or while transporting a patient at the end of a case.

- Controlled substances in use (applied over continuous infusion pumps or from syringes) may be handed off to another provider during transfer of care or for breaks. The provider who originally checked out the controlled substance box remains responsible for complete and correct documentation of administration.
    - Rationale: Controlled substances are routinely administered in almost every anesthesia case. Often they are administered via a continuous infusion or syringe pump. From practical as well as quality of care standpoints, those drugs cannot and should not be discontinued when the anesthesia provider changes. Official recommendations regarding this matter from the ASA and AANA are not available, however, statements have been made that this is considered to be the standard practice nationwide.

APPENDIX

F 1. ASA Position Statement "Security of Medications in the Operating Room"

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F.1 ASA POSITION STATEMENT "SECURITY OF MEDICATIONS IN THE OPERATION ROOM"

Statement on Security of Medications in the Operating Room

***Developed By**: ASA House of Delegates/Executive Committee*
***Committee of Oversight:** Quality Management and Departmental Administration*
***Last Amended**: October 18, 2023 (original approval: October 26, 2003)*

Preamble

A secure environment[2,3] of care is necessary for medication safety. Medication safety includes the security of oral, sublingual, parenteral, and inhaled pharmaceutical agents used for elective and emergency patient care. A secure physical area ensures the integrity of anesthesia machines as well as other equipment and materials. Security of medications, while maintaining rapid accessibility, in a secure anesthetizing location is essential for patient safety.

Recommended Policies

1. Access to secure anesthetizing locations must be strictly limited to authorized persons.
2. All Schedule II through V medications must be kept in locked enclosed areas when not under the direct control of an anesthesia professional.
3. Anesthesia professionals must have immediate access to drugs and equipment required for emergency patient care. Procedures designed to prevent unauthorized access to such drugs must not impede this imperative for patient safety.
4. Anesthesia carts and anesthesia machines may remain unlocked, and non-controlled* medications may be left in or on top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in a secure anesthetizing location, so long as there are authorized personnel present.

Rationale

A. Because a secure anesthetizing location is a limited-access secure location, it is safe practice for anesthesia professionals to leave non-controlled* medications on the top of their

Commented [AA14]: Updated to 2023 version. Minimal phrasing changes from 2018 version, ie: "Anesthetizing location" instead of "operating room".

Commented [AA15]: Include new 2023 version of this statement and check for changes.

anesthesia carts or anesthesia machines for brief periods (e.g., while going to a nearby holding area to bring a patient into the operating room).

B. At the end of anesthesia cases, when patients are particularly vulnerable, anesthesia professionals dedicate full attention to their patients. This vulnerable period extends from the time the patient emerges from anesthesia until the anesthesia professional transfers care of the patient to recovery personnel. If drugs are locked up during this vulnerable period, provider access to drugs required for emergency patient care is obstructed. Requiring anesthesia professionals to divert attention from patients in order to lock non-controlled* medications in anesthesia carts during the period between emergence from anesthesia and transport of patients out of the operating room jeopardizes patient safety. Therefore, locking non-controlled* medications at this point in the anesthetic is not required.
C. It is necessary and safe practice for non-controlled* medications to be set up for emergency cases (e.g., obstetrics, trauma). If this is a non-secure location, then medications must be made secure ("locked") by a tamper-evident device that can easily be broken by authorized persons.
D. It is necessary and safe practice for emergency anesthesia drugs (e.g., dantrolene for the treatment of malignant hyperthermia) to be kept in a dedicated emergency cart or cupboard and made secure ("locked") by a tamper-evident device that can easily be broken by authorized persons.

*The term "non-controlled" refers to medications that are not Schedule II-V. In some states, anesthesia professionals may need to include reference to Schedule VI medications in their policies and procedures.

Appendix:

1. The Joint Commission and the Center for Medicare Services (CMS) have defined a secure environment. Facility policies and procedures should reference and adhere to these guidelines. Both agencies require that all drugs and biologicals must be kept in a secure area, and locked when appropriate [TJC 03.01.01 EP 3 and CMS Conditions of Participation 482.25(b)(2)(i)].
2. CMS defines a secure area as follows. “A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. For example, if medications are kept in a private office, or other area where patients and visitors are not allowed without the supervision or presence of a health care professional (for example, ambulatory infusion), they are considered secure. Areas restricted to authorized personnel only would generally be considered ‘secure areas.’” [CMS Conditions of Participation 482.25(b)(2)(i)].
3. CMS has provided specific guidance on security in the OR environment in the Federal Register on November 27, 2006, Vol. 71, No. 227. The document states the following: “An area in which staff are actively providing patient care or preparing to receive patients, that is, setting up for procedures before the arrival of a patient, would generally be considered a “secure area.” For example, the operating room suite would be considered secure when the suite is staffed and staff are actively providing patient care. When the entire suite is not operational or otherwise not in use, for example, weekends, holidays, and after hours, the suite would not be

considered secure. When the suite is closed or otherwise not in use, we would expect all drugs and biologicals to be locked." The Joint Commission provided similar guidance in the Standards Booster Pak for Safe Medication Storage, published in April, 2014, page 14, that states that "If the individual operating room is part of a larger OR unit that is manned at all times in a fashion that monitors access to the operating room and assures constant surveillance of the anesthesia cart to prohibit access by unauthorized individuals, locking of the cart between cases would not be required." Non-licensed staff are considered authorized personnel and an area may be considered secure in the presence of non-licensed staff. The CMS Conditions of Participation allows non-licensed personnel access to locked areas if controlled substances are locked to prevent access. [TJC 03.01.01 EP 6 and CMS Conditions of Participation 482.25(b)(2)(iii)].

Last updated by: Governance

Date of last update: October 18, 2023

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APPENDIX H: MALIGNANT HYPERTHERMIA RESPONSE

TITLE: MALIGNANT HYPERTHERMIA RESPONSE

Commented [AA16]: Revised 2023

PURPOSE

The purpose of this policy is to ensure a well-coordinated response to malignant hyperthermia (MH) treatment by:

- Defining MH and providing guidelines for the diagnosis of MH
- Outlining responsibilities of the clinical team during the treatment of MH
- Providing guidelines on how to stock and check the MH emergency cart

DEFINITIONS

Malignant Hyperthermia:

- The MH crisis is a biochemical chain reaction response, "triggered" by commonly used general anesthetics and the paralyzing agent succinylcholine (a neuromuscular blocker), within the skeletal muscles of susceptible individuals.
- Some patients who are MH susceptible may experience a MH crisis without exposure to anesthetic drugs. Such events are rare. Strenuous exercise, exposure to heat, or perhaps high body temperature from infection may precipitate the crisis.
- The general signs of the MH crisis include increased heart rate, greatly increased body metabolism, muscle rigidity and/or fever that may exceed 110°F along with muscle breakdown, derangements of body chemicals and increased acid content in the blood.
- Severe complications include: cardiac arrest, brain damage, internal bleeding or failure of other body systems. Thus, death, primarily due to a secondary cardiovascular collapse, can result.
- **MH is a medical emergency.** Minimizing time to appropriate treatment is essential!

Diagnosis of Malignant Hyperthermia:

- The most consistent indicator of potential MH in the OR is an **unanticipated increase (e.g., doubling or tripling) of end-tidal CO_2** when minute ventilation is kept constant. The increase in CO_2 may occur over a brief period of time or may develop over longer periods of time (minutes to hours). If upward adjustments of minute ventilation (tidal volume and frequency) are required to maintain normal end-tidal CO_2, the possibility of MH should be considered and promptly evaluated.
- If sudden, **unexpected cardiac arrest** occurs, especially in a young male, hyperkalemia should be considered immediately and therapy started with calcium, hyperventilation, dextrose, and insulin. Plasma potassium concentration should be measured as soon as possible. Sudden unexpected cardiac arrest is not typically due to MH, but due to sudden rapid rhabdomyolysis.
- **Unexpected tachycardia, tachypnea and jaw muscle rigidity** (masseter spasm) are often common signs of MH that follow the significant CO_2 increase.
- **Respiratory and metabolic acidosis** usually indicates fulminant MH. However, metabolic acidosis is not always present prior to severe temperature increase.
    - A specific sign of the MH syndrome is **body rigidity** (i.e., limbs, abdomen and

chest). When there is a suspicion of MH, attempts should be made to determine if muscle rigidity is also present.

- **Temperature elevation** usually follows the appearance of other signs of MH. Temperature change during MH is best detected by core temperature measurement (tympanic, naso- or oropharyngeal, esophageal, rectal, or pulmonary artery). Forehead skin temperature is less acceptable; it is slower in reflecting changes in core temperature and could be influenced by peripheral vasoconstriction. **MHAUS (Malignant Hyperthermia Association of the United States) recommends that core temperature be measured whenever general anesthesia is administered for procedures lasting more than 30 minutes.**
- **Postoperative rhabdomyolysis** without intraoperative signs of MH should be treated with hydration, mannitol and bicarbonate. Plasma potassium concentration should be measured immediately or as soon as possible. The patient should be referred to a neurologist and to an MH testing center to evaluate occult myopathy and determine the need for evaluation of MH susceptibility.

Drugs and Malignant Hyperthermia:

- **All volatile inhalation anesthetics (Halothane, Enflurane, Isoflurane, Desflurane, Sevoflurane) and Succinylcholine (IV/IM neuromuscular blocker) are MH triggers.** Nitrous oxide is not a trigger.
- **DO NOT ADMINISTER** calcium channel blockers when Dantrolene has been given since it may increase the risk for hyperkalemia and subsequent cardiac arrest.
- All other currently used anesthetics and life-support drugs are considered safe.

PROTOCOL: MALIGNANT HYPERTHEMIA RESPONSE

I. Criteria for suspecting MH and Hospital Locations where MH may occur:

A. Suspect MH if one or more of the following criteria are present:

1. Unanticipated increase (e.g., doubling or tripling) of end-tidal CO_2 when minute ventilation is kept constant
2. Unexpected cardiac arrest
3. Unexpected tachycardia, tachypnea, jaw muscle rigidity (masseter spasm)
4. Respiratory and metabolic acidosis
5. Body rigidity (i.e., limbs, abdomen and chest)
6. Temperature elevation
7. Postoperative rhabdomyolysis

B. MH may occur in the following hospital locations:

1. Operating Room (including OB OR) – Primary site: MH may occur at any time during or emerging from anesthesia, including in the immediate post-operative period
2. Post Anesthesia Care Unit (PACU)
3. Emergency Department (ED)
4. MH can occur anywhere in the hospital where patients require emergency intubation with succinylcholine or in other departments that use inhaled anesthetics for procedures (i.e., IR, GI, ICU)

- "MH Emergency Alert Signs" (Appendix H1) can be posted where MH may occur outside of the operating rooms.

5. **If the patient experiences MH outside of the OR area, immediately transport the patient to the OR for appropriate care. Inform the Anesthesia D1 (VOIP phone 30001) to assign a specific OR treatment room and anesthesia team. For patients already in the ICU, the ICU Attending and Anesthesia D1 will decide whether to treat the patient in the OR or ICU.**

II. MH Response and Staff and Service Roles during an MH Crisis

A. See "MH Dantrolene Dosage Chart" (Appendix H2)
B. See "MH Response Flowsheet" (Appendix H3)
C. See "MH Staff and Service Roles (Detailed)" (Appendix H4A)
D. See "MH Staff and Service Roles (Diagram)" (Appendix H4B)

III. Documentation

A. Add inhalation anesthetics (sevoflurane, desflurane, isoflurane) and succinylcholine to the patient's adverse drug reactions in the patient's medical chart
B. Document MH Response Events on the "MH Response Flowsheet" (Appendix H3)
C. Documentation of the response to the event will be placed in the patient's medical chart
D. Report event to MHAUS via a confidential Adverse Metabolic or Muscular Reaction to Anesthesia (AMRA) Report to the North American MH Registry of MHAUS
E. File a Patient DPH UO/SAFE Report and M&M Report

IV. Maintenance of the Malignant Hyperthermia Cart

A. A Malignant Hyperthermia Emergency Cart (MH Cart) will be maintained in Building 25 Anesthesia Workroom and Building 5 6G.
B. The Refrigerated Medications for the MH Cart will be maintained in Building 25 Anesthesia Workroom Refrigerator and Building 5 6G Refrigerator.
C. The MH Cart will be stocked with the following:
1. "MH List of MH Cart Drugs" (Appendix H5)
2. "MH List of MH Cart Supplies and Equipment" (Appendix H6)

D. The MH Cart will be secured with a tamper-evident seal
E. The MH Cart will have posted on the outside a copy of the following:
1. "MH Dantrolene Dosage Chart" (Appendix H2)
2. "Copy of MH Intervention Checklist" (Appendix H11)

F. The MH Cart will have the following documents:
1. Drugs contained within and the name and date of the drug that will expire first "MH Cart Med List and Pharmacy Monthly Checks" (Appendix H7)
2. List of the supplies contained within and the name and date of the supply that will expire first "MH Cart Supply List and Anesthesia Monthly Checks" (Appendix H8).

G. The MH Cart will have the Malignant Hyperthermia Policy in a binder (3rd drawer of MH Cart).

H. On establishment or replenishment of the MH Cart:

1. The Pharmacist will verify the presence of all drugs and supplies as listed in "MH List of MH Cart Drugs" (Appendix H5). The Pharmacist will then seal the box with a tamper-evident seal and fill in the required information on the "MH Cart Medication List and Pharmacy Monthly Checks" form on the cart (Appendix H7).
2. The Anesthesia Technician will verify the presence of all supplies as listed in "MH List of MH Cart Supplies and Equipment" (Appendix H6). The Anesthesia Technician will then seal the box with a tamper evident seal and fill in all required information on the "MH Cart Supply List and Anesthesia Monthly Checks" form on the cart (Appendix H8).

I. The cart will be checked by the Pharmacist and Anesthesia Technician up to every 30 days, and after every deployment for integrity and outdating of contents. A record of such monthly unit inspections will be recorded by the Pharmacist and kept for at least three years in the pharmacy.

1. See "MH Cart Med List and Pharmacy Monthly Checks" (Appendix H7)
2. See "MH Cart Supply List and Anesthesia Monthly Checks" (Appendix H8)
3. See "MH Anesthesia Daily Medication Seals Check" (Appendix H9)

J. Anesthesia Providers are reminded of the location and the content of the MH cart during the "MH Cart Yearly Proficiency Questionnaire" (Appendix H10).

V. Resources

A. wwww.mhaus.org

B. Hirshey Dirksen SJ, Van Wicklin SA, Mashman DL, Neiderer P, Merritt, DR. Developing Effective Drills in Preparation for a Malignant Hyperthermia Crisis. AORN Journal 2013; 97(3): 329-353.

C. Ryanodex [Package Insert]. Eagle Pharmaceuticals, Inc. Woodcliff Lake, NJ; 2016. http://www.ryanodex.com/wp-content/uploads/2014/07/ryanodex-prescribing-information.pdf. Accessed Nov 20, 2017.

D. AMRA Reports: https://anest.ufl.edu/namhr/namhr-report-forms/

VI. Appendices

- **Appendix H1: MH Emergency Alert Signs**
- **Appendix H2: MH Dantrolene Dosage Chart**
- **Appendix H3: MH Response Flowsheet**
- **Appendix H4A: MH Staff and Service Roles (Detailed)**
- **Appendix H4B: MH Staff and Service Roles (Diagram)**
- **Appendix H5: MH List of MH Cart Drugs**
- **Appendix H6: MH List of MH Cart Supplies and Equipment**

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Appendix H1: MH Emergency Alert Signs

Appendix H1

Malignant Hyperthermia Emergency Alert

Malignant Hyperthermia (MH) is a rare life-threatening reaction that is most often triggered by the use of inhalation anesthetics or succinylcholine.

Early Warning Signs of MH
Muscle Rigidity Sinus Tachycardia Hyperthermia (rapid rise in core temperature) Hypercarbia (resistant to increasing minute ventilation)

What to do with Recognition of MH
Call both **30001** AND **31022** to announce "Malignant Hyperthermia Emergency" and provide exact Patient Location

Response to MH Emergency Alert
Anesthesia will bring MH Cart and Cooling Supplies

(Anesthesia Policy 10.0 Malignant Hyperthermia Response 2022-07)

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Appendix H2

Malignant Hyperthermia Response: Dantrolene Dosage Chart

Dose:	Dantrolene 2.5 mg/kg per dose via rapid IV push
	Repeat dose until symptoms subside (up to 10-30 mg/kg)
Dilution:	Use 5 mL Sterile Water for Injection to dilute each 250 mg vial of Dantrolene
	Final Concentration 50 mg/mL

Patient's Weight in Kilograms (kg)	# of Dantrolene 250 mg vials Needed	Total Dose Needed (mg)	Volume to Administer (mL)	Patient's Weight in Pounds (lbs)
5 kg	1 vial	12.5 mg	0.25 mL	**11** lbs
10 kg	1 vial	25 mg	0.5 mL	**22** lbs
15 kg	1 vial	37.5 mg	0.75 mL	**33** lbs
20 kg	1 vial	50 mg	1 mL	**44** lbs
25 kg	1 vial	62.5 mg	1.25 mL	**55** lbs
30 kg	1 vial	75 mg	1.5 mL	**66** lbs
35 kg	1 vial	87.5 mg	1.75 mL	**77** lbs
40 kg	1 vial	100 mg	2 mL	**88** lbs
45 kg	1 vial	112.5 mg	2.25 mL	**99** lbs
50 kg	1 vial	125 mg	2.5 mL	**110** lbs
55 kg	1 vial	137.5 mg	2.75 mL	**121** lbs
60 kg	1 vial	150 mg	3 mL	**132** lbs
65 kg	1 vial	162.5 mg	3.25 mL	**143** lbs
70 kg	1 vial	175 mg	3.5 mL	**154** lbs
75 kg	1 vial	187.5 mg	3.75 mL	**165** lbs
80 kg	1 vial	200 mg	4 mL	**176** lbs
85 kg	1 vial	212.5 mg	4.25 mL	**187** lbs
90 kg	1 vial	225 mg	4.5 mL	**198** lbs
95 kg	1 vial	237.5 mg	4.75 mL	**209** lbs
100 kg	1 vial	250 mg	5 mL	**220** lbs
105 kg	2 vials	262.5 mg	5.25 mL	**231** lbs
110 kg	2 vials	275 mg	5.5 mL	**242** lbs
115 kg	2 vials	287.5 mg	5.75 mL	**253** lbs
120 kg	2 vials	300 mg	6 mL	**264** lbs
125 kg	2 vials	312.5 mg	6.25 mL	**275** lbs
130 kg	2 vials	325 mg	6.5 mL	**286** lbs
135 kg	2 vials	337.5 mg	6.75 mL	**297** lbs
140 kg	2 vials	350 mg	7 mL	**308** lbs
145 kg	2 vials	362.5 mg	7.25 mL	**319** lbs
150 kg	2 vials	375 mg	7.5 mL	**330** lbs

Call OR Pharmacy x60242 or Inpatient Pharmacy x60275 if more Dantrolene vials are needed

MH Cart Contains #3 Medication Draw Up Kits:
Dantrolene (Ryanodex) 250 mg vial + Sterile Water for Injection 10 mL vial
Syringe 10 mL, Vented Spike, Blunt Fill Needle, Red Syringe Cap

Revised 2-2018

Reviewed 4/2023

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Appendix H3: Malignant Hyperthermia Response Flowsheet

Date:	Patient Name / MRN:	Location/Room Number:	Anesthesia Provider(s):	Recorder (Anesthesia/CRNA):
Time:	**Medications Used During Case (circle all that apply):** Succinylcholine / Desflurane / Isoflurane / Sevoflurane	**Patient's Weight (kg)**	**Surgery Provider(s):**	**RN(s):**

Intervention	Time
1. ☐ **Discontinue Triggers** (succinylcholine, inhaled anesthetics) **2.** ☐ **Start TIVA** (Total Intravenous Anesthesia), if anesthesia required **3.** ☐ **Hyperventilate at 2-3 times of the Predicted Minute Ventilation** (goal is to achieve normocapnia) **4.** ☐ **FiO2 1.0 at 10 L/min.** Keep circuit, absorber and ventilation machine.	
5. Obtain MH Cart / Call for Help / Inform OR Team ☐ Designate **Anesthesia Technician to obtain MH Cart** "Apex Where" or "6G" *(VOIP Phone 31022)* ☐ **Call the Anesthesia D1** or Anesthesia Night Attending *(VOIP Phone 30001)* ☐ D1 to designate an Anesthesiologist as **Team Leader** ☐ **Inform Surgeons** of MH emergency and to coordinate the most expeditious surgical plan to finish the surgical procedure	
6. Treat MH using Dantrolene *Stocked in the MH Cart* ☐ Team Leader to assign one team member to reconstitute Dantrolene ☐ Dilute only 5 mL Sterile Water for Injection in each 250 mg Dantrolene vial (i.e., a 75 kg patient will need 1 vial Dantrolene per dose) ☐ Designate one provider to administer Dantrolene via rapid IV Push ☐ **Administer Dantrolene 2.5 mg/kg per dose rapid IV Push** "MH Cart" **Repeat Dose until Symptoms Subside** (up to 10-30 mg/kg)	**Med/Dose/Time:**
7. Team Leader to Designate Other Roles and Responsibilities ☐ Designate an **Anesthesia Provider to manage vent and anesthesia** ☐ Designate **Circulating RN as Lead Nurse**. Lead RN to delegate RN duties and to **call OR Front Desk** *(x68134)* to notify the following: ☐ **Overhead Page OR** to request help in MH crisis *(x68134)* ☐ **Call PACU** *(x68127)* to bring 4 large plastic bags of ice ☐ **Call the AOD** *(x63519)* to arrange for ICU disposition ☐ **Call OR Pharmacy** *(x60242)* to request meds as needed ☐ Designate an **Anesthesia Provider or CRNA to record the events** during the MH crisis on the MH Flowsheet "MH Cart" ☐ Designate a **Provider to insert lines**, if not already present (arterial line, additional large bore IV access) ☐ Designate a separate **Provider to administer medications** ☐ Designate an **Anesthesia Technician to obtain** *(VOIP Phone 31022)*: **From the Anesthesia Workroom** ☐ Syringe Pump, Spiked IV, Triple Lumen CVC, A-line Sets **From Fridge in Main OR Anesthesia Workroom or 6G Med Room** ☐ 1L IV Plasmalyte x 3 bags ☐ 3L NS for Irrigation x 1 bag ☐ Regular Insulin 1 unit/mL 100 mL Premixed x 1 bag (or Regular Insulin 10 mL vial and NS 100 mL IV Bag x 1 kit) **From the Nearest Available Location** ☐ Crash Cart	

Intervention	Time
8. ☐ **Call MH Hotline** *(1-800-644-9737)* for additional help, as needed	
9. Obtain and Monitor Labs and Studies "sample lab sheets in MH Cart: Blood, Urine Labs" ☐ **ABG Kit:** ABG ☐ **Light Blue:** PT/INR, PTT, Fibrinogen, D-Dimer ☐ **Gold Gel:** Basic Metabolic Panel, CK, LDH, Serum Myoglobin, Thyroid Studies (TSH, Free T4, Free T3) ☐ **Lavender:** CBC, Platelets ☐ **Grey:** Lactate ☐ **Urine Dipstick / Collection Cup:** Hemoglobin / Myoglobin, UA ☐ **Other Monitoring Equipment:** EKG, Core Temperature, TEG	**Result/Time:**
10. Cool Patient to Goal Temp of 38°C using one or more methods: ☐ Cold Plasmalyte IV "Apex Workroom Fridge" or "6G Med Room Fridge 6G10" ☐ Cold Sodium Chloride 0.9% for Irrigation via nasogastric, bladder, rectal and/or open cavity lavage "Apex Workroom Fridge" or "6G Med Room Fridge 6G10" ☐ Ice for external surface cooling "PACU" or "6G Kitchen 606" ☐ Consider calling SICU *(x69954)* for intravenous cooling catheter and/or cooling blanket	
11. Treat Acidosis (if not reversed by Dantrolene administration) ☐ Sodium Bicarbonate 8.4% 1-2 mEq/kg IV (MHAUS recs max 50 mEq/dose) "Crash Cart" ☐ Ensure adequate minute ventilation	**Med/Dose/Time:**
12. Treat Hyperkalemia and Associated Dysrhythmias ☐ Calcium Chloride 10% 10 mg/kg IV (MHAUS recs max 2000 mg/dose) "Crash Cart" **Avoid Calcium Channel Blockers** ☐ Sodium Bicarbonate (above) "Crash Cart" ☐ Regular Insulin 10 units IV (or 0.1 units/kg IV for pediatric patients) "Apex Where Fridge" or "6G Med Room Fridge 6G10" ***HIGH ALERT / TWO PROVIDERS MUST DOUBLE CHECK INSULIN*** *If Insulin 1 unit/mL 100 mL Premixed Bag not available, preparation instructions*: Dilute Reg Insulin 1 mL (= 100 units) in a 100 mL NS Bag (Final Conc = 1 unit/mL), then give Insulin 10 mL = 10 units IV ☐ Dextrose 50% IV 50 mL (or 1 mL/kg for pediatric patients) "Crash Cart" ☐ Monitor glucose levels hourly ☐ Treat dysrhythmias using ACLS algorithms "Crash Cart"	**Med/Dose/Time:**
13. ☐ **Assign Nurse to Place or Confirm Foley. Monitor Urine Output** ☐ Aggressive hydration. Ensure UO of at least 2 mL/kg/hr. ☐ If myoglobinuria, Sodium Bicarbonate 1 mEq/kg/hr IV Infusion "Pharmacy" ☐ Consider diuresis with Furosemide 0.5-1 mg/kg IV Push "Apex Workroom Omnicell" or "6G Omnicell"	**Med/Dose/Time:**
14. ☐ **Transport to ICU** (and continue Dantrolene 1 mg/kg IV Push q6h)	

For more detailed information, see MH Staff and Service Roles (Appendix H4A)

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Appendix H4A: Staff/Service Roles during an MH Crisis (Detailed)

A. ANESTHESIA

1. Recognize and diagnose MH
2. Immediately discontinue volatile anesthetics or succinylcholine upon diagnosis
3. Start TIVA (Total Intravenous Anesthesia), if anesthesia is required
4. Hyperventilate patient at 2-3 times of the predicted minute ventilation with 100% oxygen with the goal to achieve normocapnia.
5. FiO_2 1.0 at 10 L/min. Keep the circuit system, absorber and ventilation machine.
6. Activate the MH response system by obtaining the MH Cart, clearly designating roles and responsibilities and ensuring closed loop communication
    a. Designate an anesthesia technician to obtain the MH Cart from the Anesthesia Workroom or 6G (VOIP phone 31022)
    b. Call the Anesthesia D1 during the day or Anesthesia Night Attending at night to assign an anesthesiologist to be the Team Leader of the MH response (VOIP phone 30001)
    c. Inform surgeons of an MH emergency and coordinate the most expeditious surgical plan to finish the surgical procedure
7. Treat MH using Dantrolene *Stocked in the MH Cart*
    a. Team Leader to designate an anesthesia attending, resident, CRNA, nurse, and/or pharmacist to reconstitute the Dantrolene
    b. Reconstitute each 250 mg vial of Dantrolene with 5 mL Sterile Water for Injection. Shake the vial to ensure the suspension is a uniform orange color. The resulting solution contains 250 mg of Dantrolene and 125 mg of Mannitol
    c. Designate one provider to administer Dantrolene via rapid IV Push.
    d. Administer Dantrolene Sodium 2.5 mg/kg by rapid IV push
    e. DO NOT use 5% Dextrose Injection, 0.9% Sodium Chloride Injection or other acidic solutions since it is not compatible with Dantrolene
    f. The contents of the vial must be used within 6 hours after reconstitution. Store reconstituted solutions at controlled room temperature (68°F to 77°F or 20°C to 25°C)
    g. DO NOT transfer Dantrolene to another container to infuse the product. Per package insert, administer the reconstituted Dantrolene suspension either:
        a. Into the intravenous catheter while an IV infusion of 0.9% Sodium Chloride Injection or 5% Dextrose Injection is freely running, or
        b. Into the indwelling catheter – after assuring its patency – without a freely running infusion. Flush the line to assure that there is no residual Dantrolene remaining in the catheter.
8. Repeat Dantrolene administration as necessary to control clinical signs of MH up to a total dose of 10 mg/kg.
    a. Note that in some patients, up to 30 mg/kg may be required
    b. Dantrolene sodium does not produce significant cardiac or pulmonary complications when administered acutely. **Therefore, there is little harm in administering Dantrolene where MH is suspected, but not yet proven**

9. Team Leader of MH Response will designate the following roles and use the MH Checklist as a guideline for management:
    a. An anesthesia provider to manage the patient's ventilation and anesthesia
    b. A circulating RN as Lead Nurse to call for help, activate the MH response system and delegate responsibilities to other nurses and assistant members of the OR team
    c. An anesthesia provider or CRNA to record the events during the MH crisis on the MH Flowsheet
    d. An anesthesia care provider to insert an arterial line and additional large bore IV access, if not already present
    e. An anesthesia provider or RN to administer medications
    f. An anesthesia technician to obtain the following (VOIP phone 31022)
        i. Refrigerated items from the Anesthesia Workroom Fridge or 6G Med Room Fridge (i.e., 1L IV Plasmalyte x 3 bags, 3L NS for Irrigation x 1 bag, Regular Insulin Premixed Bag or Kit x 1)
        ii. Crash Cart
        iii. Other supplies (i.e., syringe pump, spiked IV, triple lumen CVC, A-line sets)
10. Call the MH hotline **1-800-MH-HYPER (1-800-644-9737)** as needed for consultation to help with patient management
11. Perform and monitor the following laboratory tests and studies
    a. Arterial Blood Gas
    b. Basic Metabolic Panel, LDH, Thyroid Studies (TSH, Free T4, Free T3)
        i. Avoid parenteral potassium, if possible, during ongoing rhabdomyolysis
        ii. Following control of the acute episode, persistent hypokalemia may be treated with careful monitoring of the serum potassium level.
    c. Creatine Kinase (CK): Measure CKs every 6 hours until decreased
        i. CK may remain elevated for 2 weeks if event was severe
        ii. After the patient has improved and stabilized, CK should be measured on a declining time basis until it is normal (e.g., every 4 hours during the acute episode to every week during convalescence)
        iii. Monitoring is important because CK is elevated normally in some myopathies, and should be recognized as a part of overall evaluation and treatment
    d. Coagulation profile (PT/INR, PTT, Fibrinogen, D-Dimer, Lactate) – Disseminated intravascular coagulation (DIC) may occur. Consider running a TEG sample.
    e. CBC, Platelets, Serum Myoglobin
    f. Urine Hemoglobin and Myoglobin, Urinalysis
    g. EKG
12. Monitor core temperature and treat for hyperthermia
    a. If hyperthermic or core temperature rises rapidly, cool the subject using one or more of the following modalities:
        i. Cold IV Plasmalyte
        ii. Cold Sodium Chloride 0.9% for Irrigation via lavage of NG, bladder, rectum and/or open cavities

iii. Ice packs for external surface cooling
iv. Consider calling the SICU (x69954) for intravenous cooling catheters and/or cooling blankets

b. Cease cooling efforts when temperature has fallen to 38°C

13. Monitor and treat other conditions that can occur (e.g., acidosis, hyperkalemia, dysrhythmias, and myoglobinuria)
    a. Monitor arterial blood gases and treat acidosis if not promptly reversed by Dantrolene administration
        i. Sodium Bicarbonate (8.4%) at initial dose of 1-2mEq/kg IV
        (MHAUS recommends a maximum of 50 mEq per dose)
        ii. Or may titrate based on base deficit: Give 0.3 x weight (kg) x base deficit
        iii. Ensure adequate minute ventilation to avoid paradoxical intracellular acidosis and continue to monitor ABGs
    b. Monitor serum K^+ and EKG and treat for hyperkalemia (peaked T-waves, widened QRS, QT and PR prolongation, wide complex ventricular tachycardia)
        i. Treat cardiac arrhythmias associated with hyperkalemia
            (i) Calcium Chloride (10%) 10 mg/kg IV
            (MHAUS recommends a maximum of 2000 mg per dose)
            (ii) Monitor serum K^+ and ionized Ca^{++}
            (iii) Avoid calcium channel blockers
        ii. Treat hyperkalemia
            (i) Sodium Bicarbonate (above)
            (ii) Regular Insulin 10 units IV (or 0.1 units/kg IV for pediatric patients)
                (a) Insulin is considered a **"High Alert"** medication. As such, two providers must double check the dose prior to administration
                (b) *If Insulin 1 unit/mL 100 mL premixed bags are not available*, dilute 1 mL=100 units Regular Insulin into a 100 mL NS Bag (final concentration 1 unit/mL). Draw up 10 mL=10 unit dose.
            (iii) Follow Regular Insulin with Dextrose 50% 50 mL IV (or 1 mL/kg IV for pediatric patients).
            (iv) Monitor glucose levels hourly.
            (v) For refractory hyperkalemia, MHAUS recommends to consider using albuterol (or other beta-agonist), kayexelate, dialysis, or ECMO (if patient is in cardiac arrest).
    c. Monitor and treat for dysrhythmias
        i. Usually responds to treatment of acidosis and hyperkalemia by hyperventilation, Dantrolene, Sodium Bicarbonate, and Calcium Chloride (see above)
        ii. Treat dysrhythmias using ACLS algorithms and crash cart
14. Assign nurse to place or confirm foley catheter. Monitor urine output
    a. Ensure urine output of at least 2 mL/kg/hr by hydration and diuretics to minimize myoglobinuria.
    b. MHAUS states if CK or potassium rise, assume myoglobinuria and give a sodium bicarbonate infusion of 1 mEq/kg/hr IV to alkalinize urine.

c. Hydrate aggressively (may require CVP monitoring). Avoid potassium containing solutions that contain **more than** 5 mEq/L of potassium.
d. Diuresis with Furosemide 0.5-1 mg/kg IV Push

15. Once patient stabilized, transport to the ICU and provide detailed handoff to ICU team
    a. Continue intravenous Dantrolene for at least 24 hours after control of the episode (approximately 1 mg/kg IV Push every 6 hours)
    b. Watch for recrudescence and monitor core temperature by appropriate monitoring in an ICU for at least 24 hours
        i. May reoccur in about 25% of MH cases.
        ii. Greatest risk in muscular patients or who have received an anesthetic for at least 150 minutes prior to MH symptoms.
        iii. Refer to MHAUS Post Acute Phase Management for further information
16. Document the MH event in the medical record and Report the event to MHAUS
    a. Add inhalation anesthetics (sevoflurane, desflurane, isoflurane) and succinylcholine to the patient's adverse drug reactions
    b. Document MH event in the medical record
    c. Submit a confidential Adverse Metabolic or Muscular Reaction to Anesthesia (AMRA) report for patients who have had acute MH episodes to the **North American MH Registry of MHAUS** http://anest.ufl.edu/namhr/
    d. Have the patient call **1-888-274-7899** to add their name to the North American MH Registry Database
    e. File a Patient DPH UO/SAFE Report and M&M Report
17. Refer patients and families to MHAUS for information on the disease

B. NURSING

1. Designate circulating RN of the case as Lead Nurse to delegate responsibilities to other nursing staff and other assistant OR team members
2. In discussion with the Team Leader, activate the MH response system by calling the OR Front Desk (x68134) to have them:
    a. Overhead page the OR to request for adequate help in the MH crisis (Dial x68134)
    b. Call PACU (x68127) or 6G (x68168) to bring 4 large plastic bags of ice to the MH crisis
    c. Call the AOD (x63519) to arrange for ICU disposition
    d. Call the OR Pharmacy (x60242) or Inpatient Pharmacy (x60275) to request other medications as needed
3. Reconstitute and administer Dantrolene, if assigned
4. Prepare and administer other emergency medications as directed by the MH Leader
5. Obtain blood or urine for laboratory tests ordered
6. Assist in cooling the patient as directed by the MH Leader
7. Place or confirm foley catheter as directed by the MH Leader

C. SURGERY

1. Assess and coordinate the most expeditious surgical plan to finish the surgical procedure

(e.g., close the wound, complete the procedure, modify the procedure)
2. Assist in cooling the patient using the specified methods
3. Assist with any other activities as directed by the MH Team Leader

D. ANESTHESIA TECHNICIANS

1. Bring the MH Treatment Cart to the OR suite
2. Bring the Crash Cart to the OR suite
3. Bring refrigerated items from the Anesthesia Workroom Refrigerator or 6G Med Room Refrigerator to the OR suite
   a. 3 bags of cold 1L IV Plasmalyte
   b. 1 bag of cold 3L NS for Irrigation
   c. Regular Insulin 100 units/mL 10 mL vial and NS 100 mL IV Bag
   (or Insulin 1 unit/mL 100 mL premixed bag, if available)
4. Bring a syringe pump, spiked IV, triple lumen CVC, and A-line sets to the OR suite
5. Set up, obtain and/or arrange other supplies and equipment as necessary
6. Restock the supplies in the MH cart upon conclusion of MH treatment in the OR

E. PHARMACY

1. Reconstitute Dantrolene, if assigned
2. Prepare other emergency medications as directed by the MH Leader
3. Restock the medications in the MH cart upon conclusion of MH treatment in the OR

F. FRONT DESK PERSONNEL

1. Activate the MH response system and call for additional help (See Nursing Section)
2. Arrange for specimens to be sent to the laboratory
3. Obtain additional supplies as requested

G. PACU (or 6G)

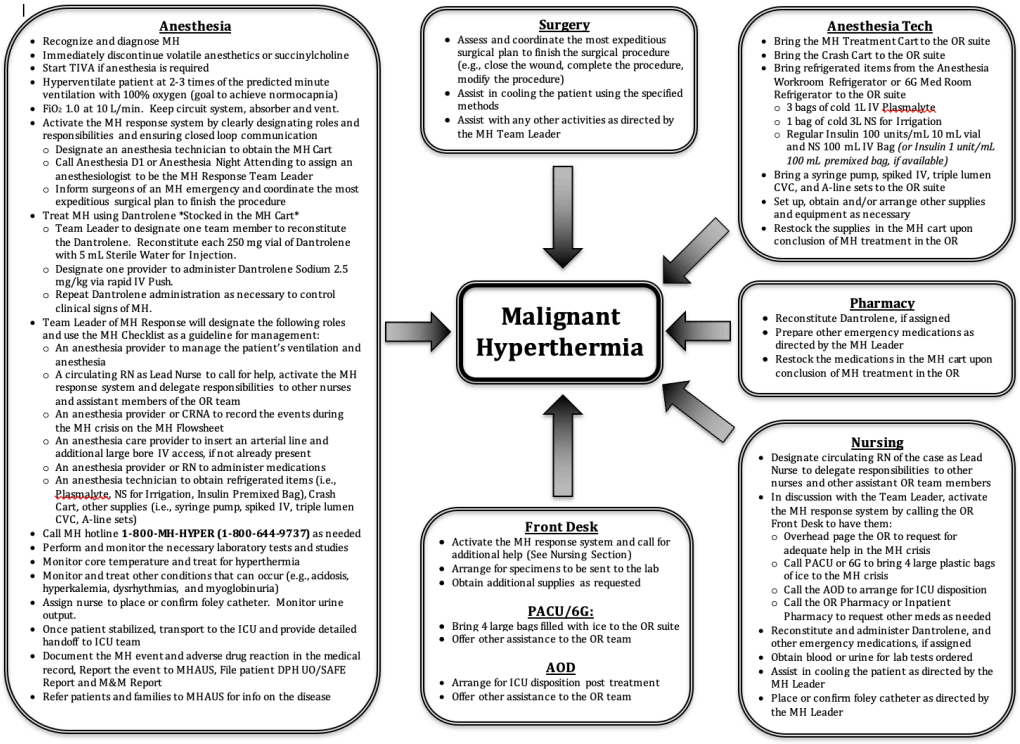
1. Bring 4 large plastic bags filled with ice to the OR suite
2. Offer other assistance to the OR team

H. ADMINISTRATOR ON DUTY (AOD)

1. Arrange for ICU disposition post treatment
2. Offer other assistance to the OR team

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Appendix H4B: Staff/Service Roles during an MH Crisis (Diagram)



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Appendix H5: List of MH Cart Drugs

Pharmacy Provided Medications and Fluids

A. Medications

1. Dantrolene (Ryanodex) 250 mg x 3 vials **(in MH Cart)**
   (dilute each 250 mg vial with 5 mL Sterile Water for Injection at the time of use).
2. Sterile Water for Injection (preservative free) 10 mL x 3 vials **(in MH Cart)**
3. Regular Insulin 1 unit/mL 100 mL premixed bag * **(in Refrigerator)**

B. Fluids

1. 1000 mL cold Plasmalyte IV x 3 bags **(in Refrigerator)**
2. 3000 mL cold Sodium Chloride 0.9% for Irrigation x 1 bag **(in Refrigerator)**

If Premixed Insulin Bag not available, Meds and Fluids needed to prepare an insulin bag:

- Regular Insulin 100 units/mL, 10 mL x 1 vial **(in Refrigerator)**
3. Sodium Chloride 0.9% 100 mL IV x 1 bag **(in Refrigerator)**
   (dilute Regular Insulin 100 units/1 mL in 100 mL NS Bag = Final Concentration of 1 unit/mL)

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Appendix H6: List of MH Cart Supplies and Equipment – Page 1

Anesthesia Provided Supplies

A. General Equipment/Nursing Supplies

- Toomy irrigation syringes (60 mL x 2) for NG irrigation
- Rectal tubes (sizes appropriate for your patient population) and collection bag
- Three-way irrigating foley catheters: (sizes appropriate for your patient population)
- Irrigation tray with piston syringe (x 1) for NG irrigation
- 5-in-1 Connector x 4
- Cysto/Bladder Irrigation Set 81" (2.1m) Regulating Clamp
- Large clear plastic bags for ice x 4
- Small plastic bags for ice x 4
- Bucket for ice

B. Monitoring Equipment

- All immediately available in anesthesia cart and pre-assembled in workroom

C. Laboratory Testing Supplies

- Needled-type ABG kits x 6
- Blood Specimen Tubes:
  - Gold Gel: Basic Metabolic Panel, CK, LDH, Thyroid Studies (TSH, Free T4, Free T3), Serum Myoglobin
  - Light Blue: PT/INR, PTT, Fibrinogen, D-Dimer
  - Grey: Lactate
  - Lavender: CBC, Platelets
- Chem Strips/Dipstick for Urinalysis: Urine Hemoglobin
- Urine Collection Container: UA, Urine Myoglobin

D. Documents (in each MH cart)

- Laboratory Request Forms: Blood/Serum Form x 2; Urinalysis Form x 2
  (see prefilled example in Binder 2nd drawer)
- Adverse Metabolic Reaction to Anesthesia (AMRA) Form (obtain from MH Registry Website)
- MH Policy (Binder 3rd drawer)
- MH Intervention Checklist (Binder 2nd drawer)
- MH Response Flow Sheet to provide documentation of the crisis (Binder 2nd drawer)
- Malignant Hyperthermia Response: Dantrolene Dosage Chart (Binder 2nd drawer)

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Appendix H6: List of MH Cart Supplies and Equipment – Page 2

Pharmacy Provided Supplies

E. Medication Preparation

- Vented spikes x 3 spikes (to reconstitute Dantrolene)
- Syringes 10 mL luer lock x 3 syringes (to reconstitute Dantrolene)
- Blunt Fill Needles 18G x 3 (to reconstitute Dantrolene)
- Red syringe caps x 3 caps

**** If Premixed Insulin Bag not available, Supplies needed for use with insulin vials:***

- Syringe to dilute insulin: 1 mL x 1 syringe
- Syringe to draw up diluted insulin: 10 mL x 1 syringe
- Blunt Fill Needles 18G x 2 to draw up insulin

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APPENDIX I: Anesthesia Intubation Bags Policy and Procedure

Title: **Anesthesia Intubation Bags Policy and Procedure**

Purpose: To establish Policy and Procedure defining the purpose, availability, maintenance, and restocking of anesthesia intubation bags that provide immediate availability of airway management tools to anesthesia personnel outside of the operating room and that are Title 22 and CMS compliant.

Policy: Four adult and one pediatric Anesthesia Intubation Bags will be maintained by the Department of Anesthesia.

Anesthesia personnel (faculty, resident or CRNA) will be responsible for stocking and maintaining the supplies of the Anesthesia Intubation Bags.

Pharmacy personnel will be responsible for stocking and sealing the medication (drug) boxes contained within the Anesthesia Intubation Bags. Oversight for establishing the contents and use of the drug boxes is the responsibility of the Director of Pharmacy or his/her designee.

Background: Anesthesiology staff are required to provide emergency airway management and resuscitative capabilities outside of the operating room. These services include: 1) airway management in the emergency department; 2) airway management in the Intensive Care Units; 3) responding to code blue calls throughout the hospital; and 4) transport of critically ill intubated patients to and from the ICU's and the operating room. These services require the immediate availability of drugs and equipment for induction of anesthesia, muscle relaxation, and resuscitation. The emergent nature of these services, and the fact that they may need to be provided in the elevators or in transit where such equipment might not be otherwise available, requires a portable bag containing the necessary drugs and equipment which can be carried by anesthesia personnel. Since these services may be required simultaneously at different locations throughout the hospital, four (4) adult and one (1) pediatric Anesthesia Intubation Bags will be established and maintained. Each Anesthesia Intubation Bag will contain standardized medications and supplies. (See Appendix I 1& 2 1 for listing of medications and supplies). Since these bags must be immediately available and restocked 24 hours a day, pharmacy will provide all necessary drugs in a self-contained box sealed with a tamperproof seal that will be used to stock and restock the drug supply in the Anesthesia Intubation Bags.

Procedure:

1. **Anesthesia stocking procedure**

a. Anesthesia Intubation Bags will be stored in the OR.

b. The Anesthesia Intubation Bags have a list of supplies and medications contained within and the name and date of the first medication to expire located in a side pocket.

c. It is the responsibility of the "Trauma anesthesia resident" to maintain and check the Anesthesia Intubation Bags Monday-Friday at the beginning of the morning shift. On Weekends, and on special dates where there is no trauma anesthesia resident, anesthesia faculty or CRNAs may be designated to complete this task.

d. The "D1-anesthesia faculty attending" is ultimately responsible to ensure completion of the maintenance and checking of the Anesthesia Intubation bags.

e. The maintenance and checking procedures are to be done every day at the beginning of the daytime shift.

f. The Anesthesia Intubation bags are to be opened and the entire contents removed. The bags are checked for cleanliness and that they are free of used or dirty equipment or supplies.

g. Anesthesia staff (defined above) will verify the presence of all contents listed in Appendix I 1 & 2 and ensure that sealed and sterile supplies are not damaged or open.

h. The Capnometer battery will be checked and replaced if it is low, before returning the device to the Bag.

i. A new sealed medication box will be checked for integrity and expiration date before placing in the Anesthesia Bag.

j. If the bags are opened and/or the contents used, the anesthesia provider will return to the Anesthesia workroom as soon as possible and the bag replenished by following items #e-i.

2. Pharmacy restocking procedure

a. Daily in the morning by no later than 8 AM, pharmacy staff will provide ten (10) drug boxes containing the medications listed on Attachment A sealed with a tamper evident seal.

b. The drug boxes will have a label on the outside listing the contents of the medications with the expiration date of the first drug to expire. A pharmacist will check the contents of the drug box for accuracy and seal the drug box with a red tamper evident seal. The seal serial number will be recorded on the label.

c. Anesthesia staff (defined above) will use the pharmacy-prepared and sealed drug boxes to perform the AM restocking of the drug supply of the Anesthesia Intubation Bags by replacing the drug box contained within the Anesthesia Intubation Bag with a fresh drug box.

d. When a drug box is used during the day, the Anesthesia staff will replace the used drug box with a fresh drug box from the Anesthesia Workroom. Anesthesia staff will secure the used drug box in the Anesthesia workroom for pick up in the morning by pharmacy staff.

References: Pharmacy P&P 6:12 Anesthesia Intubation Bag replenishment
APPENDIX
I.1 Adult Code Bag Inventory
I.2 Pediatric Code Bag Inventory

APPENDIX I.1 Adult Code Bag Inventory

ZSFG Anesthesia Code Bag Inventory
ADULT (Blue/Green/Purple/Orange)

ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Main Compartment (zip lock tie required)
Pharmacy Drug Box
AmbuBag & Mask x1
Melker Cricothyrotomy Kit x 1

Netting pocket
10mLs Saline Flushes x2
20mLs Syringe & Mini-Spike x 2
Portable Monitor & Capnograph tubing

Lower compartment
Glide Rigid Stylet x1 Bougie x1

Red Airway Roll
MAC3/4 Miller 2/3 Disposable x1 each
RediTube Styleted ETT 6.0/7.0/7.5 x1 each
Oral Airway Red/Yellow/Green x1 each
Naal Airway 36Fr/32Fr/28Fr x1 each
Lube packet x 2
CMAC PM Screen (with battery)
CMAC D-Blade + Ped D-Blade
Needle Decompression device x2
10mLs syringe x2 Orange Tape

Left Net Pocket
AirQ LMA 3/4/5 x1 each
ETT Stabilizer Rod x 2
30mL syringe x1
Magills Forceps x1

Top Pocket
Anesthesia Procedure Note x4
Anesthesia Consent Form
(English/Spanish/Chinese) x2 each
Small ziplock bags x 4
Code Bag inventory (this sheet)

Right Net Pocket
EzIO Drill + 25 & 45mm needle
IV Start Kit x 2
18g/20g Braun Safe IV x 2 each
IV extension Tubing x2
10mL Saline Flush x2

APPENDIX I.2 Pediatric Code Bag Inventory

ZSFG Anesthesia Code Bag Inventory
PEDIATRIC Airway Box

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Hospital and Trauma Center

Main Compartment
AirQ LMA 1.5/2/2.5 x1 each
Pedi Jackson Rees 2L Bag
Face Mask – Toddler/Child x 1 each
Miller 0/1 x1 each
MAC2
CMAC Miller 1 (screen in adult bag)

Inside Lid
RediTube styleted ETT 5.0 x1
Cuffed ETT 3.0/4.0 x 1 each
Pedi semi-rigid stylet x1
10mLs syringe x2
5mLs syringe x1
Orange tape
Spare ziplock bags x2

Inside Zip Compartment	**Mesh Pocket**
Oral Airway white/purple/blue x 1 each	EzIO 15mm Needle
10mLs saline flush x2	Pedi Magills Forcep
22G/24G Braun Safe IV x2 each	IV Extension Tubing x2

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APPENDIX J: Trauma Operating Room Preparedness Policy and Procedure

Title: **Trauma Operating Room Preparedness Policy and Procedure**

Purpose: To establish Policy and Procedure defining the purpose, availability, & maintenance of anesthesia readiness of urgent trauma care at ZSFG, and which is compliant with TJC and other state and federal requirements.

Policy: 24 hrs/day, 7 days/week, the Department of Anesthesia at ZSFG provides immediate readiness of one operating room (OR) for accepting urgent, severe trauma care.

Anesthesia personnel (faculty, resident, CRNA, and anesthesia technicians) will be responsible for checking, maintaining and stocking all supplies necessary for this task in the designated Trauma Operating Room.

Oversight for establishing this Policy & Procedure is the responsibility of the Chief of Staff Anesthesia or his/her designee.

Background: ZSFG is a Level-1-Trauma center in the City & County of San Francisco and is therefore required to take care of severely injured patients at any time with short notice. The emergent nature of these services requires continuous maintenance of an open and prepared OR. The designated Trauma OR is usually OR#1. If this room is in use or not ready for any other reason, a back-up OR will immediately be designated and setup as described in this P&P.

In the OR, Anesthesia staff provide anesthesia, emergency airway management, IV resuscitation, and monitoring. These services require the immediate availability of all drugs and equipment necessary for induction of anesthesia, muscle relaxation, airway management, and resuscitation. In the designated Trauma OR, anesthesia personnel are responsible for:

(1) Readiness of the anesthesia machine according to the machine's built in self-test and checklist. This is performed every 24 hours at the beginning of the day.

(2) Maintaining a fully stocked anesthesia cart containing all drugs & equipment.

(3) Medication preparedness requires that induction agents, vasoactive drugs and paralytic agents be in appropriately labeled syringes and ready at all times.

(4) Airway device preparedness.

(5) IV resuscitation preparedness of high flow infusion and transfusion systems as well as an invasive blood pressure monitoring device.

DETAILS OF (3)-(5) ARE DESCRIBED IN "OR#1 CHECKLIST", APPENDIX J1

Procedures:

1. It is the responsibility of the "D1-attending", together with the OR charge nurse, to ensure availability of a designated OR 24/7.
2. It is the responsibility of the "D1-attending" to ensure that this designated OR is prepared from an anesthesia perspective to receive a patient with no notice.
3. During regular weekdays, the "D1-attending" delegates the performance of all necessary tasks to the "trauma anesthesia resident". On Saturdays, or if for any other reason the "trauma anesthesia resident" is not available, the "D1-attending" can delegate the tasks to any other resident, CRNA or faculty.
4. Regular checks of Trauma OR anesthesia preparedness are performed:
    a. Every morning between 7AM – 8AM
    b. If a back-up OR becomes designated as the Trauma OR
    c. Following every turn-over of OR#1
5. A complete check of the anesthesia machine is performed according to FDA regulations.
6. Intubation equipment is available in the anesthesia cart. If endotracheal tubes (ETTs) are opened, they can be marked with their opening dates and are good for 1 month after the package has been opened.
7. The following emergency medications are either provided by pharmacy as pre-filled syringes or are drawn up daily between 7AM-8AM:
    a. Succinlycholine 200mg/10ml
    b. Phenylephrine 100mcg/ml in 10ml syringe (& a 90ml bag of normal saline)
    c. Ephedrine 50mg/10ml

    All drugs drawn up by anesthesia care providers are properly labeled, including concentrations, date, time and initials. They are good for 24 hrs.

    If syringes are opened to prepare for drawing up additional emergency medication, they must be dated, timed and initialed and are good for 24 hrs.
8. The Anesthesia cart is checked daily by anesthesia technicians for proper stocking. The designated anesthesia staff member double checks stocking of the cart and ensures that the cart is clean and free of equipment on top of the cart. IV and A-line starter kits are kept on top of tilt bins. The staff member ensures that the anesthesia cart is always locked when no anesthesia personal are in the room.
9. An A-line system is readily available daily.
10. An IV line system will be assembled connecting a hotline system (with extension tubing and 2 high-flow stopcocks) together with a Y-set ("blood pump"). The system is kept un-spiked, the hotline heater off, and the tubing endings off the floor. The system is dated, timed and initialed on the remaining paper tape of the hotline system. Un-spiked, the system is good for 1 month, if spiked onto a fluid bag and/or hotline heater is on, the system is good for 24 hrs.
11. A Belmont infuser is kept in the room, plugged in and powered off. The infusion system should be left 'unspiked' (not connected to any IV fluid bags). The infusion system is dated, timed and initialed on the paper tape attached to the system. Un-spiked, the system is good for 1 month, if spiked the system is good for 24 hrs.

12. All crystalloid bags are to be kept unopened in their wrappers. If opened, they are dated, timed, and initialed and are good for 24 hrs.
13. After the room is used, all 'exposed' disposable supplies are disposed of. "Exposed" is anything that is not covered during patient care, including, but not limited to, open IV setups, open Belmont setups, etc. All exposed surfaces (e.g. the anesthesia machine, anesthesia cart, and anesthesia monitors) are sanitized with an FDA approved disinfectant or replaced with clean equipment.
14. A designated anesthesia staff member completes all tasks on the "OR #1 checklist", (Appendix J1).
15. Audits of the Trauma OR readiness are performed and recorded quarterly by the Chief of Service or the Director of Clinical Anesthesia. Irregularities are documented and planned actions described.

APPENDIX

J.1 ZSFG Anesthesia OR #1 Checklist

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J.1 ZSFG Anesthesia OR 1 Daily Checklist

OR 1 DAILY CHECKLIST

Commented [AA17]: Update with Sherry's checklist as well as online survey.

Anesthesia Machine
- Check per separate protocol

Intubation Tray
- Single Use laryngoscopes
- MAC 3&4 + Miller 2&3
- 7.0 & 7.5 ETT styleted, 10ml syringe attached, with exp date and initials (good for 30d)
- 90mm oral airway, 30Fr nasal airway, tongue depressor

Emergency Medication (2nd Drawer)
- 2* Etomidate 20mg (in vial with unopened 10ml syringe & needle)
- 1* Succinylcholine 200mg (prefilled)
- 2*Rocuronium 50mg (prefilled)
- 2* Phenylephrine 100mcg/ml (prefilled)
- 2* Ephedrine 5mg/ml (prefilled)

check all for expiration

A-line setup
- spiked, de-aired, zeroed, dated (exp) done daily by techs (good for 24h)

Belmont Rapid Infuser
- power plugged in
- tubing assembled with 3liter reservoir in line
- top 5 clamps clamped
- 250ml of NS hanging, not spiked
- Belmont extension tubing, packaged hanging on pole (for use with femoral lines only)

check for expiration date (good for 30d), if freshly assembled date with expiration

Anesthesia Mayo Stand
- A-line supplies
- 2*Arrow Arterial Line
- 2* 20g Angiocath
- 1* Arrow Guidewire
- Arm board, tegaderm, A-line sterile kit, chloroprep, 4x4s, 1"tape

Monitors
- ECG with pads ready on bed

OR Table
- Plugged in, "on", @ lowest position

Anesthesia carts
- 2 large bore iv start kits on top of anesthesia machine (2* 16G iv, 2* 14G iv, 4x4s, chloroprep, 1" tape, tourniquet, tegaderm) NO open/filled syringes
- 1 arterial line starting kit on top of anesthesia machine (arrow a-line, 2* 20G iv, 4x4s, chloroprep, 1" tape, tourniquet, tegaderm, arm board)
- ensure both carts are locked

General Rules for OR 1 readiness
- cart and drugs locked
- all items arranged according to markings on floor
- all fluid containing items are good for 24h (i.e. syringes, spiked bags)
- all air containing items are good for 30d (i.e. ETT, Belmont tubing)
- everything is to be labeled with the expiration date (NOT the date when opened/ prepared)

Turnover After Each Case
- OR 1 shall be turned over ASAP after each case (to be ready for the next patient)
- All "exposed" disposables are discarded
- All "exposed" surfaces are to be wiped down with H_2O_2 wipes
- "exposed" = all items & surfaces that are not covered during patient care (i.e. anesthesia machine, monitor, carts, Belmont etc.)

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Sign off that check is complete on dedicated sign off sheet once daily

Daily Trauma Bag Check



Sign-off Sheet

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San Francisco, CA 94110

APPENDIX K: Labor and Delivery Operating Room Preparedness Policy

Title: **Labor and Delivery Operating Room Preparedness Policy**

Purpose: To establish Policy and Procedure defining the purpose, availability, and maintenance of anesthesia readiness for urgent obstetric care at ZSFG that is compliant with TJC and other state and federal requirements.

Policy: 24 hrs/day, 7 days/week, the Department of Anesthesia at ZSFG provides immediate readiness of 2 Labor and Delivery (L&D) operating rooms (ORs) for accepting urgent/emergent obstetrical care.

Anesthesia personnel (faculty, resident, CRNA and anesthesia technicians) will be responsible for checking, maintaining and stocking all supplies necessary for this task in the designated L&D ORs.

Oversight for establishing this Policy & Procedure is the responsibility of the Chief of Anesthesia or his/her designee.

Background: Obstetrician-gynecologists at ZSFG provide the full range of clinical care, including caring for high-risk pregnancies, to a diverse population of women visiting the hospital. Anesthesia services require the availability of all drugs and equipment necessary for administration of anesthesia for emergent surgical procedures such as cesarean delivery. In the designated L&D OR, anesthesia personnel are responsible for:

(1) Readiness of the anesthesia machine. This requires a complete check of the machine according to the built in machine self-test and checklist, performed every 24 hrs in the AM.

(2) Maintaining a fully stocked OB anesthesia-specific anesthesia cart containing all drugs and equipment as defined in Appendix K1, K2.

(3) Medication preparedness including the immediately availability of induction agents, vasoactive drugs and paralytic agents. Drawn up drugs are to be kept locked in the anesthesia cart.

(4) Airway device preparedness.

(5) IV resuscitation preparedness including the availability of high flow infusion and transfusion systems as well as an invasive blood pressure monitor.

DETAILS OF (3)-(5) ARE DESCRIBED IN "L&D CHECKLIST" SEE APPENDIX K1, K2.

Procedures:

1. It is the responsibility of the Anesthesia attending responsible for OR, together with the L&D charge nurse, to ensure availability of at least one designated L&D OR available 24/7.
2. It is the responsibility of the Anesthesia attending responsible for OR to ensure that these designated ORs are prepared from an anesthesia perspective to receive a patient without notice.

3. During weekdays and Sundays, the "OB-anesthesia attending" delegates the performance of all necessary tasks to the OB anesthesia resident/CRNA. On Saturdays, or if for any other reason the OB anesthesia resident/CRNA is not available, the "OB-anesthesia attending" can delegate the tasks to any other anesthesia provider.
    a. Regular checks of L&D ORs for anesthesia preparedness are performed:
        i. Every morning, ideally between 7AM – 8AM
        ii. If an additional back-up OR becomes designated as an L&D OR
        iii. Following every turnover of an L&D OR
    b. A complete check of the anesthesia machine is performed according to FDA regulations.
    c. Intubation Equipment is checked and immediately available. Opened intubation equipment expires in 1 month. Initials and the date of expiration will be written on opened equipment. Applies only to L&D OR B: A portable video laryngoscope system is available, checked for functionality daily, and is plugged in, but powered off.
    d. The following emergency medications are immediately available:
        i. Etomidate or Propofol will be available
        ii. Succinlycholine 200mg/10ml
        iii. Phenylephrine 1000mcg/10ml
        iv. Ephedrine 50mg/10ml

    When drawn up by anesthesia care providers, all syringes are to be properly labeled, including drug, concentration, date, time and initials. They expire in 24 hrs. All drugs are kept in the top two drawers of the anesthesia cart. The cart is to be kept locked whenever authorized personnel are not in the immediate vicinity.

    If syringes are opened to prepare for drawing up additional emergency medication, they must be dated, timed and initialed and are valid for 24 hrs.

    e. The Anesthesia cart is checked daily and after each use by anesthesia technicians for proper stocking. The designated anesthesia staff member double checks stocking and ensures that the cart is clean. IV and arterial line placement kits are available at all times. The staff member ensures that the anesthesia cart is always locked when no anesthesia personnel is in the room.
    f. Applies to both L&D OR A and B: An invasive pressure monitoring (arterial line) system including all necessary equipment and attachments is grouped together, unopened and in sterile packaging, in a plastic bag, ready for immediate assembly and use. Opened, but un-spiked, the system expires in 1 month; if spiked, the system expires in 24 hrs. Initials and the date/time of expiration will be written on the drip chamber in these situations. An invasive pressure transducer cable is readily available.
    g. Applies to both L&D OR A and B: An IV fluid warmer (hotline) system including all necessary equipment and attachments is grouped together, unopened and in sterile packaging, in a plastic bag, ready for immediate assembly and use. Opened, but un-spiked, the system expires in 1 month; if spiked, the system expires in 24 hrs. Initials and the date/time of expiration will be written on the drip chamber in these situations. The fluid warmer is plugged in, but powered off.

h. Applies only to L&D OR B: A trauma anesthesia-specific anesthesia cart is available and its contents maintained by the anesthesia technicians.

i. Applies only to L&D OR B or the substerile room between L&D ORs A and B: An ultrasound with a linear probe is available. The machine is plugged in, but powered off.

j. Applies only to the substerile room between L&D ORs A and B: A rapid infuser (Belmont) system including all necessary equipment and attachments is grouped together, unopened and hanging from the rapid infuser, ready for immediate assembly and use. Opened, but un-spiked, the system expires in 1 month; if spiked, the system expires in 24 hrs. Initials and the date/time of expiration will be written on the reservoir in these situations. The rapid infuser is plugged in, but powered off.

k. All crystalloid bags are to be kept unopened in their wrappers. If opened, they are dated, timed and initialed and expire in 24 hrs.

l. After the OB OR is used, all 'exposed' disposable supplies are disposed of. "Exposed" is anything that is not covered during patient care, including, but not limited to, open IV systems, open Belmont systems, etc. All exposed surfaces (e.g. the anesthesia machine, anesthesia cart, and anesthesia monitors) are sanitized with an FDA-approved disinfectant or replaced with clean equipment.

m. Following the daily OB OR checks, the designated anesthesia staff member certifies completion of all tasks by signing the "L&D OR A and B readiness sign-off sheet".

n. Audits of the L&D OR readiness are performed and recorded at least quarterly by the Chief of Service or the Director of Clinical Anesthesia. Irregularities are documented and planned actions described.

APPENDIX

K.1 L&D OR B Checklist

K.2 L&D OR A Checklist

APPENDIX K.1 L&D OB OR B, H2214B Checklist

Keep it as you would like to find it for a STAT C-section

Anesthesia Machine:
- Machine check per protocol; Circuit assembled (with mask)
- Suction functional.

Monitors:
- EKG leads with pads hanging from IV pole untangled
- SpO2 probe attached; BP cuff (adult regular, size 11) attached
- NMT, arterial line, temperature cables present and nicely tucked away

OR Table:
- Plugged in, on, and at lowest position.
- Arm board attached on side opposite of patient entrance.
- Blue ramp on OR bed, placed under hovermat.
- All chairs removed from anesthesia area

Difficult Airway Equipment:
- Glidescope plugged in.
- Glidescope 3 and 4 blades, stylet, 6.5 ETT, 10 mL syringe in basket – everything unopenedLMA 3.0, 4.0, 5.0 in anesthesia cart.
- Ambu disposable fiber screen plugged in; large, regular, and slim scopes on back of cart

Emergency Medication/Anesthesia Cart:
- Sealed anesthesia medication trays in anesthesia cart
- In 4th drawer for drawn up meds, check phenylephrine & succinylcholine available and not expired; Toss out any old drawn up medicationsCart locked and no medications out (such as on top of cart) while unattended.

IV Line:
- IV start kit on cart; pigtail and flush syringe NOT opened or attached
- 2 syringe pumps; 1 Sigma Spectrum pump

Neuraxial Kits:
- On bottom shelf of anesthesia "Mayo Stand," at least two of each:
    - Epidural kit (arrow or medline)
    - Spinal kit

Substerile Room, H2214C Checklist
- Belmont Rapid Infuser – Plugged in and components hanging on Belmont IV pole (250 mL NS bag, Belmont tubing. extension x1 – everything unopened)
- Arterial Line Setup – Unspiked A-line transducer kit (500 mL NS bag, pressure bag, A-line transducer – everything unopened) hanging from Belmont
- Hotline setup – unspiked hotline kit (1000mL plasmalyte, Y-connector, Hotline tubing, stopcock x2, IV extension – eveyrthing unopened) hanging from the Belmont

- Ultrasound – Ultrasound plugged in; Probes and probe holders clean; "CLEAN" tag attached to probes

Sign off that you checked the above on the "OB Anesthesia OR Checklist Sign Off" on the wall in OB OR B, H2214B.

APPENDIX K.2 L&D OB OR AB, H2214A Checklist

Keep it as you would like to find it for a STAT C-section

Anesthesia Machine:

- Machine check per protocol.
- Circuit assembed (with mask available)
- Suction functional.

Monitors:

- EKG leads with pads hanging from IV pole untangledSpO2 probe attached.
- Adult Regular, size 11 BP cuff attached

NMT, arterial line, temperature cables present and nicely tucked away

OR Table:

- Plugged in, on, and at lowest position.
- Arm board attached on side opposite of patient entrance.

All chairs removed from anesthesia area

Difficult Airway Equipment:

- LMA 3.5, 4.5 in anesthesia cart.

Emergency Medication/Anesthesia Cart:

- Sealed anesthesia medication trays in anesthesia cartIn 4th drawer for drawn up meds, check phenylephrine & succinylcholine available and not expired; toss out any old drawn up medications

Cart locked and no medications out (such as on top of cart) while unattended.

IV Line:

- IV start kit on anesthesia cart; pigtail and flush syringe NOT opened or attached
- 2 syringe pumps; 1 Sigma Spectrum pump

Neuraxial Kits:

- On bottom shelf of anesthesia "Mayo Stand" at least two of each:
  - Epidural kit (arrow or medline)
  - Spinal kit

Sign off that you checked the above on the "OB Anesthesia OR Checklist Sign Off" on the wall in OB OR B, H2214B

Commented [AA18]: Appendix L deleted because Operating Room Department Policy 36: Fire Safety in the Perioperative Environment is the hospital policy which addresses this issue, which extends beyond anesthesia providers alone.

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Appendix M Clinical Service Privilege Form

Commented [AA19]: From 2018. Is there a newer version?

Anesthesia ANESTHESIA & PERIOPERATIVE CARE 2022

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

6.10 CORE PHYSICIAN PRIVILEGES ___
Preoperative evaluations of patients at all levels of American Society of Anesthesia classification including emergencies (inclusive of anesthesia privilege 6.11). Management of procedures for rendering these patients insensible to pain and emotional stress before, during and after surgical, obstetric and certain medical interventions. These procedures include all anesthetic and sedative techniques inducing local infiltration, regional anesthesia and general anesthesia. They also include special skills necessary for support of life functions during an anesthetic, in the post anesthesia care unit, and elsewhere in the hospital. These include airway management, including direct laryngoscopy and fiberoptic laryngoscopy, hemodynamic monitoring, including insertion of arterial lines, central lines, and pulmonary artery catheters, and mechanical ventilation and resuscitation.

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

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 10 anesthetics

6.101 CORE CRNA PRIVILEGES ___
Preoperative evaluations of patients at all levels of American Society of Anesthesia classification including emergencies. Management of procedures for rendering these patients insensible to pain and emotional stress before, during and after surgical, obstetric and certain medical interventions under medical direction of an attending anesthesiologist. These procedures include all anesthetic and sedative techniques including local infiltration, regional anesthesia and general anesthesia. They also include special skills necessary for support of life functions during an anesthetic, in the post anesthesia care unit, and elsewhere in the hospital. These include airway management, including direct laryngoscopy and fiber optic laryngoscopy, hemodynamic monitoring, including insertion of arterial lines, central lines, and mechanical ventilation and resuscitation.

PREREQUISITES: Successful completion of CRNA program and board admissible (for initial appointment) or current certification by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 10 anesthetics

6.11 PREOPERATIVE EVALUATION PRIVILEGES ___
Preoperative evaluation of patients at all levels of American Society of Anesthesiologists classification, inclusive of emergencies, to include: Assessment of, consultation for, and preparation of patients for anesthetist; Determination of the patient's mental status, development of a plan and obtaining consent for anesthetic care.

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

PROCTORING: 5 reviewed cases

REAPPOINTMENT: Review of 5 cases

6.20 SPECIAL PRIVILEGES ___

6.21 INTENSIVE CARE ___
Evaluation and management of Critical Care Unit patients

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia with special qualifications in Critical Care Medicine. Under special circumstances, the recommendation of the Chief of Anesthesia and Perioperative Care may be required

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 30 patients

6.22 TRANSESOPHAGEAL/TRANSTHORACIC ECHOCARDIOGRAPHY FOR PERIOPERATIVE MONITORING ___

Transesophageal echocardiography (TEE)/Transthoracic echocardiography (TTE) for perioperative monitoring of wall motion, volume status and pericardial fluid

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia and documentation of competency from a residency or fellowship program, or completion of the ZSFG department of anesthesia TEE/TTE training course.

PROCTORING: Proctoring will consist of three (3) direct observations (patient or simulator) by a medical staff member who has either 6.22 or 6.23 privilege and has successfully completed proctoring. A minimum of one each, TEE/TTE, is required for proctoring. A summary monitoring report will be sent to the Clinical Service Chief at the completion of successful proctoring.

REAPPOINTMENT: Performance of a minimum of 5 (five) TEE or TTE exams (patient or simulator) for monitoring of wall motion abnormalities, volume status, or pericardial fluid every two (2) years is required for reappointment. A minimum of one each, TEE/TTE, is required for reappointment. Physician specific peer review data must include information regarding cases in which transesophageal or transthoracic echocardiography was utilized for perioperative monitoring.

6.23 TRANSESOPHAGEAL/TRANSTHORACIC ECHOCARDIOGRAPHY FOR PERIOPERATIVE COMPREHENSIVE EXAMINATION ___

Transesophageal/Transthoracic echocardiography monitoring of perioperative patients for comprehensive examination.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia. Successful completion of the Perioperative Transesophageal Echocardiography Certification Examination administered (PTEeXAM) by the National Board of Echocardiography (NBE testamur status).

PROCTORING: Proctoring will consist of five (5) direct/observations by a medical staff member who has 6.23 privilege and has successfully completed proctoring. A minimum of one each, TEE/TTE, is required for proctoring. A summary monitoring report will be sent to the Clinical Service Chief at the completion of successful proctoring.

REAPPOINTMENT: Performance of a minimum of 5 (five) complete TEE/TTE exams every two (2) years is required for reappointment. A minimum of one each, TEE/TTE, is required for reappointment. Physician specific peer review data must include information regarding cases in which transesophageal or transthoracic echocardiography was utilized for a comprehensive examination.

6.24 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH ___

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____

CTSI Medical Director Date

6.25 PAIN MEDICINE ___

Interventional Procedures For The Management Of Acute Or Chronic Pain Syndromes

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in Anesthesiology with special qualifications in Pain Medicine by the American Board of Anesthesiology and documentation of competency from a residency and fellowship program accredited by the Accreditation Council on Graduate Medical Education.

PROCTORING: Proctoring will consist of direct observations by a medical staff member who has 6.25 privilege and has successfully completed proctoring. A minimum of two (2) direct observations of each of three categories of interventional pain procedures listed below is required for proctoring.

REAPPOINTMENT: Performance and peer review of a minimum of four (4) cases in each of the three categories of procedures listed below every two (2) years is required for reappointment. Physician specific peer review data must include information regarding cases in which interventional procedures were used for management of acute or chronic pain syndromes.

PRIVILEGE DESCRIPTIONS:
- Fluoroscopy based injections/neuromodulation/neurolysis of the spinal column, peripheral nerves, ganglia, joints, or bursa sacs. NB-fluoroscopy must be performed by individual licensed to use fluoroscopy (may include: privilege 6.26, radiology technician, provider with other ZSFG fluoroscopy privilege)
- Ultrasound based neuromodulation/neurolysis of the spinal column or peripheral nerves and injection/neuromodulation/neurolysis of the ganglia, joints, or bursa sacs
- Chemodenervation (botulinum toxin) or local anesthetic injection of trigger points, scar, pericranial muscles (for migraine), or neuroma

6.26 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Anesthesiology. A current x-ray/Fluoroscopy Certificate is required.

PROCTORING: Presentation of valid California Fluoroscopy certificate

REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.

I hereby request clinical privileges as indicated above.

_____ _____
Applicant Date

APPROVED BY

_____ _____
Division Chief Date

_____ _____
Service Chief Date

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Appendix M Nurse Practitioner Privilege Form

AFF_2020 Anesthesia 2020

CORE STANDARDIZED PROCEDURES

HEALTH CARE MANAGEMENT, PRIMARY CARE / SPECIALTY CLINICS / INPATIENT UNITS

REQUIREMENT: Active California license, Board certification,(staff hired prior to Board requirement will be "grandfathered " in at reappointment), Basic Life Support (BLS) from an approved provider, Advanced Cardiac Life Support (ACLS) for noted procedures, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP, PNP or PA.

PROCTORING: A minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures demonstrate clinical competence or as noted in each special protocol.

REAPPOINTMENT: 5 chart reviews every 2 years. Charts can include reviews completed for special procedure reviews.

PRE-OP SCREENING OF ADULTS

REQUIREMENT: Active California license, Board certification, Basic Life Support (BLS) from an approved provider, possession of a Medicare/Medical Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP or PNP.

PROCTORING: 3 months in length. Presentation of 5 adult cases with chart review of the same 5 cases.

REAPPOINTMENT: Review of 3 adult cases every 2 years.

PRE-OP SCREENING OF CHILDREN

REQUIREMENT: Active California license, Board certification, Basic Life Support (BLS) from an approved provider, possession of a Medicare/Medical Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP or PNP.

PROCTORING: 3 months in length. Presentation of 5 pediatric cases with chart review of the same 5 cases.

REAPPOINTMENT: Review of 3 pediatric cases every 2 years.

FURNISHING MEDICATIONS AND DRUG ORDERS

REQUIREMENT: Active California license, Board certification,(staff hired prior to Board requirement will be "grandfathered " in at reappointment), Basic Life Support (BLS) from an approved provider, Advanced Cardiac Life Support (ACLS) for noted procedures, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP, PNP or PA.

PROCTORING: A minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures demonstrate clinical competence or as noted in each special protocol.

REAPPOINTMENT: 5 chart reviews every 2 years. Charts can include reviews completed for special procedure reviews.

SPECIAL STANDARDIZED PROCEDURES

eCONSULT

REQUIREMENT: 6 months of experience in the specific specialty and are providing care to patients in the area they are reviewing, understanding of algorithms or referral guidelines used for screening, triaging and prioritizing of patients.

PROCTORING: Concurrent review of the first 20 EConsult consultation decisions during the first 3 months.

REAPPOINTMENT: 5 eConsult consultations every 2 years.

MANAGEMENT OF NEURAXIAL/NERVE CATHETERS FOR PAIN CONTROL

REQUIREMENT: On site training by a privileged provider or documentation of previous training.

PROCTORING: A minimum of 2 observations by a qualified anesthesia attending of each of the following: clinical assessment of patient in relation to pain management, assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter.

REAPPOINTMENT: 2 observations of clinical assessment of patient in relation to pain management, assessment of catheter site, setup infusion pump, selection/administration of infusion medications and removal of catheter.

TRIGGER POINT INJECTIONS

REQUIREMENT: Training will be provided on site by an experienced provider.

PROCTORING: New Practitioner, 2 successful observed demonstrations of the procedure. Experienced, 1 successful observed demonstration of the procedure. Chart review of all observed cases.

REAPPOINTMENT: Performance of at least 2 injections every 2 years. 1 chart review every 2 years.

Appendix N Anesthesia OPPE Definition of Thresholds

Commented [AA20]: Are these updated? I recall including completion of training modules, note completion, etc.

Anesthesia OPPE Metrics

• **Metric 1 – Significant incidents, Cases of concern**
ACGME Core Competency: Patient Care
Medical Staff, CRNAs, and NPs
Data Source: SAFE Reports/M&M Database
○ 1 = Acceptable: 0–1
○ 2 = Marginal: 2, or any w/significant concern
○ 3 = Unacceptable: >2, or any with major concern

• **Metric 2 – Death**
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: Epic, M&M
○ 1 = Acceptable: 0, or any non-preventable
○ 2 = Marginal: >1, possibly preventable
○ 3 = Unacceptable: >1, probably preventable

• **Metric 3 – Cardiac Arrest/ MI**
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: M&M
○ 1 = Acceptable: 0, or any non-preventable
○ 2 = Marginal: >1, possibly preventable
○ 3 = Unacceptable: >1, probably preventable

• **Metric 4 – Medication Error**
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: M&M, SAFE Reports
○ 1 = Acceptable: 0–2
○ 2 = Marginal: 3
○ 3 = Unacceptable: >3; or with any significant error

• **Metric 5 – Perioperative Temperature Management [>65% with monitoring for >1h anes]**
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: Epic
○ 1 = Acceptable: >50% of pts w/GA or neuraxial with temp monitoring
○ 2 = Marginal: 30–50% of pts w/GA or neuraxial with temp monitoring
○ 3 = Unacceptable: <30% of pts w/GA or neuraxial without temp monitoring

• **Metric 6 – Board Certification/Recertification**
ACGME Core Competency: Medical/Clinical Knowledge
Medical Staff

Data Source: Medical Staff Office
○ 1 = Acceptable: Active/Current
○ 2 = Marginal: Received letter that boards are due at next reappointment
○ 3 = Unacceptable: Administrative suspension from medical staff during the 6-month reporting period for lack of board certification

• **Metric 7 – California License**
ACGME Core Competency: Medical/Clinical Knowledge
Medical Staff
Data Source: Medical Staff Office
○ 1 = Acceptable: Licensed
○ Marginal: n/a
○ 2 = Unacceptable: Not licensed

• **Metric 8 – Attendance at Huddles**
ACGME Core Competency: Practice-Based Learning and Improvement
Medical Staff & CRNAs
Data Source: ABO Tracking
○ 1 = Acceptable: Attendance at least 1 huddle/month
○ 2 = Marginal: Less than once a month attendance at huddles
○ 3 = Unacceptable: No huddles attended

• **Metric 9 – Completion of ZSFG Required Annual Hospital Training Modules**
ACGME Core Competency: Practice-Based Learning & Improvement
Medical Staff & CRNAs
Data Source: Hydra ZSFG Active Compliance Report
○ 1 = Acceptable: Current
○ Marginal: n/a
○ 2 = Unacceptable: Not Current

• **Metric 10 – Absence of UOs**
ACGME Core Competency: Interpersonal & Communication Skills
Medical Staff, CRNAs, and NPs
Data Source: SAFE Reports, Risk Management Committee
○ 1 = Acceptable: 0–2
○ 2 = Marginal: 3 or any w/significant concern
○ 3 = Unacceptable: >3 or any with major concern

• **Metric 11 – Absence of Issues in this Area as Reported by Peers**
ACGME Core Competency: Interpersonal & Communication Skills
Medical Staff, CRNAs, and NPs
Data Source: Any documented communication with leadership team
○ 1 = Acceptable: 0–1
○ 2 = Marginal: 2–3 or any with significant concern
○ 3 = Unacceptable: >3 or any with major concern

• **Metric 12 – Faculty Meeting Attendance**
ACGME Core Competency: Professionalism

Medical Staff
Data Source: ABO Tracking
○ 1 = Acceptable: >50%
○ 2 = Marginal: 30–50%
○ 3 = Unacceptable: <30%

• **Metric 13 – Absence of UOs & Complaints in This Area**
ACGME Core Competency: Professionalism
Medical Staff, CRNAs, and NPs
Data Source: Any documented communication with the leadership team
○ 1 = Acceptable: 0–2
○ 2 = Marginal: 3 or any w/significant concern
○ 3 = Unacceptable: >3 or any with major concern

• **Metric 14 – Intraoperative Handoff**
ACGME Core Competency: Systems-Based Practice
Medical Staff & CRNAs
Data Source: Epic
○ 1 = Acceptable: >75% of cases
○ 2 = Marginal: 25–75% of cases
○ 3 = Unacceptable: <25% of cases

• **Metric 15 – Percentage of all attributable notes closed in 3 days**
ACGME Core Competency: Systems-Based Practice
Medical Staff, CRNAs, and NPs
Data Source: Epic data entered by Medical Staff Office
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <80%

• **Metric 16 – Percentage of AVS Completed for In-Person Visit**
ACGME Core Competency: Patient Care
NP
Data Source: Epic
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <79%

• **Metric 17 – Percentage of Preop Visits Completed within 30 Days of Procedure Date**
ACGME Core Competency: Patient Care
NP
Data Source: Epic
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <79%

• **Metric 18 – Attendance at Weekly Clinic Meeting**
ACGME Core Competency: Professionalism

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NP
Data Source: Preop Clinic Director
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <79%

ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE

RULES AND REGULATIONS
2026~~3~~

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE
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I. ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE POLICIES

A. SCOPE OF SERVICE

1. OVERSIGHT - The Chief of the Anesthesia Service (Refer to Appendix A for detailed job description) is responsible for oversight of all anesthetic care at Zuckerberg San Francisco General Hospital (ZSFG) including pre-op clinic, all functions of the Post-Anesthesia Care Unit (PACU) related to the Anesthesia and Perioperative Care Clinical Services, administration of anesthesia faculty attending in the Medical-Surgical ICU, administration of anesthesia faculty attending in the Chronic Pain Clinic and Acute Pain Service, and administration of the Respiratory Care Service.

Commented [AA2]: Pain clinic? Pre-op clinic? Acute pain service? Would some of these be part of "anesthetic care"?

B. ORGANIZATION/STAFFING OF THE ANESTHESIA AND PERIOPERATIVE CARE SERVICE

1. CHIEF OF SERVICE - The Chief of the Anesthesia Service, or his/her designee, is responsible for ensuring the quality of anesthesia care. As necessary, assistance is invited from other services/departments, the Performance Improvement and Patient Safety Committee, or the appropriate ZSFG administrative committee or organization (example: Executive Committee, OR Committee, Engineering, etc.).

   To facilitate the administrative oversight of the varied clinical activities in the Department, the Chief has appointed the following clinical leaders (see Appendix B for Department of Anesthesia Organizational Chart):

   Vice Chief(s) of AnesthesiaAssociate Chief of Research

Commented [AA3]: Double check with org chart

   Associate Chief of Education

   Associate Chief of Strategy

   Associate Chief of Clinical Operations

   Clinical Director ZSFG operating rooms
   Director of Obstetrical Anesthesia
   Director of Quality Improvement
   Director of Regional Anesthesia
   Medical Director Post-Anesthesia Care Unit (PACU)
   Medical Director Anesthesia Workroom
   Medical Director of Respiratory Therapy
   Medical Director of the Anesthesia Pre-Operative Clinic
   Medical Director Trauma Anesthesia
   Medical Director Anesthesia Pain Clinic
   Medical Co-Director of the Surgical ICU
   Anesthesia SICU Director
   Director of Medical Student Education
   Director of ZSFG Resident Rotation

2. REGULAR SERVICE PROVISION – Anesthesia services at ZSFG Medical Center are administered by a combination of fully credentialed, qualified anesthesiologists who are board certified or actively pursuing board certification, or the equivalent, as determined by the Chief of Anesthesia and Perioperative Care, or certified registered nurse anesthetists **(**CRNAs**),** and trainees ~~residents~~ in the training program of the Department of Anesthesia and Perioperative Care, UCSF.

   The scope of anesthesia services is determined by a continuing process of needs assessment and negotiation with ZSFG and other clinical departments. The Chief of the Anesthesia Service, or his/her designee, is responsible to oversee and provide adequate coverage. The Department of Anesthesia and Perioperative Care will always provide qualified anesthesia personnel to meet the obligations of these agreements. Residents, fellows and CRNAs may administer anesthesia when under the supervision of an attending anesthesiologist who is immediately available if needed. This supervising attending anesthesiologist will be prepared to immediately conduct hands-on intervention if needed.

3. ON-CALL COVERAGE - A minimum of three physicians or two physicians and one nurse anesthetist will be in the hospital at all times. Of these, one physician will be available for immediate emergencies and will coordinate the activities of the other two. One of the physicians will be available for obstetrical anesthesia.

4. ON-CALL FACULTY ANESTHESIOLOGIST - At all times, one member of the attending staff is in the hospital ~~or is readily available~~ and takes responsibility for all anesthetics administered. A second attending anesthesiologist is on-call for backup and will be called in to ensure adequate in-house coverage if the coordinating anesthesia attending is confronted with or anticipates a work~~-~~load ~~which~~ that cannot be handled safely with the regular staff.

5. ANESTHESIA SERVICE IN THE EVENT OF A DISASTER – The Anesthesia Service functions within the scope of the overall hospital disaster plan. In the event of a mass casualty event, the on-call attending anesthesiologist will initiate backup attending activation and contact the Clinical Director or Departmental Administrator on call. Additional faculty, CRNAs, and Anesthesia technicians will be activated as determined by the Clinical Director and D1 attending using the Disaster Phone Tree (posted at OR front desk).~~will estimate the total need for additional faculty, nurse anesthetists and workroom technicians and initiate the disaster call-back list.~~

   In the event of a disaster that inactivates the telephone system, it is the responsibility of all personnel (who are able ~~so to d~~to do so) to come to the hospital immediately when ~~-~~they become aware of the disaster.

6. EMERGENCY PROCEDURES - In any emergency that requires resuscitation or handling of any airway problem, the Anesthesia Service may be contacted through

Commented [AA4]: Do we want a caveat that would allow the coordinating anesthesiologist to reassign providers in an emergency? As currently written this mandates us keeping OB availability even if there are no laboring patients and multiple OR emergencies. I realize there may be regulatory reasons why we need to state we always have OB availability so not sure if we can really change this.

the on-call physician on 30000 or 30001~~, immediately~~, or a "Code Blue" or airway stat may be called via the operator. When a replacement pager/phone is in use, the telephone operator, the Emergency Department~~,~~ ~~and~~ the Family Birth Center~~Delivery Room~~, and the OR front desk will be notified by the on-call anesthesia resident or faculty.

~~7.~~1. ~~JEHOVAH'S WITNESSES – Surgery that may involve any blood loss in a Jehovah's Witness may only be scheduled following prior arrangement with the Department of Anesthesia by obtaining an Anesthesia consultation. This is to ensure that the patient and anesthesia provider understand the types of blood and fluid products available, that there is a clear understanding of the patient's wishes regarding the type of products they will accept, and to ensure the availability of an anesthesiologist prepared to enter into an agreement not to transfuse blood, if that is what the patient desires.~~

~~8.~~7. NURSE ANESTHETIST JOB DESCRIPTION (CRNA)

See Section II.E. Affiliated Professionals

8. NURSE PRACTITIONER JOB DESCRIPTION (NP)

See Section II.E. Affiliated Professionals

C. DELIVERY OF ANESTHETIC CARE

1. OVERVIEW - Anesthesia providers (as described above) will routinely administer anesthesia to all patients brought to surgery, except in those cases where the surgeon desires to administer local or topical anesthesia, or where no anesthesia is required.
The Anesthesia Service will also provide anesthesia in other sections of the hospital (Labor & Delivery floor, radiology suite, emergency department, etc.) when appropriate. A uniform standard of anesthesia care will be followed wherever anesthesia services are delivered to patients.

2. PRE-OPERATIVE ANESTHESIA EVALUATION - Each patient will be evaluated either by clinic visit, ~~in~~ in-hospital visit, or chart review by a member of the anesthesia care team within the 48 hours prior to surgery. Pre-anesthesia evaluation and documentation shall be performed according to the guidelines (Basic Standards for Pre-Anesthesia Care described by the American Society of Anesthesiologists) and shall ~~take into account~~consider the patient's medical condition and surgical urgency (Appendix C). If, in his/her opinion, additional diagnostic or therapeutic measures are necessary prior to surgery, he/she will discuss these measures with the responsible surgeon/proceduralist and with an anesthesia attending. These

Commented [AA5]: Seems like the wrong section for this statement.

Commented [PR6]: Clinic visit usually happens more than 48h before the procedure. I understand that we also review the preop for those patients on the day of surgery, as stated in the next section, but this can be a little confusing. Maybe the 48h should only apply to in-hospital visits and chart review?

Commented [SM7R6]: this is the preop eval - reflected in Epic sign off language

concerns will also be discussed with the anesthesia care team assigned to the case as soon as possible.

The preoperative note shall be reviewed, verified, and signed by the anesthesia care team on the day of surgery. It will include a notation of the patient's diagnosis, surgical or obstetrical procedure anticipated; pertinent history and physical; assessment of anesthetic problems; and choice of anesthesia type (general, MAC, neur~~o~~axial block, peripheral regional anesthesia, or a combination of these). On the day of surgery, the anesthesia care team shall verify the identification of the patient, site and side of surgery, presence of consent, and any changes to the previously obtained history and physical. All questions from the patient and/or family shall be answered, ~~and~~ the preferred type of anesthesia explained, and any alternatives discussed. In the case of an emergency where the urgency of the situation precludes a complete preoperative evaluation, specific documentation of the emergent nature of the procedure should be made by the attending anesthesiologist.

3. CHOICE OF ANESTHESIA - Under most circumstances, the responsibility for the choice of anesthetic technique belongs to the anesthesiologist. When unusual circumstances cause the surgeon to have a special preference, this should be handled by prior consultation.

4. ADMINISTRATION OF ANESTHESIA - Immediately prior to the induction of anesthesia or intravenous sedation, with the patient in the OR, induction room, or procedure room, the patient's condition will be reviewed by the anesthesia provider including measurement of vital signs, ~~and~~ assessment of airway status, and response to pre-procedure medications. This physician or his/her assigned replacement will continue to be responsible for the safety of the patient throughout the anesthetic period.

   It is expected that the attending anesthesiologist will be present for induction and emergence from anesthesia and any other critical parts of the procedure.

   A record will be kept of all events taking place during the induction of, maintenance of, and emergence from anesthesia. This record will include vital signs, the amounts and duration of all drugs, anesthetic agents, intravenous fluids, and blood products given, ~~and~~ placement of invasive catheters, and description of anesthetic technique including methods of body warming. In addition, the anesthesia record will document the estimated blood loss and urinary output when measured, any unusual events during the anesthesia period, and the status of the patient at the conclusion of surgery in the PACU.

   Whenever there is a change of anesthesia care provider, for example at morning break, lunch break, or at shift changes, a formal handoff of patient care information will occur between the outgoing and incoming care provider as required by The Joint Commission (TJC) and in conformance with the Departmental Transition of Care Policy (Appendix D).

Commented [PR8]: or induction room

Standards for Basic Intra-operative Monitoring established by the American Society of Anesthesiologists will be adhered to in all cases~~.~~ (~~See~~ Appendix E)~~.~~ The anesthesia record shall document the monitors utilized and the results of such monitoring.

It is department policy that all syringes or intravenous fluids containing medication for patient administration be appropriately labeled. Medications should be prepared daily~~,~~ and discarded at the end of the work period.

a. All syringes will be labeled with drug name, concentration or total dose, the date and time of preparation and the initials of the anesthesia provider.
b. All syringes containing medications outdate 24 hours after they are drawn up, except for propofol, which outdates after 6~~12~~ hours.
c. Labeling of the syringe is not required if the drug is drawn up and administered immediately by the individual who prepared the medication with no intervening tasks.
d. In all operating rooms or procedural areas when the anesthesia provider is not present, unused medications will reside inside the lockable anesthesia cart. Anesthesia carts may be left unlocked and non-controlled medications may be left in, or on, the top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the immediate vicinity (see appendix F for detailed Policy and Procedure).
e. Anesthesia providers may carry medications on their person under the following circumstances:
    i. When taking those drugs directly for administration at the patient's bedside. These drugs may include but are not limited to analgesics, anxiolytics, sedatives, vasopressors, anti-emetics, beta-blockers, bronchodilators. Only drug sufficient for the anticipated patient need should be carried on the provider's person.
    ii. When transporting a patient to or from an acute care unit.
f. Controlled drugs must at all times be either under the direct control of the anesthesia provider or in an approved locked box or drawer in a secure area. Controlled drugs (narcotics/sedatives and ketamine) are obtained from Pharmacy or the operating room charge nurse using a locked box method. Dispensed drugs are entered in a Pharmacy Log sheet. Any unused medications in the syringes should be disposed of, with a witness, prior to the initiation of care of another patient. The waste must be documented on the controlled substance administration record and initialed by the provider and witness.
g. All used medications will be disposed of between cases. At the conclusion of the work period, all used and unused medications will be disposed of.

Commented [AA9]: 12 hours in vial, 6 hours in syringe.

h. ZSFG high-alert medications (heparin and insulin) must be drawn up and the dose checked by two providers.

i. Anesthesia care providers will be familiar with, and adhere to, the Operating Room Universal Protocol Policy and Procedure and will actively participate in the Rolling Timeout, Final Timeout and end of case debriefing.

5. ANESTHESIA EQUIPMENT

a. The anesthesia work place consists of an anesthetic machine, monitoring, and an anesthesia cart.

b. The anesthesia provider shall inspect and test the anesthetic apparatus prior to use. This should be done in accordance with the anesthesia machine's built in machine checklist per manufacturer guidelines. ~~The Anesthesia Apparatus Checkout Recommendations (Appendix G) will serve as a guide.~~ In general, this will include checking:

   i. Reserve supply of oxygen
   ii. Connected pipeline inlets
   iii. Functioning, filled vaporizers
   iv. Calibrated, functioning oxygen analyzers and respiratory gas and anesthetic analyzers
   v. That the Anesthesia machine is free of leaks
   vi. That there are functioning inspiratory and expiratory valves (if a circle system is to be used)
   vii. That there is non-exhausted CO_2 absorbent (if a circle system is to be used)
   viii That there is a functioning leak-free mechanical ventilator, where appropriate

c. If leaks or other faults are detected, the equipment must not be used until the fault is repaired.

d. The anesthesia provider shall also check the availability, readiness, cleanliness (sterility where appropriate) and working order of all other equipment used in the administration of anesthetic agents. This includes resuscitative equipment.

e. All reusable anesthesia equipment in direct contact with the patient shall be cleaned after each use (See Infection Control).

f. Regular anesthesia carts are standardized according to the Anesthesia Cart Policy and are provided for every OR. Additionally, the following specially equipped carts are available:

- Three~~wo~~ Trauma Carts, one located in the Trauma OR (in addition to a regular cart); a second Trauma cart is available in the designated Trauma Backup OR when the primary trauma OR is in use; a third Trauma cart is available in an obstetric OR.
- Obstetrical OR carts are available in each of the Labor & Delivery operating rooms. ~~An emergency airway cart is in the primary OB OR.~~
- One epidural cart is maintained on Labor and Delivery.
- Two fiberoptic/difficult airway carts.
- One regional anesthesia cart.
- Three Pediatric Carts.
- Two Malignant Hyperthermia (MH) cart.
- Two ICU difficult airway carts.

Except for the MH cart, carts will be stocked with drugs and supplies by OR workroom and pharmacy personnel according to established policy (See OR Workroom Policy and Procedures).
Responsibilities for stocking and checking the contents of the MH cart are defined in the MH cart Policy & Procedure (Appendix H).

g. Four Anesthesia Intubation Bags will be maintained for emergency airway procedures within the hospital. The contents and procedures for stocking and checking these bags are described in the Anesthesia Intubation Bags Policy and Procedure (Appendix I).

h. To ensure proper care of any surgical emergency case, designated Trauma and L&D ORs are prepared and checked at least once per day. Details of preparing and checking these areas are described in the Trauma Operating Room Preparedness Policy and Procedure (Appendix J) and Labor and Delivery Operating Room Preparedness Policy and Procedure (Appendix K).

i. The presence of flammable materials and oxidizing agents makes the operating room a location for potential fires. In order to minimize the probability of fire, the ZSFG Fire Safety in the Perioperative~~OR Guidelines~~ Environment will be followed (~~Appendix L~~Operating Room Departmental Policy 36).

Commented [AA10]: Is this anesthesia specific?

Commented [AA11R10]: Changing this to refer to the OR policy and not a separate anesthesia policy in the Appendix.

6. OTHER SPECIAL ANESTHESIA EQUIPMENT - Disposable anesthesia hoses and breathing bags are available and will be discarded after each use. Disposable anesthesia hoses, adapters, connectors, Y-pieces and other removable parts are to be replaced with clean or sterile equipment for each case. Plastic or rubber goods may be sterilized by either ethylene oxide or sterilized in perchloric acid. These items need not be sterile at the time of use as long as they are disinfected and stored in a clean manner.

Ventilators and canisters in daily use should be cleaned at monthly intervals.

Disposable endotracheal tubes are to be discarded after use.
Disposable suction catheters are to be discarded after each use.
All medication vials are single use and will be disposed of at the end of the case.
Anesthesia circuits will contain a filter to prevent contamination of those parts not replaced after each case (CO2 absorber, etc).

7. POST-ANESTHESIA CARE UNIT (PACU)

a. All patients who have had surgery and/or anesthesia who are not directly admitted to an intensive care unit should be admitted to the Post-Anesthesia Care Unit (PACU) for observation until fully recovered from anesthesia and until vital signs are stable. Patients with infections requiring respiratory isolation will require special arrangements per Infection Control policies.

b. Non-post-operative patients requiring special care and/or procedures may be admitted at the discretion of the responsible anesthesiologist after consultation with the PACU charge nurse. This will be considered if all other special care units of the hospital are at capacity. The PACU is thus the unit of last resort for critical care patients.

c. Medical Orders for Postanesthesia care, including pain medication, are provided by the anesthesia care team who admits a patient to the PACU ~~on the designated order form. The form is faxed to Pharmacy before PACU admission. Any changes or additions to the order form must be co-signed~~.

d. It is the responsibility of the anesthesia provider to give a verbal report to the PACU nurse on each patient admitted.

e. The anesthesia provider should not leave the patient until completely satisfied that the patient can be safely attended by the nurse receiving the patient, whether this be in the PACU, or intensive care unit.

f. The anesthesia attending or his/her designee will follow the progress of each patient under his/her care in the PACU. He/she will be available for consultation concerning any complications in the post-operative period. The anesthesiologist or his/her designee must evaluate the patient for anesthe~~s~~tic complications following surgery. The responsible physician or dentist who discharges the patient from the hospital must inform Anesthesia of any unusual anesthetic ~~-~~related events that may occur post discharge.

g. In general, visitors are not allowed in the PACU. Exceptions will be made, for example, when the patient is very young, or when the patient must spend an unusual amount of time in the PACU, or at the discretion of the anesthesia attending and PACU charge RN. Under these circumstances, visitors will be allowed~~,~~ when the Charge Nurse approves.

h. In the case of an emergency in the PACU, the anesthesia resident or CRNA, ~~and~~ attending on-call, and the surgeon involved will be notified.

i. An anesthesia attending must evaluate each patient who has received anesthesia services and document readiness for discharge before the patient can leave the PACU. The patient must meet PACU discharge criteria (see PACU Nursing Policy and Procedures).

II. CREDENTIALING

A. MEMBERSHIP REQUIREMENTS

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

Commented [AA12]: Is this referring to hospital R&R?

B. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Anesthesia and Perioperative Care Clinical Service Department is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

1. Attending staff appointed to the Medical Staff will be proctored at the beginning of service. This will include:

    a. Observation of the appointee discharging his/her usual clinical responsibilities, and
    b. Observation of the appointee in his/her discussion of clinical problems with housestaff or CRNAs.
    c. A sufficient number of times will be used to reach a conclusion as to competence.

2. By the end of three (3) months, the proctor will submit a report to the Chief of Anesthesia Service. This report will include:

    a. The nature of observations made
    b. The time period of observations,
    c. A recommendation may be made for a further period of proctoring if this is thought to be necessary.

3. When intensive care privileges are to be included, proctoring will include observations of care given by the appointee by a member of the Anesthesia ICU attending staff.

4. Proctoring reports will form a part of the Chief of Anesthesia Service's recommendation for appointment to the staff.

5. Quality of care issues in regard to faculty are discussed in several ways (See Section IX.D. Clinical Indicators). This information is used for reappointment.

6. Attending staff are evaluated on an ongoing basis in various ways.

    a. Initially, the proctoring protocol is followed.
    b. Through Faculty Reappointment every two years.
    c. Through twice yearly Ongoing Professional Performance Evaluation~~.~~. (See Appendix N, Anesthesia OPPE)

C. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Anesthesia and Perioperative Care Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

1. REAPPOINTMENT CRITERIA

The criteria for faculty reappointment shall include review of his or her clinical care, licensure status, professional judgment and performance, and review of health status as indicated. The reappointment process will include review of case management by the Department's Director of Quality Improvement, the Clinical Director of Anesthesia, or the Vice Chief of Anesthesia as reflected in the twice yearly OPPE. The following information will be collected and reviewed.

a. A review of the number and type of cases done by each faculty will be generated from the operating room records to allow the Chief of Anesthesia Service (or designee) to review the work performed by each faculty member and adequacy of clinical experience.

b. Further, a review of the postoperative complications will be summarized as part of the OPPE process and the appropriate faculty member's cases with problems will be noted (physician specific). These will be based on Joint ~~Commission~~ Commission-mandated clinical indicators.

c. A file will be generated for each faculty member to allow a review by the Chief of Anesthesia Service (or designee). Documentation of licensure will include current state license, and DEA license.

d. There will also be an ongoing review of cases listed for possible M & M discussion. This will be discussed at regular monthly conferences and as needed at faculty meetings. These will be kept on file and available for review at the time of reappointment. Finally, the Chief of Anesthesia Service shall file individual memos, comments, or other documentation relating to an individual physician's clinical care and competence, so that he will be able to document and re-certify the individual at reappointment time.

D. PRACTIONER PERFORMANCE PROFILES

The Anesthesia and Perioperative Care Clinical Service Practitioner Performance Profiles are maintained by the Chief of Anesthesia Service. This includes items C.1. (a – d) above.

E. AFFILIATED PROFESSIONALS

Commented [PR13]: Shall we add a section for NPs?
Commented [SM14R13]: yes
Commented [AA15R13]: Added

The process of appointment and reappointment to the Affiliated Professionals through the Anesthesia and Perioperative Care Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

1. NURSE ANESTHETIST JOB DESCRIPTION (CRNA)

a. Characteristics of Job - Under the supervision of physician anesthesiologists, CRNAs administer anesthesia, other central nervous system depressants, and necessary additional medications in the operating suite, delivery rooms, and other diagnostic and treatment areas. They may respond to trauma patients and any other ~~cardiopulmonary~~ types of emergencies in the Emergency Department and other patient care areas. They maintain records of anesthesia and other drugs administered, of resuscitations carried out, and of each patient's responses to these measures.

Commented [PR16]: including trauma
Commented [SM17R16]: added

b. Responsibilities of Job – CRNAs are responsible for: 1) carrying out established methods and procedures in administering anesthetics, including both elective and emergency operations and procedures; 2) monitoring patient's physiological status, using current electronic and other equipment; 3) preparing detailed medical and technical records relative to anesthetics administered and patient's reactions. The nature of work involves sustained physical effort and manual

dexterity with some exposure to health and accident hazards. Rotation on night and weekend call may be required.

c. Minimum Qualifications:

i. Training and experience: requires completion of high school, supplemented by graduation from an accredited school of nursing, and two years of special certified training in anesthesia, or an equivalent combination of training and experience. Current ongoing experience with a broad range of anesthetist's duties is essential.

ii. Knowledge, abilities and skills: requires thorough knowledge of various types and methods of administering anesthesia; standard operating room methods, equipment, and procedures; anesthesia equipment, instruments, and drugs used in various types of surgery.

iii. Requires ability and skill to detect unfavorable patient reactions and apply prompt remedial measures.

iv. License: requires possession of current valid license as a registered nurse issued by the State Board of Nursing Examiners, and current certification by the American Association of Nurse Anesthesiology~~tists~~ (or evidence of eligibility for the first six months' employment.)

Commented [AA18]: Do we need to include their updated name here?

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2. NURSE PRACTITIONER JOB DESCRIPTION (NP)

a. Characteristics of Job - Under the supervision of physician anesthesiologists, NPs conduct physical exams, diagnose and treat illness, order and interpret tests, counsel on preventative health care, assist in surgery, perform invasive procedures, and furnish medications/issue drug orders as established by state law.

b. Responsibilities of Job – NPs are responsible for some or all of the following tasks: 1) Health Care Management and Coordination: Primary Care/Specialty Clinics/Inpatient Units; 2) Pre-Op Screening of Adults; 3) Pre-Op Screening of Children; 4) Furnishing Medications and Drug Orders; 5) Electronic Consult (eConsult) Review; 6) Management of Neuraxial/Nerve Catheters for Pain Control; 7) Trigger Point Injections

c. Minimum Qualifications:

i. Training and experience: Successful completion of a program which conforms to the Board of Registered Nurses (BRN) standards, and

possession of an Adult Nurse Practitioner (ANP), Family Nurse Practitioner (FNP), or Pediatric Nurse Practitioner (PNP) degree. Ongoing maintenance of Board Certification.

ii. Knowledge, abilities and skills: requires preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness as relevant to perioperative coordination for anesthesia care.

iii. License: Active California Registered Nurse License.

iv. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.

v. Possession of a National Provider Identifier or must have submitted an application.

~~iv.~~

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F. STAFF CATEGORIES

Anesthesia and Perioperative Care Clinical Service attending staff fall into the same staff categories that are described in Article III of the ZSFG Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF STAFF PRIVILEGE CRITERIA

Anesthesia privileges are developed in accordance with ZSFG Medical Staff. All requests for clinical privileges will be evaluated and approved by the Chief of Anesthesia.

B. PRIVILEGE CATEGORIES: See Appendix M

C. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Anesthesia and Perioperative Care Clinical Service Privilege Request Form shall be reviewed annually.

~~**D. DEVELOPMENT OF PRIVILEGE CRITERIA**~~

~~Refer to Section III A – Development of Staff Privilege Criteria~~

Commented [AA19]: Is this duplicative?

~~E~~D. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

The process for modification/change to the privileges for members of the Anesthesia Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, and accompanying manuals.

IV. PROCTORING AND MONITORING – See Section II A and B, and IX

A. REQUIREMENTS

Monitoring (Proctoring) requirements for the Anesthesia and Perioperative Care Clinical Service shall be the responsibility of the Chief of the Anesthesia Service.

B. ADDITIONAL PRIVILEGES

Request for additional privileges for the Anesthesia and Perioperative Care Clinical Service shall be in accordance with the ZSFG Bylaws, Rules and Regulations, ~~and~~ accompanying manuals, as well as these Clinical Service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Request for removal of privileges for the Anesthesia and Perioperative Care Clinical Service shall be in accordance with the ZSFG Bylaws, Rules and Regulations, ~~and~~ accompanying manuals, as well as these Clinical Service Rules and Regulations.

V. EDUCATION

The Anesthesia and Perioperative Care Service offers an extensive lecture series for 1st, 2nd, and 3rd year residents. A well-organized course structure is provided for medical student rotations. Faculty education is provided on a regular basis based on high-yield identified topics selected internally. In addition, all members of the staff can attend UCSF department courses for CME credits.

Commented [PR20]: shall we mention continuous faculty education here?

Commented [SM21R20]: looks like you did - agreed

Commented [AA22R20]: We added that sentence on faculty education prior to Romain's review. Romain, did you want something additional from what we already have?

VI. ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience.

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF:

1. The resident physician shall be responsible for preoperative evaluation, planning and administration of an anesthetic, and postoperative care of assigned patients. This will be done under the supervision of an attending faculty member. It is expected that all cases will be discussed with the attending anesthesiologist prior to the induction of anesthesia.

2. Decisions regarding the progressive involvement and independence of the resident in the above-mentioned patient care activities are made following close observation of the skills and knowledge base of the resident.

B. RESIDENT EVALUATION PROCESS:

1. Each of the staff completes a written evaluation which~~and this~~ is entered into an electronic departmental database. General recommendations are then passed on to a faculty advisor. The UCSF Anesthesia Department reports on resident clinical competence to the American Board of Anesthesiology~~a~~ on a regular basis. The period of time at ZSFG is closely scrutinized for quality of care. Clinical comments are made to the house staff on a daily basis when needed.

2. Didactic Educational Activities

   a. ~~Tuesday/~~Thursday afternoon conferences are directed at topics of clinical relevance to the practice of anesthesia at ZSFG, as well as reviews of recent journal articles relevant to the clinical cases seen at ZSFG and are run by faculty members.

   b. Monthly Wednesday morning M&~~/~~M Conference includes evaluation and discussion of all department~~-~~-wide deaths, as well as significant complications, near misses, and appropriate cases with an emphasis on specific problems and/or possible changes in practice and improved care.

   c. All residents are required to attend ~~bi-~~weekly didactic sessions and grand rounds.

3. Ability to write patient care orders:
   House staff members may write patient care orders following management discussions with an attending.

VII. ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE CONSULTATION CRITERIA

A. In cases in which the patient has a significant systemic disease or an unusual surgical problem, consultation is required. ~~Previously mentioned, this includes patients who are Jehovah's Witness.~~ All consultations must be in writing and signed by the consultant. This consultation may be accomplished by a visit to the preoperative clinic or by an individual consultation regarding an inpatient or a patient in clinic.

1. ~~JEHOVAH'S WITNESSES~~Jehovah's Witnesses – Surgery that may involve any blood loss in a Jehovah's Witness may only be scheduled following prior arrangement with the Department of Anesthesia by obtaining an Anesthesia consultation. This is to ensure that the patient and anesthesia provider understand the types of blood and fluid products available, that there is a clear understanding of the patient's wishes regarding the type of products they will accept, and to ensure the availability of an anesthesiologist prepared to enter into an agreement not to transfuse blood, if that is what the patient desires.

Commented [AA23]: Would move the Jehovah's witness paragraph from above as a sub-point here.

Commented [AA24]: Seems like the wrong section for this statement.

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~~A.~~

B. Consultation is not required in the case of extreme emergency when, in the opinion of the attending physician, the life of the patient would be jeopardized by the delay necessary to obtain qualified consultation. In such emergency cases, the physician shall record the emergency situation~~,~~ which required this action.

C. When a member of the medical staff has discussed a case preoperatively, or given advice about the patient, or where consultation is the result of a clinical conference, this should be so stated in the chart.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations, and accompanying manuals will govern all disciplinary action involving members of the ZSFG Anesthesia and Perioperative Care Clinical Service.

IX. PERFORMANCE IMPROVEMENT/PATIENT SATETY (PIPS) and UTILIZATION MANAGEMENT

The overall responsibility for Performance Improvement/Patient Safety and Utilization Management rests with the Chief of the Anesthesia and Perioperative Care Clinical Service. Design and implementation and other portions of the programs will be delegated to members of the department, recognizing that this is a department-wide responsibility.

A. GOALS AND OBJECTIVES

The Chief of the Anesthesia Service, or his/her designee, is responsible for ensuring resolution of quality care issues. As necessary, assistance is invited from other departments, the Performance/Improvement Patient Safety (PIPS) Committee, or the appropriate ZSFG administrative committee or organization (example: Executive Committee, OR Committee, Engineering, etc.).

1. To ensure appropriate care of all patients receiving anesthetic care or intervention. It is understood that this care is provided chiefly in the OR and PACU, but includes other areas such as the Emergency Room, intensive care units, obstetrical suite, GI suite, and Radiology.

2. To minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care. ~~—~~Efficiency in delivery of service is also a prime objective.

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B. RESPONSIBILITY

1. Anesthetic morbidity and mortality is identified~~,~~ by postoperative visits, reports submitted into the division's M&M database, and SAFE~~Unusual Occurence~~ reports. A record of this is kept for individual anesthetists~~,~~ and major problems are highlighted. This is maintained within the Anesthesia and Perioperative Care Clinical Service. These are reviewed regularly to determine the adequacy of care. Specific problems are tabulated for the faculty reappointment database. The Chief and his/her designees also review near~~-~~miss reports made by CRNAs, residents, and faculty contemporaneously, and appropriate follow-up and/or corrective actions are taken.

2. Monthly staff meetings address organizational as well as performance improvement and patient safety issues. Minutes are submitted to the Medical Staff Office. The minutes outline topics covered~~,~~ and ~~"~~track~~"~~ ongoing problems. Performance improvement and patient safety issues are discussed at most meetings.

3. A~~s topics arise from M&M Conference, notices from other departments of physicians, patients, or administration, a~~ member of the attending staff undertakes further evaluation of any issues identified at M&M or from other departments, patients, or administration. This may take the form of a broad review or specific attention to a clinical problem.

   Follow-up on the above might include:

   a. Inservice (or departmental education/training). (Example: A follow-up on the review of epidural narcotics or lecture to the nursing staff on these modalities and means to decrease side effects.)

   b. Revision of policy or procedures.

   c. Potential staff changes/proctoring, dismissal, etc.

   d. Purchase of equipment. (Example: The O.R. monitoring equipment has expanded dramatically in recent years and exceeds the American Society of Anesthesiology standards).

C. REPORTING

Performance Improvement/Patient Safety (PIPS) and Utilization Management activity records will be maintained by the department. Further, minutes will be sent to the Medical Staff Office and will include PIPS and Utilization Management information/follow-up, etc.

Commented [PR25]: Do we want to indicate what triggers an RCA beyond our departmental M&M?

Commented [SM26R25]: no - leave that to hospital RR

D. CLINICAL INDICATORS

The Department of Anesthesia and Perioperative Care believes in the consistent delivery of quality patient care, as defined by the Institute of Medicine, i.e. that it is safe, timely, effective, efficient, equitable, and patient-centered. The Anesthesia and Perioperative Care Clinical Service reviews and evaluates the quality and appropriateness of the care delivered on a continuous basis. This is a multi-faceted program with data collection from numerous sources. These include:

1. Direct supervision of the performance of residents and CRNA's by members of the attending staff. Monthly evaluation of each resident includes direct comment on patient care issues. Performance evaluations of CRNA's are done on an annual basis.
2. All anesthesia-related deaths and complications are reviewed at monthly Morbidity and Mortality meetings. Cases are reviewed for deaths, myocardial infarction, neurologic injury, aspiration, and other adverse events occurring within 48 hours of anesthesia care. These indicators are reviewed at the monthly M&M conference and are included as part of OPPE. All members of the Anesthesia Service, including faculty, CRNA's, residents, and students are expected to attend these meetings. They are accredited for Continuing Medical Education. An attempt is made to determine ways to improve patient outcomes and avoid future problems. This is an open forum for frank discussion and educational opportunities. Records are kept in the departmental office. M&M conference is protected and confidential (California Evidence Code section 1157).

   Cases are also reviewed at routine ZSFG departmental faculty meetings with an emphasis on specific problems on possible changes in practice. Some cases are also presented and discussed at UCSF departmental Grand Rounds.

3. STARS conferences (ZSFG ~~Tuesday/~~Thursday Afternoon Resident Seminars) are for primarily residents and are directed to topics relevant to the care of patients at ZSFG. These meetings are to discuss cases, recent and topical journal articles, special techniques and ideas to improve anesthesia management, especially as pertains to trauma and indigent care, and avoidance of future problems.

Commented [PR27]: and education?

Commented [SM28R27]: good point

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Section IX.D.

F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

It is understood that regular review by the Performance Improvement/Patient Safety Committee will occur as reports and problems arise from our department or others within ZSFG. Further, there shall be an annual review of our program and Performance Improvement and Patient Safety Issues from the previous year. Refer to Section IX.D.

G. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

See Attending, Resident, and CRNA staff. Refer to Section IX.D.

H. CLINICAL INDICATORS

Refer to Section IX.D, Clinical Indicators

X. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws 7.2.I, All Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, and the annual Medical Staff Meeting.

The Anesthesia and Perioperative Care Clinical Service shall meet as frequently as necessary, but at least quarterly, to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

Commented [PR29]: Does this refer to the PIPS committee meetings?
Or is that Faculty meeting ? QI group meeting?

Commented [PR30R29]: In addition, shall we mention somewhere our faculty meetings? with minutes / required attendance, etc?

Commented [SM31R29]: no - this is internal - review/adjudication of MM - dini and ashish do this

would not add faculty meeting - "in doubt dont add"

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. Monthly orientation sessions are held to inform house staff of ZSFG--specific rules and regulations, patient care issues, schedules, etc.

B. Ongoing educational sessions are held for faculty and CRNAs regarding hospital and department policies and procedures, equipment, performance improvement and patient safety, etc.

C. Scheduling of house staff is done in accordance with the UCSF resident work hour ~~improvement project~~requirements and the UCSF GME Office.

D. Risk Management: the department adheres to all hospital policies. Any untoward events are reported promptly to risk management.

E. Well Being: The ~~Department of Anesthesia~~ZSFG Medical Staff Office has an active Physician Well Being Committee which accepts self-referrals as well as referrals of other medical staff. Any evidence of impairment is referred to the committee ~~and~~ where a prompt and thorough investigation is carried out. If impairment is identified, recommendations are made for ongoing treatment and monitoring. Whenever possible, the Physician Well Being

Committee aims to provide a supportive and non-punitive approach to allow medical staff to return to work while prioritizing safe patient care.~~found it is promptly treated appropriately.~~

XII. ADOPTION AND AMENDMENT

The Anesthesia and Perioperative Care Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Anesthesia and Perioperative Care Clinical Service every two years at an Anesthesia and Perioperative Care Clinical Service meeting.

APPENDIX A: Clinical Service Chief of Anesthesia and Perioperative Care Service Job Description

Title: Clinical Service Chief of Anesthesia and Perioperative Care Service Job Description

Chief of Anesthesia and Peri-Operative Care Clinical Service Position Summary:

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

Reporting Relationships:

The Chief of Anesthesia and Peri-Operative Care Clinical Service reports directly to the Vice Dean and the University of California, San Francisco (UCSF) Anesthesia Department Chair. A committee appointed by the Chief of Staff reviews the Chief not less than every four years. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Vice Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of Anesthesia and Peri-Operative Care Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Anesthesia and Peri-Operative Care Clinical Service include the following:

Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of ZSFG and the DPH;~~.~~

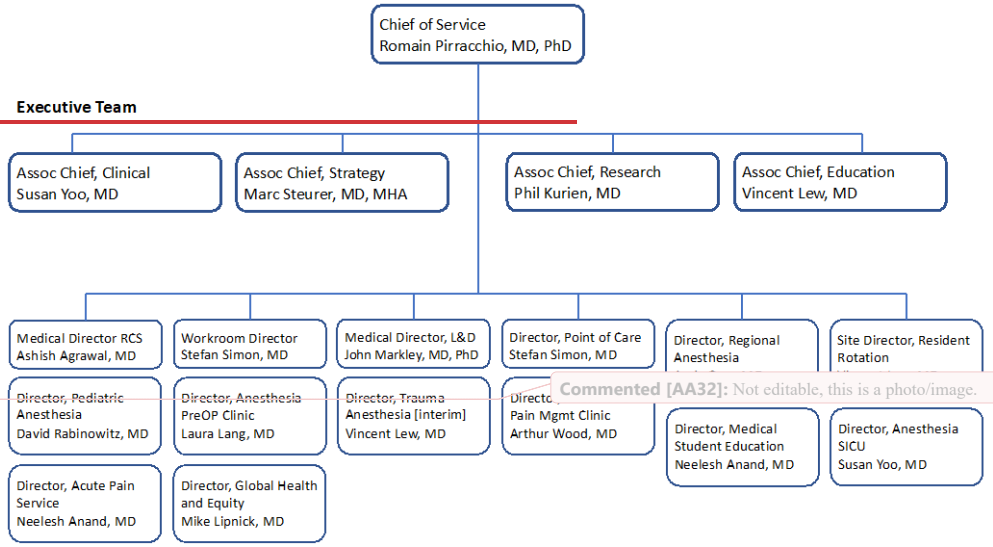
In collaboration with the Executive Administrator and other ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;

In collaboration with the Executive Administrator and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs,

selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

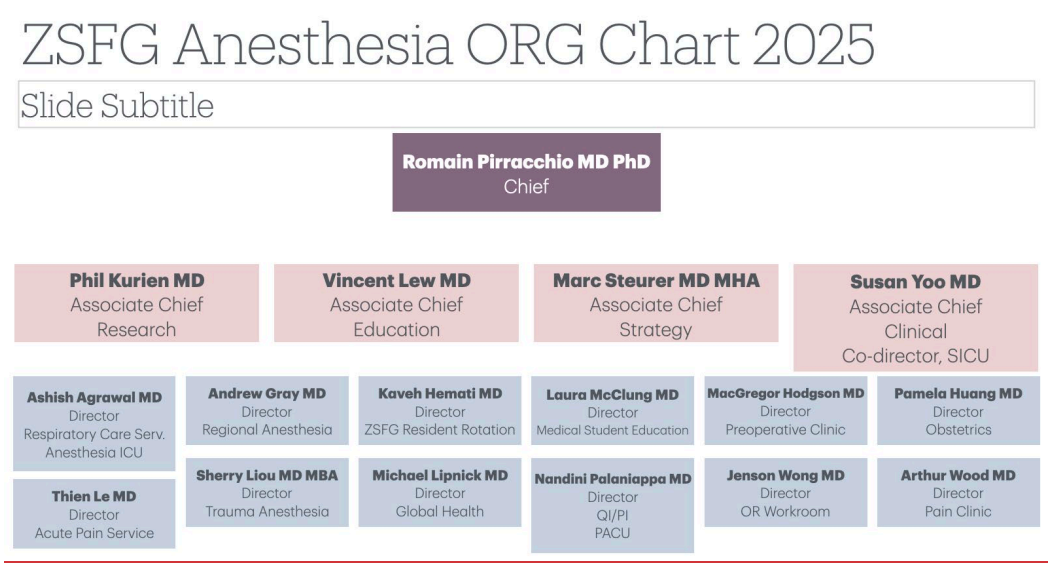
Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.

APPENDIX B: UCSF Department of Anesthesia and Perioperative Care Zuckerberg San Francisco General Hospital Division Organization



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San Francisco, CA 94110



APPENDIX C: Basic Standards for Preaanesthesia nesthesia Care

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(Approved by the American Society of Anesthesiologists House of Delegates on October 14, 1987, and last affirmed on December 13, 2020)

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.

2. Interviewing and performing a focused examination of the patient to:

   a. Discuss the medical history, including previous anesthetic experiences and medical therapy.

   b. Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.

3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.

4. Ordering appropriate preoperative medications.

5. Ensuring that consent has been obtained for the anesthesia care.

6. Documenting in the chart that the above has been performed.

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APPENDIX D: ZSFG Anesthesia Department Transition of Care Policy

Title: ZSFG Anesthesia Department Transition of Care Policy

Purpose: To establish Policy and Procedure defining the purpose and procedure concerning perioperative transition of care. This Policy is compliant with the Joint Commission Standard PC.02.02.01 (Coordinating the patient's care, treatment, and services based on the patient's needs).

Policy: An anesthesia team consisting of a faculty member and an anesthesia ~~resident~~ trainee or CRNA, or an anesthesia faculty member alone, provides Perioperative anesthesia care at ZSFG. Transition of anesthesia care ("hand-off") to a different provider may become necessary at the end of the care giver's regular working shift, or during the regular working hours for a short time to ensure adequate breaks. This Policy formalizes and standardizes the process of any transition of care, which becomes necessary during the intraoperative period.

Oversight for establishing this Policy & Procedure is the responsibility of the Chief of Anesthesia or his/her designee.

Background: Adequate transfer of patient care is a crucial part of a safe medical practice. TJC recognizes this in implementing a National Patient Safety Goal in 2007 to ensure standardization when patient care is transferred to another care~~-~~giver. This P&P defines a safe and standardized process to transfer accurate information about the patient including medical history, surgical procedure, current conditions and anticipated intraoperative course.

Procedures:

1. For shift-related transfers of care, providers will follow departmental handover checklists.
    a. These handovers~~A Handover will also~~ occur at 7AM and 6PM between incoming and departing anesthesia faculty managing the OR, Obstetrical Suites, and Anesthesia Pain Service to ensure appropriate transfer of patient information and management duties.
    This Handover will follow the ZSFG Anesthesia Shift Handover Checklist and the ZSFG Anesthesia OB/Pain Service Shift Handover Checklist
    b.

~~1.~~ For the ~~Intraoperative~~ intraoperative transfer of care ~~and other shift related transfers~~, standardized checklists are available in Epic under the intraoperative care tab ~~will follow a standardized checklist with standardized responsibilities~~. This includes pre-op history, pre-op meds, lines, drains, airways, intraop medications, ins and outs, major intraop events, requests from surgeons, and postprocedure care plan.

2. ~~The ZSFG Anesthesia Handover Checklist will be followed for transfer of patient care in the main OR and all satellite anesthetizing locations including obstetrical anesthesia.~~
    ~~a.~~

~~2.~~3. Handover procedures are performed whenever care or responsibilities are

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transferred between caregivers. This includes:

a. Any permanent transfers of care between faculty and/or between residents and CRNA's.

~~b.~~ Intermittent transfers of care (e.g. as occurs for morning, lunch, and preoperative breaks)

~~3.~~b. ~~Handovers are performed face to face and at the bedside by going through the items on the Handover Checklist as well as going over and verifying all drawn up medications including controlled substances.~~

~~4.~~1. ~~A Handover will also occur at 7AM and 6PM between incoming and departing anesthesia faculty managing the OR, Obstetrical Suites, and Anesthesia Pain Service to ensure appropriate transfer of patient information and management duties.~~

~~a. This Handover will follow the ZSFG Anesthesia Shift Handover Checklist and the ZSFG Anesthesia OB/Pain Service Shift Handover Checklist~~

APPENDIX D1-~~3~~2

~~D.1 ZSFG Anesthesia Case Handover Checklist~~

D.~~2~~1 ~~ZSFG~~ Anesthesia OB/Pain Service Shift Handover Checklist

D.~~3~~2 ~~A & B~~ ZSFG Anesthesia Shift Handover Checklist

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~~D.1 ZSFG Anesthesia Case Handover Checklist (to be performed for all anesthesia personnel changes)~~

~~(unknown patient only)~~

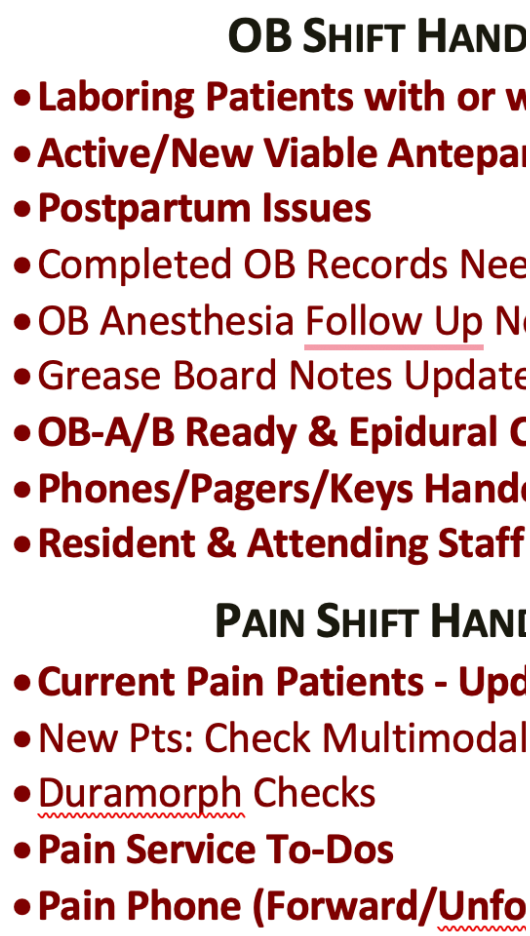
- ~~Name, Age, ASA, Language~~
- ~~Surgical Phase & Estimated Length~~
- ~~H&P / Co-Morbidities~~
- ~~Allergies~~
- ~~Patient's Daily Medication~~
- ~~Anesthesia Type~~
- ~~Patient Position~~
- ~~Airway & Ventilation~~
- ~~Cardiovascular Status (ABG?)~~
- ~~Opioid & Paralytic~~
- ~~Lines & Location of IV Port~~
- ~~EBL & I/O Balance~~
- ~~Requests by Surgeons~~
- ~~Disposition Plan~~
- ~~Antibiotic & Medication Hand-Off~~

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~~○ Current pain patients~~

D.~~2~~ 1 ZSFG Anesthesia OB/Pain Service Shift Handover Checklist

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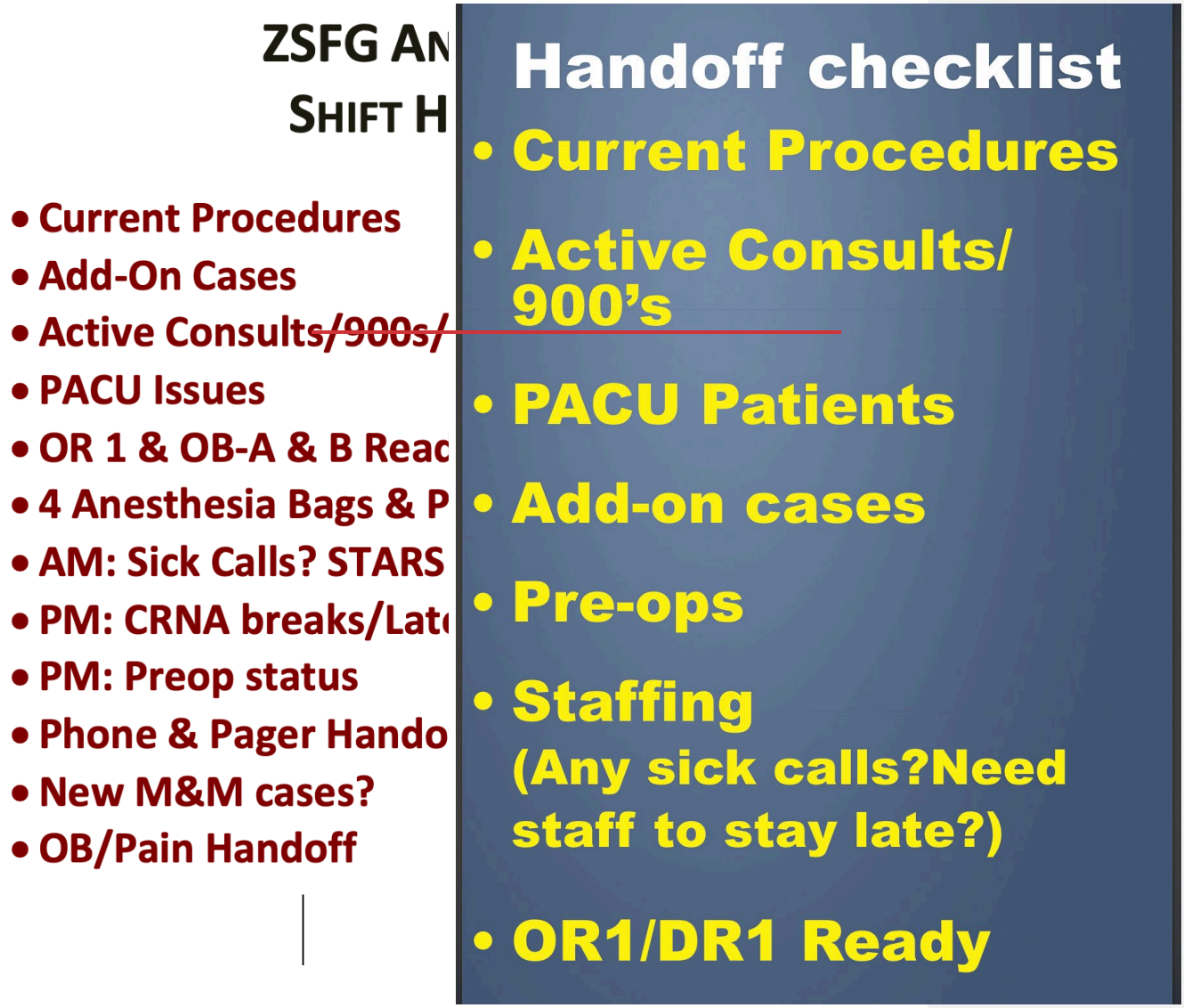


D.~~3~~2~~A~~ ZSFG Anesthesia Shift Handover Checklist

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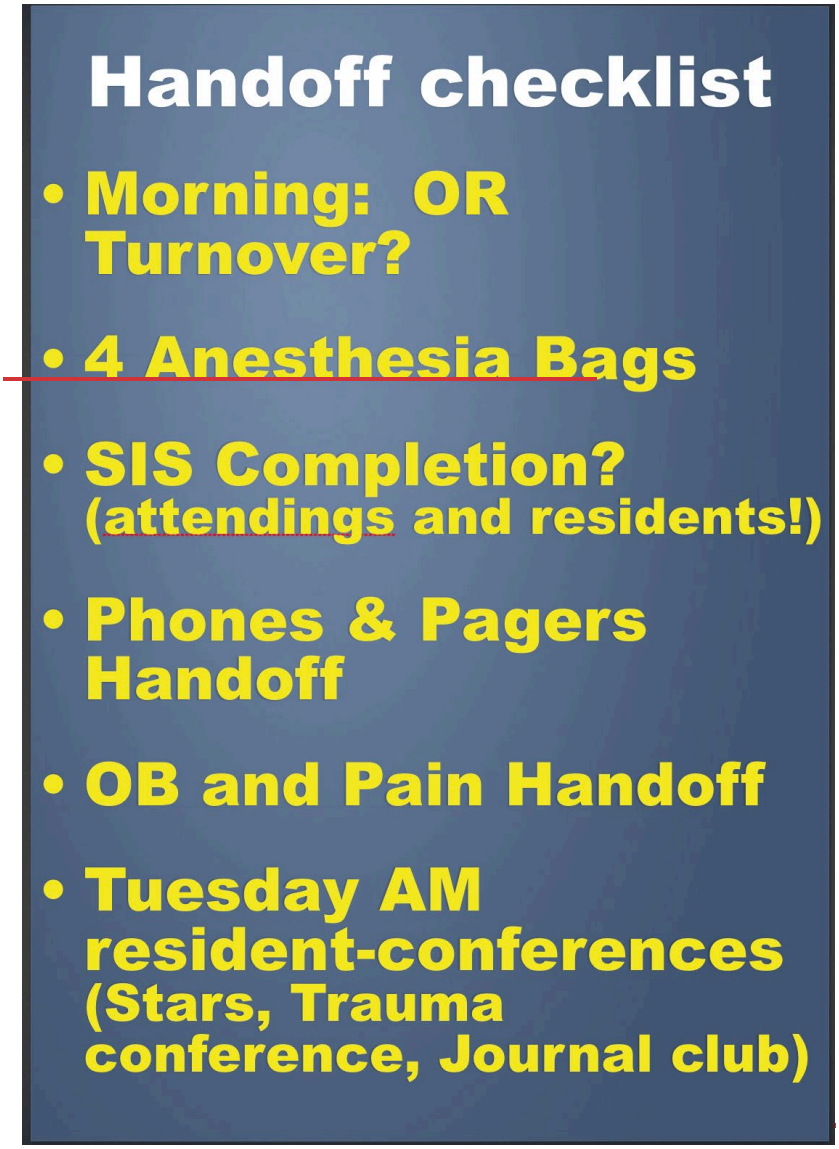
- ~~○ Current ongoing or scheduled surgical procedures in OB~~
- ~~○ Current laboring patients~~
- ~~○ Current Epidurals/Continuous SpA~~
- ~~○ Readiness of LD Ors~~

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~~D.3B ZSFG Anesthesia Shift Handover Checklist~~

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APPENDIX E: Standards for Basic Anesthetic Monitoring

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STANDARDS FOR BASIC ANESTHETIC MONITORING

(Approved by the ASA House of Delegates on October 21, 1986, last amended on October 20, 2010, and reaffirmed on December 13, 2020)

These standards apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. They apply to all general anesthetics, regional anesthetics and monitored anesthesia care. This set of standards addresses only the issue of basic anesthetic monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, 1) some of these methods of monitoring may be clinically impractical, and 2) appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual† monitoring may be unavoidable. These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

STANDARD I

Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

Objective

Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, e.g., radiation, to the anesthesia personnel which might require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgment of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

STANDARD II

During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

Oxygenation

Objective

To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.

Methods

1. Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.*
2. Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed.* When the pulse oximeter is utilized, the variable pitch pulse tone and the low

threshold alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.* Adequate illumination and exposure of the patient are necessary to assess color.*

Ventilation

Objective

To ensure adequate ventilation of the patient during all anesthetics.

Methods

1. Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.*

2. When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.* When capnography or capnometry is utilized, the end tidal CO2 alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.*

3. When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

4. During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

Circulation

Objective

To ensure the adequacy of the patient's circulatory function during all anesthetics.

Methods

1. Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.*

2. Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.*

3. Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry**.**

Body Temperature

Objective

To aid in the maintenance of appropriate body temperature during all anesthetics.

Methods

1. Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.

† Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."

* Under extenuating circumstances, the responsible anesthesiologist may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record.

APPENDIX F: Anesthesia Cart Locking, Medication Safety and Controlled Substance Policy and Procedure

Title: **Anesthesia Cart Locking, Medication Safety and Controlled Substance Policy and Procedure**

Purpose: To establish Policy and Procedure for the locking of anesthesia carts and handling of controlled substances. Oversight for establishing and updating this Policy & Procedure is the responsibility of the Chief of Anesthesia or his/her designee.

Background: Anesthesia carts contain various equipment and drugs needed for induction and maintenance of anesthesia and the support of additional anesthesia-related tasks e.g. difficult airway management, central line placement, etc. To avoid illegitimate access to the carts, all carts are generally kept locked. At the beginning and end of cases, however, it is necessary for the anesthesia provider to have immediate access to drugs and equipment. As stated in the attached Security of Medications in the Operating Room position statement drafted by the American Society of Anesthesiologists (ASA), "At the end of anesthesia cases, when patients are particularly vulnerable, anesthesia professionals dedicate full attention to their patients. This vulnerable period extends from the time the patient emerges from anesthesia until the anesthesia professional transports the patient to a recovery area. If drugs are locked up during this vulnerable period, provider access to drugs required for emergency patient care is obstructed. Furthermore, requiring anesthesia professionals to divert attention from patients in order to lock non-controlled medications in anesthesia carts during the period between emergence from anesthesia and transport of patients out of the operating room jeopardizes patient safety. Therefore, locking non-controlled medications at this point in the anesthetic should not be required." (Appendix F1) Similarly, anesthesia providers bring premedicated patients from the preoperative holding area into the operating room. Immediate access to anesthesia drugs and equipment may be required. For these reasons the ASA states in the position statement "Anesthesia carts may be left unlocked and non-controlled medications may be left in or on the top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the OR suite."
The position of the regulatory authorities on this issue is in flux. While the State Operations Manual require that carts containing anesthesia medications be locked whenever they are not directly monitored by an individual with legal access to the medications, even within a secure operation room suite CMS published a proposed revision on March 25, 2005 requiring now that "all drugs and biologicals be kept in a secure area, and locked ***when appropriate***" [§482.25(b)(2)]. ~~This has now been finalized in 482.25(b)(2)(i) (Appendix F2).~~ The California Department of Health

Commented [AA38]: This Appendix is not attached here. Does it need to be?

Services issued a memorandum stating that "anesthesia carts and anesthetic machines may remain unlocked during and in between surgical cases in a given operation room, as long as there are surgical service personnel in the immediate vicinity." This statement follows American Society of Anesthesiologists (ASA) policy. The Anesthesia Locked Cart Policy follows the final CMS rule as well as the ASA position statement on this issue.

Policies:

- Anesthesia carts are generally to be kept locked at all times. However, in certain situations Anesthesia professionals must have immediate access to drugs required for emergency patient care. Procedures designed to prevent unauthorized access to such drugs must be consistent with this imperative for patient safety. Therefore, the following exemptions apply to the locked cart policy:
  - Anesthesia carts may be left unlocked and non-controlled medications may be left in, or on, the top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the immediate vicinity.
  - Anesthesia carts may also remain unlocked whenever the anesthesia provider is able to directly monitor access to the anesthesia cart.

- All medications (including controlled substances) and solutions will be labeled with the medication name, concentration, date, time drawn up, and initials of the care provider whenever transferred from their original container.
  - Medications transferred from their original container will expire 24 hours after they are drawn up, except for propofol, which expires after 6 hours.
  - ~~No more than 1 medication will be labeled at a time.~~
  - All labels are to be verified verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.
  - Any medications found unlabeled or incompletely labeled are to be immediately discarded.

Commented [AA39]: This is confusing phrasing. No more than one syringe can be labeled at a time, like finish labeling one syringe before labeling another? Or no more than one medication per syringe, ie: what happens with lido + epi + bicarb on OB? Would eliminate this line unless it comes from standard medication preparing instructions.

- At shift change or break relief, all medications and their labels will be reviewed by entering and exiting personnel.

- Drug boxes containing controlled substances are picked up from pharmacy prior to starting work and must be returned immediately to pharmacy after the shift ends. Proper hospital ID is required when obtaining controlled substance boxes. The controlled substance box must be brought directly to the providers assigned location~~OR~~ and kept locked to the top of the anesthesia cart. **Drug box keys are always to be kept with the provider. Keys may not be stored in the anesthesia cart, even if the cart is locked.**

  Exemptions:

  - ~~Open and/or unlocked controlled substance boxes are acceptable whenever the anesthesia provider is in the immediate vicinity and able to directly monitor access to the drug box.~~
  - ~~Controlled substances drawn up into syringes require labels with concentration, date, time & the initials of the provider drawing up the medication if not administered immediately and completely~~

- Controlled substances in syringes must remain in the OR at all times.
  - Exemption:
  - To obtain adequate pre- or postoperative sedation and pain management the anesthesia provider is allowed to carry a reasonable amount of controlled substances on his/her body in syringes if directly heading to the pre-operative area to premedicate a patient or while transporting a patient at the end of a case.

- Controlled substances in use (applied over continuous infusion pumps or from syringes) may be handed off to another provider during transfer of care or for breaks. The provider who originally checked out the controlled substance box remains responsible for complete and correct documentation of administration.
  - Rationale: Controlled substances are routinely administered in almost every anesthesia case. Often they are administered via a continuous infusion or syringe pump. From practical as well as quality of care standpoints, those

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drugs cannot and should not be discontinued when the anesthesia provider changes. Official recommendations regarding this matter from the ASA and AANA are not available, however, statements have been made that this is considered to be the standard practice nationwide.

APPENDIX

F 1. ASA Position Statement "Security of Medications in the Operating Room"

F.1 ASA POSITION STATEMENT "SECURITY OF MEDICATIONS IN THE OPERATION ROOM"

Commented [AA42]: Include new 2023 version of this statement and check for changes.

Commented [AA41]: Updated to 2023 version. Minimal phrasing changes from 2018 version, ie: "Anesthetizing location" instead of "operating room".

American Society of Anesthesiologists

Statement on Security of Medications in the Operating Room

Committee of Oversight: Quality Management and Departmental Administration

(Approved by the ASA Executive Committee in October 2003, and last amended by the ASA House of Delegates on October 17, 2018)

Preamble

A secure environment of care is necessary for medication safety. Medication safety includes the security of oral, sublingual, parenteral, and inhaled pharmaceutical agents used for elective and emergency patient care. A secure physical area ensures the integrity of anesthesia machines as well as other equipment and materials. Security of medications in the operating room suite is essential for patient safety.

Recommended Policies

1. Access to operating room suites must be strictly limited to authorized persons.
2. All Schedule II through V medications must be kept in locked enclosed areas when not under the direct control of an anesthesia professional.
3. Anesthesia professionals must have immediate access to drugs and equipment required for emergency patient care. Procedures designed to prevent unauthorized access to such drugs must not impede this imperative for patient safety.
4. Anesthesia carts and anesthesia machines may remain unlocked, and non-controlled* medications may be left in or on top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the OR suite.

Rationale

A. Because the operating room suite is a limited-access secure location, it is safe practice for anesthesia professionals to leave non-controlled* medications on the top of their anesthesia carts or anesthesia machines for brief periods (e.g., while going to a nearby holding area to bring a patient into the operating room).

B. At the end of anesthesia cases, when patients are particularly vulnerable, anesthesia professionals dedicate full attention to their patients. This vulnerable period extends from the time the patient emerges from anesthesia until the anesthesia professional transfers care of the patient to recovery personnel. If drugs are locked up during this vulnerable period, provider access to drugs required for emergency patient care is obstructed. Requiring anesthesia professionals to divert attention from patients in order to lock non-controlled* medications in anesthesia carts during the period between emergence from anesthesia and transport of patients out of the operating room jeopardizes patient safety. Therefore, locking non-controlled* medications at this point in the anesthetic should not be required.

C. It is necessary and safe practice for non-controlled* medications to be set up for emergency cases (e.g., obstetrics, trauma) and made secure ("locked") by a tamper-evident device that can easily be broken by authorized persons. Locks requiring knowledge of a combination or possession of a physical key jeopardize patient safety in this setting.

1

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1001 Potrero Avenue
San Francisco, CA 94110

***Last Amended**: October 18, 2023 (original approval: October 26, 2003)*

Statement on Security of Medications in the Operating Room

***Developed By**: ASA House of Delegates/Executive Committee*

***Committee of Oversight:** Quality Management and Departmental Administration*

D. It is necessary and safe practice for emerge
treatment of malignant hyperthermia) to be kep
made secure ("locked") by a tamper-evident
persons. Locks requiring knowledge of a
jeopardize patient safety, in this setting.

*The term "non-controlled" refers to medications tl

Preamble

A secure environment[2,3] of care is necessary for medication safety. Medication safety includes the security of oral, sublingual, parenteral, and inhaled pharmaceutical agents used for elective and emergency patient care. A secure physical area ensures the integrity of anesthesia machines as well as other equipment and materials. Security of medications, while maintaining rapid accessibility, in a secure anesthetizing location is essential for patient safety.

Recommended Policies

1. Access to secure anesthetizing locations must be strictly limited to authorized persons.
2. All Schedule II through V medications must be kept in locked enclosed areas when not under the direct control of an anesthesia professional.
3. Anesthesia professionals must have immediate access to drugs and equipment required for emergency patient care. Procedures designed to prevent unauthorized access to such drugs must not impede this imperative for patient safety.
4. Anesthesia carts and anesthesia machines may remain unlocked, and non-controlled* medications may be left in or on top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and

immediately following surgical cases in a secure anesthetizing location, so long as there are authorized personnel present.

Rationale

A. Because a secure anesthetizing location is a limited-access secure location, it is safe practice for anesthesia professionals to leave non-controlled* medications on the top of their anesthesia carts or anesthesia machines for brief periods (e.g., while going to a nearby holding area to bring a patient into the operating room).
B. At the end of anesthesia cases, when patients are particularly vulnerable, anesthesia professionals dedicate full attention to their patients. This vulnerable period extends from the time the patient emerges from anesthesia until the anesthesia professional transfers care of the patient to recovery personnel. If drugs are locked up during this vulnerable period, provider access to drugs required for emergency patient care is obstructed. Requiring anesthesia professionals to divert attention from patients in order to lock non-controlled* medications in anesthesia carts during the period between emergence from anesthesia and transport of patients out of the operating room jeopardizes patient safety. Therefore, locking non-controlled* medications at this point in the anesthetic is not required.
C. It is necessary and safe practice for non-controlled* medications to be set up for emergency cases (e.g., obstetrics, trauma). If this is a non-secure location, then medications must be made secure ("locked") by a tamper-evident device that can easily be broken by authorized persons.
D. It is necessary and safe practice for emergency anesthesia drugs (e.g., dantrolene for the treatment of malignant hyperthermia) to be kept in a dedicated emergency cart or cupboard and made secure ("locked") by a tamper-evident device that can easily be broken by authorized persons.

*The term "non-controlled" refers to medications that are not Schedule II-V. In some states, anesthesia professionals may need to include reference to Schedule VI medications in their policies and procedures.

Appendix:

1. The Joint Commission and the Center for Medicare Services (CMS) have defined a secure environment. Facility policies and procedures should reference and adhere to these guidelines. Both agencies require that all drugs and biologicals must be kept in a secure area, and locked when appropriate [TJC 03.01.01 EP 3 and CMS Conditions of Participation 482.25(b)(2)(i)].
2. CMS defines a secure area as follows. "A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. For example, if medications are kept in a private office, or other area where patients and visitors are not allowed without the supervision or presence of a health care professional (for example, ambulatory infusion), they are considered secure. Areas restricted to authorized personnel only would generally be considered 'secure areas.'" [CMS Conditions of Participation 482.25(b)(2)(i)].

3. CMS has provided specific guidance on security in the OR environment in the Federal Register on November 27, 2006, Vol. 71, No. 227. The document states the following: "An area in which staff are actively providing patient care or preparing to receive patients, that is, setting up for procedures before the arrival of a patient, would generally be considered a "secure area." For example, the operating room suite would be considered secure when the suite is staffed and staff are actively providing patient care. When the entire suite is not operational or otherwise not in use, for example, weekends, holidays, and after hours, the suite would not be considered secure. When the suite is closed or otherwise not in use, we would expect all drugs and biologicals to be locked." The Joint Commission provided similar guidance in the Standards Booster Pak for Safe Medication Storage, published in April, 2014, page 14, that states that "If the individual operating room is part of a larger OR unit that is manned at all times in a fashion that monitors access to the operating room and assures constant surveillance of the anesthesia cart to prohibit access by unauthorized individuals, locking of the cart between cases would not be required." Non-licensed staff are considered authorized personnel and an area may be considered secure in the presence of non-licensed staff. The CMS Conditions of Participation allows non-licensed personnel access to locked areas if controlled substances are locked to prevent access. [TJC 03.01.01 EP 6 and CMS Conditions of Participation 482.25(b)(2)(iii)].

Date of last update: October 18, 2023

Last updated by: Governance

~~APPENDIX G: ZSFG MACHINE CHECKLIST~~

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~~ZSFG Machine Checklist~~

~~The Draeger anesthesia machine is equipped with an internal checklist specific for the device. A full machine check will be performed prior to the first use of the device for the day. Between uses, the manufacturers abbreviated machine check will be performed.~~

~~Draeger Machine Checklist~~
~~(morning check only)~~

- ~~New Circuit System Attached & Extended to Anticipated Use~~
- ~~Self-Test Completed~~
- ~~New Circuit System Attached~~
- ~~Suction System Complete & Function Test~~
- ~~Final Status Machine~~
- ~~Monitor Set~~

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APPENDIX ~~H~~H: MALIGNANT HYPERTHERMIA RESPONSE

TITLE: MALIGNANT HYPERTHERMIA RESPONSE

PURPOSE

The purpose of this policy is to ensure a well-coordinated response to malignant hyperthermia (MH) treatment by:

- Defining MH and providing guidelines for the diagnosis of MH
- Outlining responsibilities of the clinical team during the treatment of MH
- Providing guidelines on how to stock and check the MH emergency cart

DEFINITIONS

Malignant Hyperthermia:

- The MH crisis is a biochemical chain reaction response, "triggered" by commonly used general anesthetics and the paralyzing agent succinylcholine (a neuromuscular blocker), within the skeletal muscles of susceptible individuals.
- Some patients who are MH susceptible may experience a MH crisis without exposure to anesthetic drugs. Such events are rare. Strenuous exercise, exposure to heat, or perhaps high body temperature from infection may precipitate the crisis.
- The general signs of the MH crisis include increased heart rate, greatly increased body metabolism, muscle rigidity and/or fever that may exceed 110°F along with muscle breakdown, derangements of body chemicals and increased acid content in the blood.
- Severe complications include: cardiac arrest, brain damage, internal bleeding or failure of other body systems. Thus, death, primarily due to a secondary cardiovascular collapse, can result.
- **MH is a medical emergency.** Minimizing time to appropriate treatment is essential!

~~Diagnosis of Malignant Hyperthermia:~~

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- The most consistent indicator of potential MH in the OR is an **unanticipated increase (e.g., doubling or tripling) of end-tidal CO_2** when minute ventilation is kept constant. The increase in CO_2 may occur over a brief period of time or may develop over longer periods of time (minutes to hours). If upward adjustments of minute ventilation (tidal volume and frequency) are required to maintain normal end-tidal CO_2, the possibility of MH should be considered and promptly evaluated.
- If sudden, **unexpected cardiac arrest** occurs, especially in a young male, hyperkalemia should be considered immediately and therapy started with calcium, hyperventilation, dextrose, and insulin. Plasma potassium concentration should be measured as soon as possible. Sudden unexpected cardiac arrest is not typically due to MH, but due to sudden rapid rhabdomyolysis.
- **Unexpected tachycardia, tachypnea and jaw muscle rigidity** (masseter spasm) are often common signs of MH that follow the significant CO_2 increase.
- **Respiratory and metabolic acidosis** usually indicates fulminant MH. However, metabolic acidosis is not always present prior to severe temperature increase.
  - A specific sign of the MH syndrome is **body rigidity** (i.e., limbs, abdomen and chest). When there is a suspicion of MH, attempts should be made to determine if muscle rigidity is also

present.

- **Temperature elevation** usually follows the appearance of other signs of MH. Temperature change during MH is best detected by core temperature measurement (tympanic, naso- or oropharyngeal, esophageal, rectal, or pulmonary artery). Forehead skin temperature is less acceptable; it is slower in reflecting changes in core temperature and could be influenced by peripheral vasoconstriction. **MHAUS (Malignant Hyperthermia Association of the United States) recommends that core temperature be measured whenever general anesthesia is administered for procedures lasting more than 30 minutes.**
- **Postoperative rhabdomyolysis** without intraoperative signs of MH should be treated with hydration, mannitol and bicarbonate. Plasma potassium concentration should be measured immediately or as soon as possible. The patient should be referred to a neurologist and to an MH testing center to evaluate occult myopathy and determine the need for evaluation of MH susceptibility.

Drugs and Malignant Hyperthermia:

- **All volatile inhalation anesthetics (Halothane, Enflurane, Isoflurane, Desflurane, Sevoflurane) and Succinylcholine (IV/IM neuromuscular blocker) are MH triggers.** Nitrous oxide is not a trigger.
- **DO NOT ADMINISTER** calcium channel blockers when Dantrolene has been given since it may increase the risk for hyperkalemia and subsequent cardiac arrest.
- All other currently used anesthetics and life-support drugs are considered safe.

PROTOCOL: MALIGNANT HYPERTHEMIA RESPONSE

I. Criteria for suspecting MH and Hospital Locations where MH may occur:

A. Suspect MH if one or more of the following criteria are present:

1. Unanticipated increase (e.g., doubling or tripling) of end-tidal CO_2 when minute ventilation is kept constant
2. Unexpected cardiac arrest
3. Unexpected tachycardia, tachypnea, jaw muscle rigidity (masseter spasm)
4. Respiratory and metabolic acidosis
5. Body rigidity (i.e., limbs, abdomen and chest)
6. Temperature elevation
7. Postoperative rhabdomyolysis

B. MH may occur in the following hospital locations:

1. Operating Room (including OB OR) – Primary site: MH may occur at any time during or emerging from anesthesia, including in the immediate post-operative period
2. Post Anesthesia Care Unit (PACU)
3. Emergency Department (ED)
4. MH can occur anywhere in the hospital where patients require emergency intubation with succinylcholine or in other departments that use inhaled

anesthetics for procedures (i.e., IR, GI, ICU)
- "MH Emergency Alert Signs" (Appendix H1) can be posted where MH may occur outside of the operating rooms.

5. If the patient experiences MH outside of the OR area, immediately transport the patient to the OR for appropriate care. Inform the Anesthesia D1 (VOIP phone 30001) to assign a specific OR treatment room and anesthesia team. For patients already in the ICU, the ICU Attending and Anesthesia D1 will decide whether to treat the patient in the OR or ICU.

II. MH Response and Staff and Service Roles during an MH Crisis

A. See "MH Dantrolene Dosage Chart" (Appendix H2)

B. See "MH Response Flowsheet" (Appendix H3)

C. See "MH Staff and Service Roles (Detailed)" (Appendix H4A)

D. See "MH Staff and Service Roles (Diagram)" (Appendix H4B)

III. Documentation

A. Add inhalation anesthetics (sevoflurane, desflurane, isoflurane) and succinylcholine to the patient's adverse drug reactions in the patient's medical chart

B. Document MH Response Events on the "MH Response Flowsheet" (Appendix H3)

C. Documentation of the response to the event will be placed in the patient's medical chart

D. Report event to MHAUS via a confidential Adverse Metabolic or Muscular Reaction to Anesthesia (AMRA) Report to the North American MH Registry of MHAUS

E. File a Patient DPH UO/SAFE Report and M&M Report

IV. Maintenance of the Malignant Hyperthermia Cart

A. A Malignant Hyperthermia Emergency Cart (MH Cart) will be maintained in Building 25 Anesthesia Workroom and Building 5 6G.

B. The Refrigerated Medications for the MH Cart will be maintained in Building 25 Anesthesia Workroom Refrigerator and Building 5 6G Refrigerator.

C. The MH Cart will be stocked with the following:
1. "MH List of MH Cart Drugs" (Appendix H5)
2. "MH List of MH Cart Supplies and Equipment" (Appendix H6)

D. The MH Cart will be secured with a tamper-evident seal

E. The MH Cart will have posted on the outside a copy of the following:
1. "MH Dantrolene Dosage Chart" (Appendix H2)
2. "Copy of MH Intervention Checklist" (Appendix H11)

F. The MH Cart will have the following documents:
1. Drugs contained within and the name and date of the drug that will expire first "MH Cart Med List and Pharmacy Monthly Checks" (Appendix H7)
2. List of the supplies contained within and the name and date of the supply that will expire first "MH Cart Supply List and Anesthesia Monthly Checks" (Appendix H8).

G. The MH Cart will have the Malignant Hyperthermia Policy in a binder (3rd drawer of MH Cart).

during the "MH Cart Yearly Proficiency Questionnaire" (Appendix H10).

H. On establishment or replenishment of the MH Cart:

1. The Pharmacist will verify the presence of all drugs and supplies as listed in "MH List of MH Cart Drugs" (Appendix H5). The Pharmacist will then seal the box with a tamper-evident seal and fill in the required information on the "MH Cart Medication List and Pharmacy Monthly Checks" form on the cart (Appendix H7).
2. The Anesthesia Technician will verify the presence of all supplies as listed in "MH List of MH Cart Supplies and Equipment" (Appendix H6). The Anesthesia Technician will then seal the box with a tamper evident seal and fill in all required information on the "MH Cart Supply List and Anesthesia Monthly Checks" form on the cart (Appendix H8).

I. The cart will be checked by the Pharmacist and Anesthesia Technician up to every 30 days, and after every deployment for integrity and outdating of contents. A record of such monthly unit inspections will be recorded by the Pharmacist and kept for at least three years in the pharmacy.

1. See "MH Cart Med List and Pharmacy Monthly Checks" (Appendix H7)
2. See "MH Cart Supply List and Anesthesia Monthly Checks" (Appendix H8)
3. See "MH Anesthesia Daily Medication Seals Check" (Appendix H9)

J. Anesthesia Providers are reminded of the location and the content of the MH cart

V. Resources

A. wwww.mhaus.org
B. Hirshey Dirksen SJ, Van Wicklin SA, Mashman DL, Neiderer P, Merritt, DR. Developing Effective Drills in Preparation for a Malignant Hyperthermia Crisis. AORN Journal 2013; 97(3): 329-353.
C. Ryanodex [Package Insert]. Eagle Pharmaceuticals, Inc. Woodcliff Lake, NJ; 2016. http://www.ryanodex.com/wp-content/uploads/2014/07/ryanodex-prescribing-information.pdf. Accessed Nov 20, 2017.
D. AMRA Reports: https://anest.ufl.edu/namhr/namhr-report-forms/

VI. Appendices

- **Appendix H1: MH Emergency Alert Signs**
- **Appendix H2: MH Dantrolene Dosage Chart**
- **Appendix H3: MH Response Flowsheet**
- **Appendix H4A: MH Staff and Service Roles (Detailed)**
- **Appendix H4B: MH Staff and Service Roles (Diagram)**
- **Appendix H5: MH List of MH Cart Drugs**
- **Appendix H6: MH List of MH Cart Supplies and Equipment**

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TITLE: MALIGNANT HYPERTHERMIA RESPONSE

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- The general signs of the MH crisis include increased heart rate, greatly increased body metabolism, muscle rigidity and/or fever that may exceed 110°F along with muscle breakdown, derangements of body chemicals and increased acid content in the blood.
- Severe complications include: cardiac arrest, brain damage, internal bleeding or failure of other body systems. Thus, death, primarily due to a secondary cardiovascular collapse, can result.
- **MH is a medical emergency.** Minimizing time to appropriate treatment is essential!

Diagnosis of Malignant Hyperthermia:

- The most consistent indicator of potential MH in the OR is an **unanticipated increase (e.g., doubling or tripling) of end-tidal CO_2** when minute ventilation is kept constant. The increase in CO_2 may occur over a brief period of time or may develop over longer periods of time (minutes to hours). If upward adjustments of minute ventilation (tidal volume and frequency) are required to maintain normal end-tidal CO_2, the possibility of MH should be considered and promptly evaluated.
- If sudden, **unexpected cardiac arrest** occurs, especially in a young male, hyperkalemia should be considered immediately and therapy started with calcium, hyperventilation, glucose, and insulin. Plasma potassium concentration should be measured as soon as possible. Sudden unexpected cardiac arrest is not typically due to MH, but due to sudden rapid rhabdomyolysis.
- **Unexpected tachycardia, tachypnea and jaw muscle rigidity** (masseter spasm) are often common signs of MH that follow the significant CO_2 increase.
- **Respiratory and metabolic acidosis** usually indicates fulminant MH. However, metabolic acidosis is not always present prior to severe temperature increase.
  - A specific sign of the MH syndrome is **body rigidity** (i.e., limbs, abdomen and chest). When there is a suspicion of MH, attempts should be made to determine if muscle rigidity is also present.

- **Temperature elevation** usually follows the appearance of other signs of MH. Temperature change during MH is best detected by core temperature measurement (tympanic, naso- or oropharyngeal, esophageal, rectal, or pulmonary artery). Forehead skin temperature is less acceptable; it is slower in reflecting changes in core temperature and could be influenced by peripheral vasoconstriction. **MHAUS recommends that core temperature be measured whenever general anesthesia is administered for procedures lasting more than 30 minutes.**
- **Postoperative rhabdomyolysis** without intraoperative signs of MH should be treated with hydration, mannitol and bicarbonate. Plasma potassium concentration should be measured immediately or as soon as possible. The patient should be referred to a neurologist and to an MH testing center to evaluate occult myopathy and determine the need for evaluation of MH susceptibility.

Drugs and Malignant Hyperthermia:

- **All volatile inhalation anesthetics (Halothane, Enflurane, Isoflurane, Desflurane, Sevoflurane) and Succinylcholine are MH triggers.** Nitrous oxide is not a trigger.
- **DO NOT ADMINISTER** calcium channel blockers when Dantrolene has been given since it may increase the risk for hyperkalemia and subsequent cardiac arrest.
- All other currently used anesthetics and life-support drugs are considered safe.

PROTOCOL: MALIGNANT HYPERTHEMIA RESPONSE

I. Criteria for suspecting MH and Hospital Locations where MH may occur:

A. Suspect MH if one or more of the following criteria are present:

1. Unanticipated increase (e.g., doubling or tripling) of end-tidal CO_2 when minute ventilation is kept constant
2. Unexpected cardiac arrest
3. Unexpected tachycardia, tachypnea, jaw muscle rigidity (masseter spasm)
4. Respiratory and metabolic acidosis
5. Body rigidity (i.e., limbs, abdomen and chest)
6. Temperature elevation
7. Postoperative rhabdomyolysis

B. MH may occur in the following hospital locations:

1. Operating Room (including OB OR) – Primary site: MH may occur at any time during or emerging from anesthesia, including in the immediate post-operative period
2. Post Anesthesia Care Unit (PACU)
3. Emergency Department (ED)
4. MH can occur anywhere in the hospital where patients require emergency intubation with succinylcholine or in other departments that use inhaled anesthetics for procedures (i.e., IR, GI, ICU)
5. **If the patient experiences MH outside of the OR area, immediately transport the patient**

to the OR for appropriate care. The Anesthesia D1 to assign the specific OR treatment room. For patients already in the ICU, the ICU Attending and Anesthesia D1 will decide whether to treat the patient in the OR or ICU.

II. Staff/Service Roles during an MH Crisis

A. ANESTHESIA

1. Recognize and diagnose MH
2. Immediately discontinue volatile anesthetics or succinylcholine upon diagnosis
3. Start TIVA (Total Intravenous Anesthesia), if anesthesia is required
4. Hyperventilate patient at 2-3 times predicted minute ventilation with 100% oxygen.
5. FiO_2 1.0 at 10 L/min. Keep the circuit system, absorber and ventilation machine.
6. Activate the MH response system by obtaining the MH Cart, clearly designating roles and responsibilities and ensuring closed loop communication
    a. Designate an anesthesia technician to obtain the MH Cart from the Anesthesia Workroom (VOIP phone 31022)
    b. Page the Anesthesia D1 during the day or Anesthesia Night Attending at night to assign an anesthesiologist to be the team leader of the MH response (VOIP phone 30001)
    c. Inform surgeons of an MH emergency and coordinate the most expeditious surgical plan to finish the surgical procedure
7. Administer Dantrolene Sodium 2.5 mg/kg by rapid IV bolus
    a. Designate an anesthesia attending, resident, CRNA, nurse, and/or pharmacist to reconstitute the Dantrolene (designate multiple team members solely for Dantrolene reconstitution, as the process is time intensive).
    b. Reconstitute each 20 mg vial of Dantrolene with 60 mL Sterile Water for Injection. Shake the vial until the solution is clear. The resulting solution contains 20 mg of Dantrolene and 3gm of Mannitol
    c. Designate one provider to administer Dantrolene via rapid IV push.
    d. DO NOT use 5% Dextrose Injection, 0.9% Sodium Chloride Injection or other acidic solutions since it is not compatible with Dantrolene
    e. DO NOT transfer Dantrolene to large glass bottles for prophylactic infusion due to precipitate formation observed with the use of some glass bottles as reservoirs
    f. The contents of the vial must be protected from direct light and used within 6 hours after

Commented [AA45]: Is this the recommended workflow? Would we take someone from PACU into an actual OR?

reconstitution. Store reconstituted solutions at controlled room temperature (59°F to 86°F or 15°C to 30°C)

8. Repeat Dantrolene administration as often as necessary
    a. Titrate to control clinical signs of MH to a total dose of 10 mg/kg. Note that in some patients, up to 30 mg/kg may be required
    b. Dantrolene sodium does not produce significant cardiac or pulmonary complications when administered acutely. **Therefore, there is little harm in administering Dantrolene where MH is suspected, but not yet proven**
9. Team Leader of MH Response will designate the following roles and use the MH Checklist as a guideline for management:
    a. An anesthesia provider to manage the patient's ventilation and anesthesia
    b. A circulating RN as lead nurse to call for help, activate the MH response system and delegate responsibilities to other nurses and techs
    c. An anesthesia provider or CRNA to record the events during the MH crisis on the MH Flowsheet
    d. An anesthesia care provider to insert an arterial line and additional large bore IV access, if not already present
    e. An anesthesia provider or RN to administer medications
    f. An anesthesia technician to obtain the following (VOIP phone 31022)
        i. Refrigerated items from the anesthesia workroom (i.e., 1L IV Plasmalyte x 3 bags, 3L NS for Irrigation x 1 bag, Regular Insulin 10mL vial with NS 100 mL IV Bag x 1 kit)
        ii. Crash Cart
        iii. Other supplies (i.e., syringe pump, spiked IV, triple lumen CVC, A-line sets)
10. Call the MH hotline **1-800-MH-HYPER (1-800-644-9737)** as needed for consultation to help with patient management
11. Perform and monitor the following laboratory tests and studies
    a. Arterial Blood Gas
    b. Basic Metabolic Panel, LDH, Thyroid Studies (TSH, Free T4, Free T3)
        i. Avoid parenteral potassium, if possible, during ongoing rhabdomyolysis
        ii. Following control of the acute episode, persistent hypokalemia may be treated with careful

monitoring of the serum potassium level.

c. Creatine Kinase (CK): Measure CKs every 6 hours until decreased
   i. CK may remain elevated for 2 weeks if event was severe
   ii. After the patient has improved and stabilized, CK should be measured on a declining time basis until it is normal (e.g., every 4 hours during the acute episode to every week during convalescence)
   iii. Monitoring is important because CK is elevated normally in some myopathies, and should be recognized as a part of overall evaluation and treatment
d. Coagulation profile (PT/INR, PTT, Fibrinogen, D-Dimer, Lactate) – Disseminated intravascular coagulation (DIC) may occur
e. CBC, Platelets, Serum Myoglobin
f. Urine Hemoglobin and Myoglobin, Urinalysis
g. EKG

12. Monitor core temperature and treat for hyperthermia
   a. If hyperthermic or core temperature rises rapidly, cool the subject using one or more of the following modalities:
      i. Cold IV Plasmalyte-148
      ii. Cold Sodium Chloride 0.9% for Irrigation via lavage of NG, bladder, rectum and/or open cavities
      iii. Ice packs for external surface cooling
      iv. Consider calling the SICU (x69954) for intracool catheters and/or cooling blankets
   b. Cease cooling efforts when temperature has fallen to 38°C
13. Monitor and treat other conditions that can occur (e.g., acidosis, hyperkalemia, dysrhythmias, and myoglobinuria)
   a. Monitor arterial blood gases and treat acidosis if not promptly reversed by Dantrolene administration
      i. Sodium Bicarbonate (8.4%) IV at initial dose of 1-2mEq/kg
      ii. Or may titrate based on base deficit: Give 0.3 x weight (kg) x base deficit
      iii. Ensure adequate minute ventilation to avoid paradoxical intracellular acidosis and continue to monitor ABGs

b. Monitor serum K^+ and EKG and treat for hyperkalemia (peaked T-waves, widened QRS, QT and PR prolongation, wide complex ventricular tachycardia)
   i. Treat cardiac arrhythmias associated with hyperkalemia
      (i) Calcium Chloride (10%) IV 10 mg/kg
      (ii) Monitor serum K^+ and ionized Ca^{++}
      (iii) Avoid calcium channel blockers
   ii. Treat hyperkalemia
      (i) Sodium Bicarbonate (above)
      (ii) Regular Insulin IV bolus 0.15 units/kg (or 10 units).
         (a) Insulin is co

nsidered a **"High Alert"** medication. Assuch, two providers must double

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se.

(iii) Follow Insulin with Dextrose 50% IV bolus 1 mL/kg. Monitor serum glucose.

c. Monitor and treat for dysrhythmias

ii. Usually responds to treatment of acidosis and hyperkalemia by hyperventilation, Dantrolene, Sodium Bicarbonate, and Calcium Chloride (see above)

iii. Treat dysrhythmias using ACLS algorithms and crash cart

14. Place or confirm foley catheter. Monitor urine output

a. Ensure urine output of at least 2 mL/kg/hr by hydration and diuretics to minimize myoglobinuria

b. Hydrate aggressively (may require CVP monitoring). Avoid potassium containing solutions that contain **more than** 5 mEq/L of potassium

c. Diuresis with Furosemide 0.5-1 mg/kg IVP

d. Additional Mannitol is not usually necessary since 1 vial of Dantrolene contains 3gms of Mannitol

15. Once patient stabilized, transport to the ICU and provide detailed handoff to ICU team

a. Continue intravenous Dantrolene for at least 24 hours after control of the episode (approximately 1 mg/kg every 6 hours either by IV bolus or infusion)

b. Watch for recrudescence and monitor core temperature by appropriate monitoring in an ICU for at least 24 hours

i. May reoccur in about 25% of MH cases.

ii. Greatest risk in muscular patients or who have received an anesthetic for at least 150 minutes prior to MH symptoms.

16. Report the event to MHAUS

a. Submit a confidential Adverse Metabolic or Muscular Reaction to Anesthesia (AMRA) report for patients who have had acute MH episodes to the **North American MH Registry of MHAUS** (see www.mhreg.org)

b. Have the patient call **1-888-274-7899** to add their name to the North

American MH Registry Database

17. Refer patients and families to MHAUS for information on the disease

B. NURSING

1. Designate circulating RN of the case as lead nurse to delegate responsibilities to other nursing staff
2. Active the MH response system by calling the OR Front Desk (x68134) to have them:
    a. Overhead page the OR to request for adequate help in the MH crisis
    b. (Dial 68134)
    c. Call PACU (x68127) to bring 4 large plastic bags of ice to the MH crisis
    d. Page the AOD (63519) to arrange for ICU disposition
    e. Call the OR Pharmacy (x60242) to request other medications as needed
3. Reconstitute and administer Dantrolene
4. Prepare and administer other emergency medications as directed by the MH Lead
5. Obtain blood or urine for laboratory tests ordered
6. Assist in cooling the patient as directed by the MH Lead

C. SURGERY

1. Assess and coordinate the most expeditious surgical plan to finish the surgical procedure (e.g., close the wound, complete the procedure, modify the procedure)
2. Assist in cooling the patient using the specified methods
3. Assist with any other activities as directed by the MH Lead

D. ANESTHESIA TECHNICIANS

1. Bring the MH Treatment cart to the OR suite
2. Bring the Crash Cart to the OR suite
3. Bring refrigerated items from the anesthesia workroom refrigerator to the OR suite
    a. 3 bags of cold 1L IV Plasmalyte
    b. 1 bag of cold 3L NS for Irrigation
    c. Regular Insulin 100units/mL 10 mL vial with NS 100 mL IV Bag
4. Bring a syringe pump, spiked IV, triple lumen CVC, and A-line sets to the OR suite
5. Set up, obtain and/or arrange other supplies and equipment as necessary
6. Restock the supplies in the MH cart upon conclusion of MH treatment in the OR

E. PHARMACY

1. Reconstitute Dantrolene
2. Prepare other emergency medications as directed by the MH Lead
3. Restock the medications in the MH cart upon conclusion of MH treatment in the OR

F. FRONT DESK PERSONNEL

1. Activate the MH response system and call for additional help (See Nursing Section)
2. Arrange for specimens to be sent to the laboratory
3. Obtain additional supplies as requested

G. PACU

1. Bring 4 large plastic bags filled with ice to the OR suite
2. Offer other assistance to the OR team

H. ADMINISTRATOR ON DUTY (AOD)

1. Arrange for ICU disposition post treatment
2. Offer other assistance to the OR team

III. Documentation

A. Document MH Response Events on the MH Response Flow Sheet (see Appendix H1)

B. Documentation of the response to the event will be placed in the patient's medical chart

C. Report event to MHAUS via a confidential Adverse Metabolic or Muscular Reaction to Anesthesia (AMRA) Report to the North American MH Registry of MHAUS

IV. Maintenance of the Malignant Hyperthermia Cart

A. A Malignant Hyperthermia Emergency Cart (MH Cart) will be maintained in the Anesthesia Workroom.

B. The MH Cart will be stocked with the drugs listed in Appendix H2 and the supplies listed in Appendix C as described in the body of this policy

C. The MH Cart will be secured with a tamper-evident seal

D. The MH Cart will have attached to it a list of the drugs contained within and the name and date of the drug that will expire first.

E. The MH Cart will have the Malignant Hyperthermia Policy attached

F. On establishment of the MH Cart, a pharmacist will verify the presence of all drugs and supplies listed in Appendix H2. The anesthesia technician will ensure the presence of all supplies listed in Appendix H3. The pharmacist will then seal the box with a tamper-evident seal and fill in the required information on the "Operating Room Malignant Hyperthermia Cart" form on the cart.

G. The cart will be checked by the pharmacist and anesthesia technician every 30 days, and after every deployment for integrity and outdating of contents. A record of such inspections will be recorded by the pharmacist and kept for at least three years in the pharmacy.

V. Resources

A. wwww.mhaus.org

B. Hirshey Dirksen SJ, Van Wicklin SA, Mashman DL, Neiderer P, Merritt, DR. Developing Effective Drills in Preparation for a Malignant Hyperthermia Crisis. AORN Journal 2013; 97(3): 329-353.

Appendix H1H1: MH Emergency Alert Signs

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

Appendix H1

Malignant Hyperthermia Emergency Alert

Malignant Hyperthermia (MH) is a rare life-threatening reaction that is most often triggered by the use of inhalation anesthetics or succinylcholine.

Early Warning Signs of MH
Muscle Rigidity Sinus Tachycardia Hyperthermia (rapid rise in core temperature) Hypercarbia (resistant to increasing minute ventilation)

What to do with Recognition of MH
Call both **30001** AND **31022** to announce "Malignant Hyperthermia Emergency" and provide exact Patient Location

Response to MH Emergency Alert
Anesthesia will bring MH Cart and Cooling Supplies

(Anesthesia Policy 10.0 Malignant Hyperthermia Response 2022-07)

Appendix H2

Malignant Hyperthermia Response: Dantrolene Dosage Chart

Dose:	**Dantrolene 2.5 mg/kg per dose via rapid IV push**
	Repeat dose until symptoms subside (up to 10-30 mg/kg)
Dilution:	Use 5 mL Sterile Water for Injection to dilute each 250 mg vial of Dantrolene
	Final Concentration 50 mg/mL

Patient's Weight in Kilograms (kg)	# of Dantrolene 250 mg vials Needed	Total Dose Needed (mg)	Volume to Administer (mL)	Patient's Weight in Pounds (lbs)
5 kg	1 vial	12.5 mg	0.25 mL	**11** lbs
10 kg	1 vial	25 mg	0.5 mL	**22** lbs
15 kg	1 vial	37.5 mg	0.75 mL	**33** lbs
20 kg	1 vial	50 mg	1 mL	**44** lbs
25 kg	1 vial	62.5 mg	1.25 mL	**55** lbs
30 kg	1 vial	75 mg	1.5 mL	**66** lbs
35 kg	1 vial	87.5 mg	1.75 mL	**77** lbs
40 kg	1 vial	100 mg	2 mL	**88** lbs
45 kg	1 vial	112.5 mg	2.25 mL	**99** lbs
50 kg	1 vial	125 mg	2.5 mL	**110** lbs
55 kg	1 vial	137.5 mg	2.75 mL	**121** lbs
60 kg	1 vial	150 mg	3 mL	**132** lbs
65 kg	1 vial	162.5 mg	3.25 mL	**143** lbs
70 kg	1 vial	175 mg	3.5 mL	**154** lbs
75 kg	1 vial	187.5 mg	3.75 mL	**165** lbs
80 kg	1 vial	200 mg	4 mL	**176** lbs
85 kg	1 vial	212.5 mg	4.25 mL	**187** lbs
90 kg	1 vial	225 mg	4.5 mL	**198** lbs
95 kg	1 vial	237.5 mg	4.75 mL	**209** lbs
100 kg	1 vial	250 mg	5 mL	**220** lbs
105 kg	2 vials	262.5 mg	5.25 mL	**231** lbs
110 kg	2 vials	275 mg	5.5 mL	**242** lbs
115 kg	2 vials	287.5 mg	5.75 mL	**253** lbs
120 kg	2 vials	300 mg	6 mL	**264** lbs
125 kg	2 vials	312.5 mg	6.25 mL	**275** lbs
130 kg	2 vials	325 mg	6.5 mL	**286** lbs
135 kg	2 vials	337.5 mg	6.75 mL	**297** lbs
140 kg	2 vials	350 mg	7 mL	**308** lbs
145 kg	2 vials	362.5 mg	7.25 mL	**319** lbs
150 kg	2 vials	375 mg	7.5 mL	**330** lbs

Call OR Pharmacy x60242 or Inpatient Pharmacy x60275 if more Dantrolene vials are needed

MH Cart Contains #3 Medication Draw Up Kits:
Dantrolene (Ryanodex) 250 mg vial + Sterile Water for Injection 10 mL vial
Syringe 10 mL, Vented Spike, Blunt Fill Needle, Red Syringe Cap

Revised 2-2018

Reviewed 4/2023

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue, San Francisco, CA 94110

Appendix H3: Malignant Hyperthermia Response Flowsheet

Date:	Patient Name / MRN:	Location/Room Number:	Anesthesia Provider(s):	Recorder (Anesthesia/CRNA):
Time:	**Medications Used During Case (circle all that apply):** Succinylcholine / Desflurane / Isoflurane / Sevoflurane	Patient's Weight (kg)	Surgery Provider(s):	RN(s):

Intervention	Time
1. ☐ **Discontinue Triggers** (succinylcholine, inhaled anesthetics) 2. ☐ **Start TIVA** (Total Intravenous Anesthesia), if anesthesia required 3. ☐ **Hyperventilate at 2-3 times of the Predicted Minute Ventilation** (goal is to achieve normocapnia) 4. ☐ **FiO2 1.0 at 10 L/min.** Keep circuit, absorber and ventilation machine.	
5. **Obtain MH Cart / Call for Help / Inform OR Team** ☐ Designate **Anesthesia Technician to obtain MH Cart** "Anes Warm" or "6G" *(VOIP Phone 31022)* ☐ **Call the Anesthesia D1** or Anesthesia Night Attending *(VOIP Phone 30001)* ☐ D1 to designate an Anesthesiologist as **Team Leader** ☐ **Inform Surgeons** of MH emergency and to coordinate the most expeditious surgical plan to finish the surgical procedure	
6. **Treat MH using Dantrolene *Stocked in the MH Cart*** ☐ Team Leader to assign one team member to reconstitute Dantrolene ☐ Dilute only 5 mL Sterile Water for Injection in each 250 mg Dantrolene vial (i.e., a 75 kg patient will need 1 vial Dantrolene per dose) ☐ Designate one provider to administer Dantrolene via rapid IV Push ☐ **Administer Dantrolene 2.5 mg/kg per dose rapid IV Push** "MH Cart" **Repeat Dose until Symptoms Subside** (up to 10-30 mg/kg)	Med/Dose/Time:
7. **Team Leader to Designate Other Roles and Responsibilities** ☐ Designate an **Anesthesia Provider to manage vent and anesthesia** ☐ Designate **Circulating RN as Lead Nurse**. Lead RN to delegate RN duties and to **call OR Front Desk** *(x68134)* to notify the following: ☐ **Overhead Page OR** to request help in MH crisis *(x68134)* ☐ **Call PACU** *(x68127)* to bring 4 large plastic bags of ice ☐ **Call the AOD** *(x63519)* to arrange for ICU disposition ☐ **Call OR Pharmacy** *(x60242)* to request meds as needed ☐ Designate an **Anesthesia Provider or CRNA to record the events** during the MH crisis on the MH Flowsheet "MH Cart" ☐ Designate a **Provider to insert lines**, if not already present (arterial line, additional large bore IV access) ☐ Designate a separate **Provider to administer medications** ☐ Designate an **Anesthesia Technician to obtain** *(VOIP Phone 31022)*: **From the Anesthesia Workroom** ☐ Syringe Pump, Spiked IV, Triple Lumen CVC, A-line Sets **From Fridge in Main OR Anesthesia Workroom or 6G Med Room** ☐ 1L IV Plasmalyte x 3 bags ☐ 3L NS for Irrigation x 1 bag ☐ Regular Insulin 1 unit/mL 100 mL Premixed x 1 bag (or Regular Insulin 10 mL vial and NS 100 mL IV Bag x 1 kit) **From the Nearest Available Location** ☐ Crash Cart	

Intervention	Time
8. ☐ **Call MH Hotline** *(1-800-644-9737)* for additional help, as needed	
9. **Obtain and Monitor Labs and Studies** "sample lab sheets in MH Cart: Blood, Urine Labs" ☐ **ABG Kit:** ABG ☐ **Light Blue:** PT/INR, PTT, Fibrinogen, D-Dimer ☐ **Gold Gel:** Basic Metabolic Panel, CK, LDH, Serum Myoglobin, Thyroid Studies (TSH, Free T4, Free T3) ☐ **Lavender:** CBC, Platelets ☐ **Grey:** Lactate ☐ **Urine Dipstick / Collection Cup:** Hemoglobin / Myoglobin, UA ☐ **Other Monitoring Equipment:** EKG, Core Temperature, TEG	Result/Time:
10. **Cool Patient to Goal Temp of 38°C** using one or more methods: ☐ Cold Plasmalyte IV "Anes Workroom Fridge" or "6G Med Room Fridge 6G10" ☐ Cold Sodium Chloride 0.9% for Irrigation via nasogastric, bladder, rectal and/or open cavity lavage "Anes Workroom Fridge" or "4G Med Room Fridge 6G10" ☐ Ice for external surface cooling "PACU" or "6G Kitchen 606" ☐ Consider calling SICU *(x69954)* for intravenous cooling catheter and/or cooling blanket	
11. **Treat Acidosis** (if not reversed by Dantrolene administration) ☐ Sodium Bicarbonate 8.4% 1-2 mEq/kg IV (MHAUS recs max 50 mEq/dose) "Crash Cart" ☐ Ensure adequate minute ventilation	Med/Dose/Time:
12. **Treat Hyperkalemia and Associated Dysrhythmias** ☐ Calcium Chloride 10% 10 mg/kg IV (MHAUS recs max 2000 mg/dose) "Crash Cart" **Avoid Calcium Channel Blockers** ☐ Sodium Bicarbonate (above) "Crash Cart" ☐ Regular Insulin 10 units IV (or 0.1 units/kg IV for pediatric patients) "Anes Warm Fridge" or "6G Med Room Fridge 6G10" ***HIGH ALERT / TWO PROVIDERS MUST DOUBLE CHECK INSULIN*** *If Insulin 1 unit/mL 100 mL Premixed Bag not available, preparation instructions*: Dilute Reg Insulin 1 mL (= 100 units) in a 100 mL NS Bag (Final Conc = 1 unit/mL), then give Insulin 10 mL = 10 units IV ☐ Dextrose 50% IV 50 mL (or 1 mL/kg for pediatric patients) "Crash Cart" ☐ Monitor glucose levels hourly ☐ Treat dysrhythmias using ACLS algorithms "Crash Cart"	Med/Dose/Time:
13. ☐ **Assign Nurse to Place or Confirm Foley. Monitor Urine Output** ☐ Aggressive hydration. Ensure UO of at least 2 mL/kg/hr. ☐ If myoglobinuria, Sodium Bicarbonate 1 mEq/kg/hr IV Infusion "Pharmacy" ☐ Consider diuresis with Furosemide 0.5-1 mg/kg IV Push "Anes Workroom Omnicell" or "6G Omnicell"	Med/Dose/Time:
14. ☐ **Transport to ICU** (and continue Dantrolene 1 mg/kg IV Push q6h)	

For more detailed information, see MH Staff and Service Roles (Appendix H4A)

Rev: 4/2023

Appendix H4A: Staff/Service Roles during an MH Crisis (Detailed)

A. ANESTHESIA

1. Recognize and diagnose MH
2. Immediately discontinue volatile anesthetics or succinylcholine upon diagnosis
3. Start TIVA (Total Intravenous Anesthesia), if anesthesia is required
4. Hyperventilate patient at 2-3 times of the predicted minute ventilation with 100% oxygen with the goal to achieve normocapnia.
5. FiO_2 1.0 at 10 L/min. Keep the circuit system, absorber and ventilation machine.
6. Activate the MH response system by obtaining the MH Cart, clearly designating roles and responsibilities and ensuring closed loop communication
    a. Designate an anesthesia technician to obtain the MH Cart from the Anesthesia Workroom or 6G (VOIP phone 31022)
    b. Call the Anesthesia D1 during the day or Anesthesia Night Attending at night to assign an anesthesiologist to be the Team Leader of the MH response (VOIP phone 30001)
    c. Inform surgeons of an MH emergency and coordinate the most expeditious surgical plan to finish the surgical procedure
7. Treat MH using Dantrolene *Stocked in the MH Cart*
    a. Team Leader to designate an anesthesia attending, resident, CRNA, nurse, and/or pharmacist to reconstitute the Dantrolene
    b. Reconstitute each 250 mg vial of Dantrolene with 5 mL Sterile Water for Injection. Shake the vial to ensure the suspension is a uniform orange color. The resulting solution contains 250 mg of Dantrolene and 125 mg of Mannitol
    c. Designate one provider to administer Dantrolene via rapid IV Push.
    d. Administer Dantrolene Sodium 2.5 mg/kg by rapid IV push
    e. DO NOT use 5% Dextrose Injection, 0.9% Sodium Chloride Injection or other acidic solutions since it is not compatible with Dantrolene
    f. The contents of the vial must be used within 6 hours after reconstitution. Store reconstituted solutions at controlled room temperature (68°F to 77°F or 20°C to 25°C)
    g. DO NOT transfer Dantrolene to another container to infuse the product. Per package insert, administer the reconstituted Dantrolene suspension either:
        a. Into the intravenous catheter while an IV infusion of 0.9% Sodium Chloride Injection or 5% Dextrose Injection is freely running, or
        b. Into the indwelling catheter – after assuring its patency – without a freely running infusion. Flush the line to assure that there is no residual Dantrolene remaining in the catheter.
8. Repeat Dantrolene administration as necessary to control clinical signs of MH up to a total dose of 10 mg/kg.
    a. Note that in some patients, up to 30 mg/kg may be required
    b. Dantrolene sodium does not produce significant cardiac or pulmonary complications when administered acutely. **Therefore, there is little harm in administering Dantrolene where MH is suspected, but not yet proven**

9. Team Leader of MH Response will designate the following roles and use the MH Checklist as a guideline for management:

a. An anesthesia provider to manage the patient's ventilation and anesthesia
b. A circulating RN as Lead Nurse to call for help, activate the MH response system and delegate responsibilities to other nurses and assistant members of the OR team
c. An anesthesia provider or CRNA to record the events during the MH crisis on the MH Flowsheet
d. An anesthesia care provider to insert an arterial line and additional large bore IV access, if not already present
e. An anesthesia provider or RN to administer medications
f. An anesthesia technician to obtain the following (VOIP phone 31022)
    i. Refrigerated items from the Anesthesia Workroom Fridge or 6G Med Room Fridge (i.e., 1L IV Plasmalyte x 3 bags, 3L NS for Irrigation x 1 bag, Regular Insulin Premixed Bag or Kit x 1)
    ii. Crash Cart
    iii. Other supplies (i.e., syringe pump, spiked IV, triple lumen CVC, A-line sets)

10. Call the MH hotline **1-800-MH-HYPER (1-800-644-9737)** as needed for consultation to help with patient management
11. Perform and monitor the following laboratory tests and studies
    a. Arterial Blood Gas
    b. Basic Metabolic Panel, LDH, Thyroid Studies (TSH, Free T4, Free T3)
        i. Avoid parenteral potassium, if possible, during ongoing rhabdomyolysis
        ii. Following control of the acute episode, persistent hypokalemia may be treated with careful monitoring of the serum potassium level.
    c. Creatine Kinase (CK): Measure CKs every 6 hours until decreased
        i. CK may remain elevated for 2 weeks if event was severe
        ii. After the patient has improved and stabilized, CK should be measured on a declining time basis until it is normal (e.g., every 4 hours during the acute episode to every week during convalescence)
        iii. Monitoring is important because CK is elevated normally in some myopathies, and should be recognized as a part of overall evaluation and treatment
    d. Coagulation profile (PT/INR, PTT, Fibrinogen, D-Dimer, Lactate) – Disseminated intravascular coagulation (DIC) may occur. Consider running a TEG sample.
    e. CBC, Platelets, Serum Myoglobin
    f. Urine Hemoglobin and Myoglobin, Urinalysis
    g. EKG
12. Monitor core temperature and treat for hyperthermia
    a. If hyperthermic or core temperature rises rapidly, cool the subject using one or more of the following modalities:
        i. Cold IV Plasmalyte
        ii. Cold Sodium Chloride 0.9% for Irrigation via lavage of NG, bladder, rectum and/or open cavities
        iii. Ice packs for external surface cooling
        iv. Consider calling the SICU (x69954) for intravenous cooling catheters and/or cooling blankets
    b. Cease cooling efforts when temperature has fallen to 38°C
13. Monitor and treat other conditions that can occur (e.g., acidosis, hyperkalemia, dysrhythmias,

and myoglobinuria)

a. Monitor arterial blood gases and treat acidosis if not promptly reversed by Dantrolene administration
   i. Sodium Bicarbonate (8.4%) at initial dose of 1-2mEq/kg IV (MHAUS recommends a maximum of 50 mEq per dose)
   ii. Or may titrate based on base deficit: Give 0.3 x weight (kg) x base deficit
   iii. Ensure adequate minute ventilation to avoid paradoxical intracellular acidosis and continue to monitor ABGs

b. Monitor serum K^+ and EKG and treat for hyperkalemia (peaked T-waves, widened QRS, QT and PR prolongation, wide complex ventricular tachycardia)
   i. Treat cardiac arrhythmias associated with hyperkalemia
      (i) Calcium Chloride (10%) 10 mg/kg IV (MHAUS recommends a maximum of 2000 mg per dose)
      (ii) Monitor serum K^+ and ionized Ca^{++}
      (iii) Avoid calcium channel blockers
   ii. Treat hyperkalemia
      (i) Sodium Bicarbonate (above)
      (ii) Regular Insulin 10 units IV (or 0.1 units/kg IV for pediatric patients)
         (a) Insulin is considered a **"High Alert"** medication. As such, two providers must double check the dose prior to administration
         (b) *If Insulin 1 unit/mL 100 mL premixed bags are not available*, dilute 1 mL=100 units Regular Insulin into a 100 mL NS Bag (final concentration 1 unit/mL). Draw up 10 mL=10 unit dose.
      (iii) Follow Regular Insulin with Dextrose 50% 50 mL IV (or 1 mL/kg IV for pediatric patients).
      (iv) Monitor glucose levels hourly.
      (v) For refractory hyperkalemia, MHAUS recommends to consider using albuterol (or other beta-agonist), kayexelate, dialysis, or ECMO (if patient is in cardiac arrest).

c. Monitor and treat for dysrhythmias
   i. Usually responds to treatment of acidosis and hyperkalemia by hyperventilation, Dantrolene, Sodium Bicarbonate, and Calcium Chloride (see above)
   ii. Treat dysrhythmias using ACLS algorithms and crash cart

14. Assign nurse to place or confirm foley catheter. Monitor urine output
   a. Ensure urine output of at least 2 mL/kg/hr by hydration and diuretics to minimize myoglobinuria.
   b. MHAUS states if CK or potassium rise, assume myoglobinuria and give a sodium bicarbonate infusion of 1 mEq/kg/hr IV to alkalinize urine.
   c. Hydrate aggressively (may require CVP monitoring). Avoid potassium containing solutions that contain **more than** 5 mEq/L of potassium.
   d. Diuresis with Furosemide 0.5-1 mg/kg IV Push
15. Once patient stabilized, transport to the ICU and provide detailed handoff to ICU team
   a. Continue intravenous Dantrolene for at least 24 hours after control of the episode (approximately 1 mg/kg IV Push every 6 hours)
   b. Watch for recrudescence and monitor core temperature by appropriate monitoring in an

ICU for at least 24 hours

i. May reoccur in about 25% of MH cases.

ii. Greatest risk in muscular patients or who have received an anesthetic for at least 150 minutes prior to MH symptoms.

iii. Refer to MHAUS Post Acute Phase Management for further information

16. Document the MH event in the medical record and Report the event to MHAUS
    a. Add inhalation anesthetics (sevoflurane, desflurane, isoflurane) and succinylcholine to the patient's adverse drug reactions
    b. Document MH event in the medical record
    c. Submit a confidential Adverse Metabolic or Muscular Reaction to Anesthesia (AMRA) report for patients who have had acute MH episodes to the **North American MH Registry of MHAUS** http://anest.ufl.edu/namhr/
    d. Have the patient call **1-888-274-7899** to add their name to the North American MH Registry Database
    e. File a Patient DPH UO/SAFE Report and M&M Report
17. Refer patients and families to MHAUS for information on the disease

B. NURSING

1. Designate circulating RN of the case as Lead Nurse to delegate responsibilities to other nursing staff and other assistant OR team members
2. In discussion with the Team Leader, activate the MH response system by calling the OR Front Desk (x68134) to have them:
    a. Overhead page the OR to request for adequate help in the MH crisis (Dial x68134)
    b. Call PACU (x68127) or 6G (x68168) to bring 4 large plastic bags of ice to the MH crisis
    c. Call the AOD (x63519) to arrange for ICU disposition
    d. Call the OR Pharmacy (x60242) or Inpatient Pharmacy (x60275) to request other medications as needed
3. Reconstitute and administer Dantrolene, if assigned
4. Prepare and administer other emergency medications as directed by the MH Leader
5. Obtain blood or urine for laboratory tests ordered
6. Assist in cooling the patient as directed by the MH Leader
7. Place or confirm foley catheter as directed by the MH Leader

C. SURGERY

1. Assess and coordinate the most expeditious surgical plan to finish the surgical procedure (e.g., close the wound, complete the procedure, modify the procedure)
2. Assist in cooling the patient using the specified methods
3. Assist with any other activities as directed by the MH Team Leader

D. ANESTHESIA TECHNICIANS

1. Bring the MH Treatment Cart to the OR suite
2. Bring the Crash Cart to the OR suite
3. Bring refrigerated items from the Anesthesia Workroom Refrigerator or 6G Med Room

Refrigerator to the OR suite
a. 3 bags of cold 1L IV Plasmalyte
b. 1 bag of cold 3L NS for Irrigation
c. Regular Insulin 100 units/mL 10 mL vial and NS 100 mL IV Bag *(or Insulin 1 unit/mL 100 mL premixed bag, if available)*

4. Bring a syringe pump, spiked IV, triple lumen CVC, and A-line sets to the OR suite
5. Set up, obtain and/or arrange other supplies and equipment as necessary
6. Restock the supplies in the MH cart upon conclusion of MH treatment in the OR

E. PHARMACY

1. Reconstitute Dantrolene, if assigned
2. Prepare other emergency medications as directed by the MH Leader
3. Restock the medications in the MH cart upon conclusion of MH treatment in the OR

F. FRONT DESK PERSONNEL

1. Activate the MH response system and call for additional help (See Nursing Section)
2. Arrange for specimens to be sent to the laboratory
3. Obtain additional supplies as requested

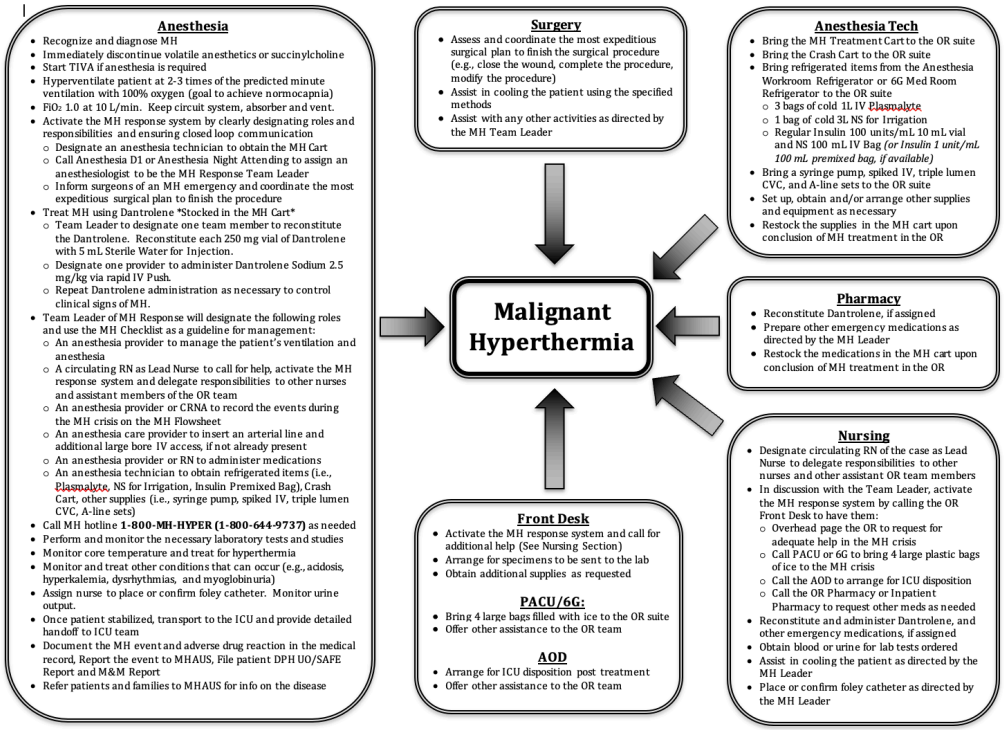
G. PACU (or 6G)

1. Bring 4 large plastic bags filled with ice to the OR suite
2. Offer other assistance to the OR team

H. ADMINISTRATOR ON DUTY (AOD)

1. Arrange for ICU disposition post treatment
2. Offer other assistance to the OR team

Appendix H4B: Staff/Service Roles during an MH Crisis (Diagram)



Rev: 4/2023

Appendix H5: List of MH Cart Drugs

Pharmacy Provided Medications and Fluids

A. Medications

1. Dantrolene (Ryanodex) 250 mg x 3 vials **(in MH Cart)**
   (dilute each 250 mg vial with 5 mL Sterile Water for Injection at the time of use).
2. Sterile Water for Injection (preservative free) 10 mL x 3 vials **(in MH Cart)**
3. Regular Insulin 1 unit/mL 100 mL premixed bag * **(in Refrigerator)**

B. Fluids

1. 1000 mL cold Plasmalyte IV x 3 bags **(in Refrigerator)**
2. 3000 mL cold Sodium Chloride 0.9% for Irrigation x 1 bag **(in Refrigerator)**

If Premixed Insulin Bag not available, Meds and Fluids needed to prepare an insulin bag:

- Regular Insulin 100 units/mL, 10 mL x 1 vial **(in Refrigerator)**
3. Sodium Chloride 0.9% 100 mL IV x 1 bag **(in Refrigerator)**
   (dilute Regular Insulin 100 units/1 mL in 100 mL NS Bag = Final Concentration of 1 unit/mL)

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Appendix H6: List of MH Cart Supplies and Equipment – Page 1

Anesthesia Provided Supplies

A. General Equipment/Nursing Supplies

- Toomy irrigation syringes (60 mL x 2) for NG irrigation
- Rectal tubes (sizes appropriate for your patient population) and collection bag
- Three-way irrigating foley catheters: (sizes appropriate for your patient population)
- Irrigation tray with piston syringe (x 1) for NG irrigation
- 5-in-1 Connector x 4
- Cysto/Bladder Irrigation Set 81" (2.1m) Regulating Clamp
- Large clear plastic bags for ice x 4
- Small plastic bags for ice x 4
- Bucket for ice

B. Monitoring Equipment

- All immediately available in anesthesia cart and pre-assembled in workroom

C. Laboratory Testing Supplies

- Needled-type ABG kits x 6
- Blood Specimen Tubes:
  - Gold Gel: Basic Metabolic Panel, CK, LDH, Thyroid Studies (TSH, Free T4, Free T3), Serum Myoglobin
  - Light Blue: PT/INR, PTT, Fibrinogen, D-Dimer
  - Grey: Lactate
  - Lavender: CBC, Platelets
- Chem Strips/Dipstick for Urinalysis: Urine Hemoglobin
- Urine Collection Container: UA, Urine Myoglobin

D. Documents (in each MH cart)

- Laboratory Request Forms: Blood/Serum Form x 2; Urinalysis Form x 2 (see prefilled example in Binder 2nd drawer)
- Adverse Metabolic Reaction to Anesthesia (AMRA) Form (obtain from MH Registry Website)
- MH Policy (Binder 3rd drawer)
- MH Intervention Checklist (Binder 2nd drawer)
- MH Response Flow Sheet to provide documentation of the crisis (Binder 2nd drawer)
- Malignant Hyperthermia Response: Dantrolene Dosage Chart (Binder 2nd drawer)

Appendix H6: List of MH Cart Supplies and Equipment – Page 2

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Pharmacy Provided Supplies

E. Medication Preparation

- Vented spikes x 3 spikes (to reconstitute Dantrolene)
- Syringes 10 mL luer lock x 3 syringes (to reconstitute Dantrolene)
- Blunt Fill Needles 18G x 3 (to reconstitute Dantrolene)
- Red syringe caps x 3 caps

**** If Premixed Insulin Bag not available, Supplies needed for use with insulin vials:***

- Syringe to dilute insulin: 1 mL x 1 syringe
- Syringe to draw up diluted insulin: 10 mL x 1 syringe
- Blunt Fill Needles 18G x 2 to draw up insulin

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~~**Date:**~~	~~**Patient Name / MRN:**~~	~~**Location/Room Number:**~~	~~**Anesthesia Provider(s):**~~	~~**Recorder (Anesthesia/CRNA):**~~
~~**Time:**~~	~~**Medications Used During Case (circle all that apply):**~~ ~~Succinylcholine / Desflurane / Isoflurane / Sevoflurane~~	~~**Patient's Weight (kg)**~~	~~**Surgery Provider(s):**~~	~~**RN(s):**~~

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Intervention	Time
1. ☐ Discontinue Triggers (succinylcholine, inhaled anesthetics) **2. ☐ Start TIVA** (Total Intravenous Anesthesia), if anesthesia required **3. ☐ Hyperventilate 2-3 Times Predicted Minute Ventilation** **4. ☐ FiO2 1.0 at 10 L/min.** Keep circuit, absorber and machine.	
5. Obtain MH Cart / Call for Help / Inform OR Team ☐ Designate **anesthesia technician to obtain MH Cart** *Anes Workroom* *(VOIP phone 31022)* ☐ **Page the Anesthesia D1** or Anesthesia Night Attending *(VOIP phone 30001)* ☐ D1 to designate an Anesthesiologist as **Team Leader** ☐ **Inform Surgeons** of MH emergency and to coordinate the most expeditious surgical plan to finish the surgical procedure	
6. ☐ Administer Dantrolene 2.5 mg/kg per dose IV Bolus *MH Cart* **Repeat Dose until Symptoms Subside** (up to 10-30 mg/kg) ☐ Dilute only 60 mL Sterile Water for Injection in each 20 mg Dantrolene vial (i.e., 75 kg patient = 9 vials Dantrolene per dose) ☐ Assign multiple team members to reconstitute Dantrolene ☐ Designate a provider to administer Dantrolene via IV push	**Med/Dose/Time:**
7. Team Leader to Designate Roles and Responsibilities ☐ Designate an anesthesia **provider to manage vent and anesthesia** ☐ Designate **circulating RN as Lead Nurse**. Lead RN to delegate RN duties and to **call OR Front Desk** *(x68134)* to notify the following: ☐ **Overhead Page OR** to request adequate help in MH crisis *(Dial 68134)* ☐ **Call PACU** *(x68127)* to bring 4 large plastic bags of ice ☐ **Page the AOD** *(63519)* to arrange for ICU disposition ☐ **Call OR Pharmacy** *(x60242)* to request meds as needed ☐ Designate an anesthesia **provider or CRNA to record the events** during the MH crisis on the MH Flowsheet *MH Cart* ☐ Designate a **provider to insert lines** (arterial line, additional large bore IV access), if not already present ☐ Designate a separate **provider to administer medications** ☐ Designate an **anesthesia technician to obtain**: **From the Anesthesia Workroom** *(phone 31022)* ☐ Syringe Pump, Spiked IV, Triple Lumen CVC, A-line Sets **From the Anesthesia Workroom Refrigerator** ☐ 1L IV Plasmalyte x 3 bags ☐ 3L NS for Irrigation x 1 bag ☐ Insulin 10 mL vial / NS 100 mL IV Bag x 1 kit **From the Nearest Available Location** ☐ Crash Cart	

Intervention	Time
8. ☐ Call MH Hotline *(1-800-644-9737)* for additional help, as needed	
9. Obtain and Monitor Labs and Studies *sample lab sheets in MH Cart* ☐ **ABG Kit:** ABG ☐ **Light Blue:** PT/INR, PTT, Fibrinogen, D-Dimer ☐ **Gold Gel:** Basic Metabolic Panel, CK, LDH, Serum Myoglobin, Thyroid Studies (TSH, Free T4, Free T3) ☐ **Lavender:** CBC, Platelets ☐ **Grey:** Lactate ☐ **Urine Dipstick / Collection Cup:** Hemoglobin / Myoglobin, UA ☐ **Monitoring Equipment:** EKG, Core Temperature	**Result/Time:**
10. Cool Patient to Goal Temp of 38°C using one or more methods: ☐ Cold Plasmalyte 148 IV *Anes Workroom Fridge* ☐ Cold Sodium Chloride 0.9% for Irrigation via nasogastric, bladder, rectal and/or open cavity lavage *Anes Workroom Fridge* ☐ Ice Packs for external surface cooling *PACU* ☐ Consider calling 4E ICU *(x69954)* for intracool catheter and/or cooling blanket	
11. Treat Acidosis (if not reversed by Dantrolene administration) ☐ Sodium Bicarbonate 8.4% IV 1-2 mEq/kg *Crash Cart* ☐ Ensure adequate minute ventilation	**Med/Dose/Time:**
12. Treat Hyperkalemia and Associated Dysrhythmias ☐ Calcium Chloride 10% IV 10 mg/kg *Crash Cart* **Avoid Calcium Channel Blockers** ☐ Sodium Bicarbonate (above) *Crash Cart* ☐ Insulin IV 0.15 units/kg (or 10 units) *Anes Workroom Fridge* ***HIGH ALERT / TWO PROVIDERS MUST DOUBLE CHECK*** Dilute Insulin 1 mL (= 100 units) in 100 mL NS Bag (Final Conc = 1 unit/mL), then give Insulin 10 mL = 10 units IV ☐ Dextrose 50% IV 1 mL/kg *Crash Cart* Monitor serum glucose. ☐ Treat dysrhythmias using ACLS algorithms *Crash Cart*	**Med/Dose/Time:**
13. ☐ Place or Confirm Foley to Monitor Urine Output ☐ Aggressive hydration. Ensure UO of at least 2 mL/kg/hr. ☐ Consider diuresis with Furosemide 0.5-1 mg/kg IVP *Omnicell*	**Med/Dose/Time:**
14. ☐ Transport to ICU (and continue Dantrolene 1 mg/kg IV q6h)	

Commented [AA46]: May want to change this to new formulation?

APPENDIX H2: List of MH Cart Drugs

A. Medications

1. Dantrolene Sodium for injection 20 mg x 36 vials (dilute each vial with 60 mL sterile water at the time of use).
2. Sterile Water for Injection USP (preservative free) 100 mL x 36 vials
3. Regular Insulin (100 units/mL) 10 mL x 1 vial **(in anesthesia workroom refrigerator)**

B. Fluids

1. Sodium Chloride 0.9% 100 mL IV x 1 bag (to dilute insulin to a 1 unit/mL concentration **(in anesthesia workroom refrigerator)**
2. 1L cold Plasmalyte-148 IV x 3 bags **(in anesthesia workroom refrigerator)**
3. 3L cold Sodium Chloride 0.9% for Irrigation x 1 bag **(in anesthesia workroom refrigerator)**

~~**APPENDIX H3: List of MH Cart Supplies and Equipment**~~

~~**A. General Equipment/Nursing Supplies**~~

1. ~~Toomy irrigation syringes (60 mL x 2) for NG irrigation~~
2. ~~Rectal tubes (sizes appropriate for your patient population) and collection bag~~
3. ~~Three-way irrigating foley catheters: (sizes appropriate for your patient population)~~
4. ~~Irrigation tray with piston syringe (x 1) for NG irrigation~~
5. ~~5-in-1 Connector x 4~~
6. ~~Cysto/Bladder Irrigation Set 81" (2.1m) Regulating Clamp~~
7. ~~Large clear plastic bags for ice x 4~~
8. ~~Small plastic bags for ice x 4~~
9. ~~Bucket for ice~~

~~**B. Medication Preparation**~~

1. ~~Vented spikes x 36 spikes (to reconstitute Dantrolene)~~
2. ~~Syringes 60 mL luer lock x 36 syringes (to reconstitute Dantrolene)~~
3. ~~Red syringe caps x 36 caps~~
4. ~~Syringes to draw up insulin: 1 mL x 1 syringe, 10 mL x 1 syringe~~
5. ~~Needles 18G x 4, 16G x 4 to draw up medications~~

~~**C. Monitoring Equipment**~~

1. ~~All immediately available in anesthesia cart and pre-assembled in workroom~~

~~**D. Laboratory Testing Supplies**~~

1. ~~Needled-type ABG kits x 6~~
2. ~~Blood Specimen Tubes:~~
    a. ~~Gold Gel: Basic Metabolic Panel, CK, LDH, Thyroid Studies (TSH, Free T4, Free T3), Serum Myoglobin~~
    b. ~~Light Blue: PT/INR, PTT, Fibrinogen, D-Dimer~~
    c. ~~Grey: Lactate~~
    d. ~~Lavender: CBC, Platelets~~
3. ~~Chem Strips/Dipstick for Urinalysis: Urine Hemoglobin~~
4. ~~Urine Collection Container: UA, Urine Myoglobin~~

~~**E. Documents**~~

1. ~~Physician Order Form x 2~~
2. ~~Laboratory Request Forms: Blood/Serum Form x 2; Urinalysis Form x 2 (see prefilled example on MH Cart)~~
3. ~~Adverse Metabolic Reaction to Anesthesia (AMRA) Report Form (obtain from MH Registry Website)~~
4. ~~MH Response Flow Sheet to provide documentation of the crisis (on MH Cart)~~
5. ~~MH Policy (posted on the outside of the MH Cart)~~
6. ~~MH Intervention Checklist (posted on the outside of the MH Cart)~~

APPENDIX I: Anesthesia Intubation Bags Policy and Procedure

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Title: **Anesthesia Intubation Bags Policy and Procedure**

Purpose: To establish Policy and Procedure defining the purpose, availability, maintenance, and restocking of anesthesia intubation bags that provide immediate availability of airway management tools to anesthesia personnel outside of the operating room and that are Title 22 and CMS compliant.

Policy: ~~Three~~ Four adult and one pediatric Anesthesia Intubation Bags will be maintained by the Department of Anesthesia.

Anesthesia personnel (faculty, resident or CRNA) will be responsible for stocking and maintaining the supplies of the Anesthesia Intubation Bags.

Pharmacy personnel will be responsible for stocking and sealing the medication (drug) boxes contained within the Anesthesia Intubation Bags. Oversight for establishing the contents and use of the drug boxes is the responsibility of the Director of Pharmacy or his/her designee.

Background: Anesthesiology staff are required to provide emergency airway management and resuscitative capabilities outside of the operating room. These services include: 1) airway management in the emergency department; 2) airway management in the Intensive Care Units; 3) responding to code blue calls throughout the hospital; and 4) transport of critically ill intubated patients to and from the ICU's and the operating room. These services require the immediate availability of drugs and equipment for induction of anesthesia, muscle relaxation, and resuscitation. The emergent nature of these services, and the fact that they may need to be provided in the elevators or in transit where such equipment might not be otherwise available, requires a portable bag containing the necessary drugs and equipment which can be carried by anesthesia personnel. Since these services may be required simultaneously at different locations throughout the hospital, four~~three~~ (~~3~~4) adult and one (1) pediatric Anesthesia Intubation Bags will be established and maintained. Each Anesthesia Intubation Bag will contain standardized medications and supplies. (See Appendix I 1& 2 1 for listing of medications and supplies). Since these bags must be immediately available and restocked 24 hours a day, pharmacy will provide all necessary drugs in a self-contained box sealed with a tamperproof seal that will be used to stock and restock the drug supply in the Anesthesia Intubation Bags.

Procedure:

1. Anesthesia stocking procedure

a. Anesthesia Intubation Bags will be stored in the OR.

b. The Anesthesia Intubation Bags have a list of supplies and medications contained within and the name and date of the first medication to expire located in a side pocket.

c. It is the responsibility of the "~~E4 (t~~Trauma~~)~~ anesthesia resident" to maintain and check the Anesthesia Intubation Bags Monday-Friday at the beginning of the morning shift. On Weekends, and on special dates where there is no trauma

anesthesia~~E4~~ resident, anesthesia faculty or CRNAs may be designated to complete this task.

d. The "D1-anesthesia faculty attending" is ultimately responsible to ensure completion of the maintenance and checking of the Anesthesia Intubation bags.

e. The maintenance and checking procedures are to be done every day at the beginning of the daytime shift.

f. The Anesthesia Intubation bags are to be opened and the entire contents removed. The bags are checked for cleanliness and that they are free of used or dirty equipment or supplies.

g. Anesthesia staff (defined above) will verify the presence of all contents listed in Appendix I 1 & 2 and ensure that sealed and sterile supplies are not damaged or open.

h. The Capnometer battery will be checked and replaced if it is low, before returning the device to the Bag.

i. A new sealed medication box will be checked for integrity and expiration date before placing in the Anesthesia Bag.

j. If the bags are opened and/or the contents used, the anesthesia provider will return to the Anesthesia workroom as soon as possible and the bag replenished by following items #e-i.

2. Pharmacy restocking procedure

a. Daily in the morning by no later than 8 AM, pharmacy staff will provide ten (10) drug boxes containing the medications listed on Attachment A sealed with a tamper evident seal.

b. The drug boxes will have a label on the outside listing the contents of the medications with the expiration date of the first drug to expire. A pharmacist will check the contents of the drug box for accuracy and seal the drug box with a red tamper evident seal. The seal serial number will be recorded on the label.

c. Anesthesia staff (defined above) will use the ~~pharmacy~~ pharmacy-prepared and sealed drug boxes to perform the AM restocking of the drug supply of the Anesthesia Intubation Bags by replacing the drug box contained within the Anesthesia Intubation Bag with a fresh drug box.

d. When a drug box is used during the day, the Anesthesia staff will replace the used drug box with a fresh drug box from the Anesthesia Workroom. Anesthesia staff will secure the used drug box in the Anesthesia workroom for pick up in the morning by pharmacy staff.

References: Pharmacy P&P 6:12 Anesthesia Intubation Bag replenishment
APPENDIX
I.1 Adult Code Bag Inventory
I.2 Pediatric Code Bag Inventory

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APPENDIX I.1 Adult Code Bag Inventory

ZSFG Anesthesia Code Bag Inventory
ADULT (Blue/Green/Purple/Orange)

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Hospital and Trauma Center

Main Compartment (zip lock tie required)
Pharmacy Drug Box
AmbuBag & Mask x1
Melker Cricothyrotomy Kit x 1

Netting pocket
10mLs Saline Flushes x2
20mLs Syringe & Mini-Spike x 2
Portable Monitor & Capnograph tubing

Lower compartment
Glide Rigid Stylet x1 Bougie x1

Red Airway Roll
MAC3/4 Miller 2/3 Disposable x1 each
RediTube Styleted ETT 6.0/7.0/7.5 x1 each
Oral Airway Red/Yellow/Green x1 each
Naal Airway 36Fr/32Fr/28Fr x1 each
Lube packet x 2
CMAC PM Screen (with battery)
CMAC D-Blade + Ped D-Blade
Needle Decompression device x2
10mLs syringe x2 Orange Tape

Left Net Pocket
AirQ LMA 3/4/5 x1 each
ETT Stabilizer Rod x 2
30mL syringe x1
Magills Forceps x1

Top Pocket
Anesthesia Procedure Note x4
Anesthesia Consent Form
(English/Spanish/Chinese) x2 each
Small ziplock bags x 4
Code Bag inventory (this sheet)

Right Net Pocket
EzIO Drill + 25 & 45mm needle
IV Start Kit x 2
18g/20g Braun Safe IV x 2 each
IV extension Tubing x2
10mL Saline Flush x2

Denali, Matterhorn, Shasta INVENTORY drug expiration _____ _____
date initial

Pharmacy Drug Box

Rocuronium PFS 50mg x2 Propofol 200mg x2 Etomidate PFS 40mg x1 Epinehprine PFS 1mg x2	Succinylcholine PFS 200mg x2 Ephedrine PFS 50mg x1 Phenylephrine PFS 1000mcg x2

Top Compartment in zippered compartment • 10ml Syringe x6 (in plastic bag) • 18G Needle x6 (in plastic bag) • drug label roll Pharmacy Drug Box Intubation Roll • ET tubes (6.0, 7.0, 7.5) • ETT 14 Fr stylet • Oral Airways (80, 90) • Nasal Airway (28, 32, 36 depending on availability) • 2x DISPOSABLE LARYNGOSCOPES: • Mac 3&4 2x each size • Miller 2&3 2 x each size • pink tape, 2x 10ml Syringes • 2x Spare plastic bags • Magill forceps	**Bottom Compartment** • Cricothyrotomy set • AirQ 3.5 & 4.5 (with ETT stylet) • 30ml syringe • Gum elastic bougie • Jackson Reese & large (blue ring) face mask **Left Lateral Compartment** • Capnograph • Capnograph sampling line • Spare plastic bags x2 **Right Lateral Compartment** • IO drill • IO needle 25mm (IN PLASTIC BAG) x2 • Procedure Forms x5 • Anesthesia Preop Form x2 • Anesthesia Consent x2 • Laminated SFGH Map & inventory list, signed

Commented [AA47]: Have these checklists been updated?

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APPENDIX I.2 Pediatric Code Bag Inventory

Potrero Hill (PEDIATRIC) INVENTORY drug expiration _____
Pharmacy Drug Box _____ date initial

Rocuronium PFS 50mg x2 Propofol 200mg x2 Etomidate PFS 40mg x1 Epinehprine PFS 1mg x2	Succinylcholine PFS 200mg x2 Ephedrine PFS 50mg x1 Phenylephrine PFS 1000mcg x2
Top Compartment in zippered compartment • 10ml Syringes x6 (in plastic bag) • 18G Needles x6 (in plastic bag) • drug label roll Pharmacy Drug Box Intubation Roll • ET tubes cuffed (3.0,3.5,4.0,4.5,5.0) • ET tubes UNcuffed (2.5,3.0,3.5,4.0) • ETT 14 Fr stylet & 6Fr stylet • Oral (50,60,70) & Nasal Airways (24,28) • 2x DISPOSABLE LARYNGOSCOPES each size: • MAC 1, 2, 3 2x each size • Miller 0,1, 2 2x each size • Pink tape, 2x 10ml syringes, 1x 3ml syringe • 2x Spare plastic bags • Pediatric Magill forceps	**Bottom Compartment** • Cricothyrotomy set • AirQ 1.0,1.5,2.5 (with pediatric ETT stylet) • 10ml syringe • Pediatric Ambu bag & Jackson Reese system • Breathing bags (0.5l, 1.0l) • Masks (neonate, infant, toddler, child) **Left Lateral Compartment** • Capnograph & sampling line • Spare plastic bags x2 **Right Lateral Compartment** • EZ IO power driver • IO needle (15mm & 25mm) (IN PLASTIC BAG) • Procedure Forms x5 • Anestehsia Preop Form x2 • Anesthesia Consent x2 • Laminated SFGH Map; Inventory list, signed

ZSFG Anesthesia Code Bag Inventory
PEDIATRIC Airway Box

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Hospital and Trauma Center

Main Compartment
AirQ LMA 1.5/2/2.5 x1 each
Pedi Jackson Rees 2L Bag
Face Mask – Toddler/Child x 1 each
Miller 0/1 x1 each
MAC2
CMAC Miller 1 (screen in adult bag)

Inside Lid
RediTube styleted ETT 5.0 x1
Cuffed ETT 3.0/4.0 x 1 each
Pedi semi-rigid stylet x1
10mLs syringe x2
5mLs syringe x1
Orange tape
Spare ziplock bags x2

Inside Zip Compartment	**Mesh Pocket**
Oral Airway white/purple/blue x 1 each 10mLs saline flush x2 22G/24G Braun Safe IV x2 each	EzIO 15mm Needle Pedi Magills Forcep IV Extension Tubing x2

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APPENDIX J: Trauma Operating Room Preparedness Policy and Procedure

Title: **Trauma Operating Room Preparedness Policy and Procedure**

Purpose: To establish Policy and Procedure defining the purpose, availability, & maintenance of anesthesia readiness of urgent trauma care at ZSFG, and which is compliant with TJC and other state and federal requirements.

Policy: 24 hrs/day, 7 days/week, the Department of Anesthesia at ZSFG provides immediate readiness of one operatingon room (OR) for accepting urgent, severe trauma care.

Anesthesia personnel (faculty, resident, CRNA, and anesthesia technicians) will be responsible for checking, maintaining and stocking all supplies necessary for this task in the designated Trauma Operating Room.

Oversight for establishing this Policy & Procedure is the responsibility of the Chief of Staff Anesthesia or his/her designee.

Background: ZSFG is a Level-1-Trauma center in the City & County of San Francisco and is therefore required to take care of severely injured patients at any time with short notice. The emergent nature of these services requires continuous maintenance of an open and prepared OR. The designated Trauma OR is usually OR#1. If this room is in use or not ready for any other reason, a back-up OR will immediately be designated and setup as described in this P&P.

In the OR, Anesthesia staff provide anesthesia, emergency airway management, IVi.v. resuscitation, and monitoring. These services require the immediate availability of all drugs and equipment necessary for induction of anesthesia, muscle relaxation, airway management, and resuscitation. In the designated Trauma OR, anesthesia personnel are responsible for:

(1) Readiness of the anesthesia machine according to the machine's built in self-test and checklist. This is performed every 24 hours at the beginning of the day.. This requires a complete check of the machine according to the ZSFG Machine Checklist (SEE APPENDIX G), performed every 24 hrs in the AM.

(2) Maintaining a fully stocked anesthesia cart containing all drugs & equipment.

(3) Medication preparedness requires that induction agents, vasoactive drugs and paralytic agents be in appropriately labeled syringes and ready at all times.

(4) Airway device preparedness.

(5) IV resuscitation preparedness of high flow infusion and transfusion systems as well as an invasive blood pressure monitoring device.

DETAILS OF (3)-(5) ARE DESCRIBED IN "OR#1 CHECKLIST", APPENDIX J1

Procedures:

1. It is the responsibility of the "D1-attending", together with the OR charge nurse, to ensure availability of a designated OR 24/7.
2. It is the responsibility of the "D1-attending" to ensure that this designated OR is prepared from an anesthesia perspective to receive a patient with no notice.
3. During regular weekdays, the "D1-attending" delegates the performance of all necessary tasks to the "trauma anesthesia~~E4-~~ resident". On Saturdays, or if for any other reason the "~~E4-~~trauma anesthesia resident" is not available, the "D1-attending" can delegate the tasks to any other resident, CRNA or faculty.
4. Regular checks of Trauma OR anesthesia preparedness are performed:
    a. Every morning between 7AM – 8AM
    b. If a back-up OR becomes designated as the Trauma OR
    c. Following every turn-over of OR#1
5. A complete check of the anesthesia machine is performed according to FDA regulations. ~~A checklist (Appendix G) is attached to the anesthesia machine.~~
6. Intubation equipment is available in the anesthesia cart. If endotracheal tubes (ETTs) are opened, they can be marked with their opening dates and are good for ~~Intubation Equipment is placed in a tray on the anesthesia machine. This includes two laryngoscope handles, which are exchanged daily between 7AM-8AM by anesthesia technicians; a Miller 2 and a Mac 3 blade are attached to the handles and tested. Additional blades in the airway tray include a Mil 3 and Mac 4. Two endotracheal tubes (ETT) size 7.0 & 7.5 with attached syringes and stylets complete the airway tray. ETTs are good for~~ 1 month after the package has been opened. ~~Opening dates are marked on the ETT packages.~~

    Commented [AA48]: We stopped doing this
7. The following emergency medications are either provided by pharmacy as pre-filled syringes or are drawn up daily between 7AM-8AM:
    a. Succinlycholine 200mg/10ml
    b. Phenylephrine 100mcg/ml in 10ml syringe (& a 90ml bag of normal saline)
    c. Ephedrine 50mg/10ml

    All drugs drawn up by anesthesia care providers are properly labeled, including concentrations, date, time and initials. They are good for 24 hrs.

    If syringes are opened to prepare for drawing up additional emergency medication, they must be dated, timed and initialed and are good for 24 hrs.
8. The Anesthesia cart is checked daily by anesthesia technicians for proper stocking. The designated anesthesia staff member double checks stocking of the cart and ensures that the cart is clean and free of equipment on top of the cart. IV and A-line starter kits are kept on top of tilt bins. The staff member ensures that the anesthesia cart is always locked when no anesthesia personal are in the room.
9. An A-line system is readily available daily.
10. An IV line system will be assembled connecting a hotline system (with extension tubing and 2 high-flow stopcocks) together with a Y-set ("blood pump"). The system is kept un-spiked, the hotline heater off, and the tubing endings off the floor. The system is dated, timed and initialed on

the remaining paper tape of the hotline system. Un-spiked, the system is good for 1 month, if spiked onto a fluid bag and/or hotline heater is on, the system is good for 24 hrs.

11. A Belmont infuser is kept in the room, plugged in and powered off. The infusion system should be left 'unspiked' (not connected to any IV fluid bags). The infusion system is dated, timed and initialed on the paper tape attached to the system. Un-spiked, the system is good for 1 month, if spiked the system is good for 24 hrs.
12. All crystalloid bags are to be kept unopened in their wrappers. If opened, they are dated, timed, and initialed and are good for 24 hrs.
13. After the room is used, all 'exposed' disposable supplies are disposed of. "Exposed" is anything that is not covered during patient care, including, but not limited to, open IV setups, open Belmont setups, etc. All exposed surfaces (e.g. the anesthesia machine, anesthesia cart, and anesthesia monitors) are sanitized with an FDA approved disinfectant or replaced with clean equipment.
14. A designated anesthesia staff member completes all tasks on the "OR #1 checklist", (Appendix J1).
15. Audits of the Trauma OR readiness are performed and recorded quarterly by the Chief of Service or the Director of Clinical Anesthesia. Irregularities are documented and planned actions described.

APPENDIX

J.1 ZSFG Anesthesia OR #1 Checklist

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OR 1 DAILY CHECKLIST

Anesthesia Machine
- Check per separate protocol

Intubation Tray
- Single Use laryngoscopes
- MAC 3&4 + Miller 2&3
- 7.0 & 7.5 ETT styleted, 10ml syringe attached, with exp date and initials (good for 30d)
- 90mm oral airway, 30Fr nasal airway, tongue depressor

Emergency Medication (2nd Drawer)
- 2* Etomidate 20mg (in vial with unopened 10ml syringe & needle)
- 1* Succinylcholine 200mg (prefilled)
- 2*Rocuronium 50mg (prefilled)
- 2* Phenylephrine 100mcg/ml (prefilled)
- 2* Ephedrine 5mg/ml (prefilled)

check all for expiration

A-line setup
- spiked, de-aired, zeroed, dated (exp) done daily by techs (good for 24h)

Belmont Rapid Infuser
- power plugged in
- tubing assembled with 3liter reservoir in line
- top 5 clamps clamped
- 250ml of NS hanging, not spiked
- Belmont extension tubing, packaged hanging on pole (for use with femoral lines only)

check for expiration date (good for 30d), if freshly assembled date with expiration

Anesthesia Mayo Stand
- A-line supplies
- 2*Arrow Arterial Line
- 2* 20g Angiocath
- 1* Arrow Guidewire
- Arm board, tegaderm, A-line sterile kit, chloroprep, 4x4s, 1"tape

Monitors
- ECG with pads ready on bed

OR Table
- Plugged in, "on", @ lowest position

Anesthesia carts
- 2 large bore iv start kits on top of anesthesia machine (2* 16G iv, 2* 14G iv, 4x4s, chloroprep, 1" tape, tourniquet, tegaderm) NO open/filled syringes
- 1 arterial line starting kit on top of anesthesia machine (arrow a-line, 2* 20G iv, 4x4s, chloroprep, 1" tape, tourniquet, tegaderm, arm board)
- ensure both carts are locked

General Rules for OR 1 readiness
- cart and drugs locked
- all items arranged according to markings on floor
- all fluid containing items are good for 24h (i.e. syringes, spiked bags)
- all air containing items are good for 30d (i.e. ETT, Belmont tubing)
- everything is to be labeled with the expiration date (NOT the date when opened/ prepared)

Turnover After Each Case
- OR 1 shall be turned over ASAP after each case (to be ready for the next patient)
- All "exposed" disposables are discarded
- All "exposed" surfaces are to be wiped down with H_2O_2 wipes
- "exposed" = all items & surfaces that are not covered during patient care (i.e. anesthesia machine, monitor, carts, Belmont etc.)

Sign off that check is complete on dedicated sign off sheet once daily

Commented [AA49]: Update with Sherry's checklist as well as online survey.

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APPENDIX K: Labor and Delivery Operating Room Preparedness Policy

Title: **Labor and Delivery Operating Room Preparedness Policy**

Purpose: To establish Policy and Procedure defining the purpose, availability, and maintenance of anesthesia readiness for urgent obstetric care at ZSFG that is compliant with TJC and other state and federal requirements.

Policy: 24 hrs/day, 7 days/week, the Department of Anesthesia at ZSFG provides immediate readiness of 2 Labor and Delivery (L&D) operating rooms (ORs) for accepting urgent/emergent obstetrical care.

Anesthesia personnel (faculty, resident, CRNA and anesthesia technicians) will be responsible for checking, maintaining and stocking all supplies necessary for this task in the designated L&D ORs.

Oversight for establishing this Policy & Procedure is the responsibility of the Chief of Anesthesia or his/her designee.

Background: Obstetrician-gynecologists at ZSFG provide the full range of clinical care, including caring for high-risk pregnancies, to a diverse population of women visiting the hospital. Anesthesia services require the availability of all drugs and equipment necessary for administration of anesthesia for emergent surgical procedures such as cesarean delivery. In the designated L&D OR, anesthesia personnel are responsible for:

(1) Readiness of the anesthesia machine. This requires a complete check of the machine according to the built in machine self-test and checklist~~ZSFG Machine Checklist (SEE APPENDIX G)~~, performed every 24 hrs in the AM.

(2) Maintaining a fully stocked OB anesthesia-specific anesthesia cart containing all drugs and equipment as defined in Appendix K1, K2.

(3) Medication preparedness including the immediately availability of induction agents, vasoactive drugs and paralytic agents. Drawn up drugs are to be kept locked in the anesthesia cart.

(4) Airway device preparedness.

(5) IV resuscitation preparedness including the availability of high flow infusion and transfusion systems as well as an invasive blood pressure monitor.

DETAILS OF (3)-(5) ARE DESCRIBED IN "L&D CHECKLIST" SEE APPENDIX K1, K2.

Procedures:

1. It is the responsibility of the Anesthesia attending responsible for OR, together with the L&D charge nurse, to ensure availability of at least one designated L&D OR available 24/7.
2. It is the responsibility of the Anesthesia attending responsible for OR to ensure that these designated ORs are prepared from an anesthesia perspective to receive a patient without notice.

3. During weekdays and Sundays, the "OB-anesthesia attending" delegates the performance of all necessary tasks to the OB anesthesia resident/CRNA. On Saturdays, or if for any other reason the OB anesthesia resident/CRNA is not available, the "OB-anesthesia attending" can delegate the tasks to any other anesthesia provider.
    a. Regular checks of L&D ORs for anesthesia preparedness are performed:
        i. Every morning, ideally between 7AM – 8AM
        ii. If an additional back-up OR becomes designated as an L&D OR
        iii. Following every turnover of an L&D OR
    b. A complete check of the anesthesia machine is performed according to FDA regulations. ~~A checklist (APPENDIX G) is attached to the anesthesia machine.~~
    c. Intubation Equipment is checked and immediately available. Opened intubation equipment expires in 1 month. Initials and the date of expiration will be written on opened equipment. Applies only to L&D OR B: A portable video laryngoscope system is available, checked for functionality daily, and is plugged in, but powered off.
    d. The following emergency medications are immediately available:
        i. Etomidate or Propofol will be available
        ii. Succinlycholine 200mg/10ml
        iii. Phenylephrine 1000mcg/10ml
        iv. Ephedrine 50mg/10ml

    When drawn up by anesthesia care providers, all syringes are to be properly labeled, including drug, concentration, date, time and initials. They expire in 24 hrs. All drugs are kept in the top two drawers of the anesthesia cart. The cart is to be kept locked whenever authorized personnel are not in the immediate vicinity.

    If syringes are opened to prepare for drawing up additional emergency medication, they must be dated, timed and initialed and are valid for 24 hrs.

    e. The Anesthesia cart is checked daily and after each use by anesthesia technicians for proper stocking. The designated anesthesia staff member double checks stocking and ensures that the cart is clean. IV and arterial line placement kits are available at all times. The staff member ensures that the anesthesia cart is always locked when no anesthesia personnel is in the room.
    f. Applies to both L&D OR A and B: An invasive pressure monitoring (arterial line) system including all necessary equipment and attachments is grouped together, unopened and in sterile packaging, in a plastic bag, ready for immediate assembly and use. Opened, but un-spiked, the system expires in 1 month; if spiked, the system expires in 24 hrs. Initials and the date/time of expiration will be written on the drip chamber in these situations. An invasive pressure transducer cable is readily available.
    g. Applies to both L&D OR A and B: An IV fluid warmer (hotline) system including all necessary equipment and attachments is grouped together, unopened and in sterile packaging, in a plastic bag, ready for immediate assembly and use. Opened, but un-spiked, the system expires in 1 month; if spiked, the system expires in 24 hrs. Initials and the

date/time of expiration will be written on the drip chamber in these situations. The fluid warmer is plugged in, but powered off.

h. Applies only to L&D OR B: A trauma anesthesia-specific anesthesia cart is available and its contents maintained by the anesthesia technicians.

i. Applies only to L&D OR B or the substerile room between L&D ORs A and B: An ultrasound with a linear probe is available. The machine is plugged in, but powered off.

j. Applies only to the substerile room between L&D ORs A and B: A rapid infuser (Belmont) system including all necessary equipment and attachments is grouped together, unopened and hanging from the rapid infuser, ready for immediate assembly and use. Opened, but un-spiked, the system expires in 1 month; if spiked, the system expires in 24 hrs. Initials and the date/time of expiration will be written on the reservoir in these situations. The rapid infuser is plugged in, but powered off.

k. All crystalloid bags are to be kept unopened in their wrappers. If opened, they are dated, timed and initialed and expire in 24 hrs.

l. After the OB OR is used, all 'exposed' disposable supplies are disposed of. "Exposed" is anything that is not covered during patient care, including, but not limited to, open IV systems, open Belmont systems, etc. All exposed surfaces (e.g. the anesthesia machine, anesthesia cart, and anesthesia monitors) are sanitized with an FDA-approved disinfectant or replaced with clean equipment.

m. Following the daily OB OR checks, the designated anesthesia staff member certifies completion of all tasks by signing the "L&D OR A and B readiness sign-off sheet".

n. Audits of the L&D OR readiness are performed and recorded at least quarterly by the Chief of Service or the Director of Clinical Anesthesia. Irregularities are documented and planned actions described.

APPENDIX

~~G. ZSFG Machine Checklist~~

K.1 L&D OR B Checklist

K.2 L&D OR A Checklist

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APPENDIX K.1 L&D OB OR B, H2214B Checklist

Keep it as you would like to find it for a STAT C-section

Anesthesia Machine:
- Machine check per protocol; Circuit assembled (with mask)
- Suction functional.

Monitors:
- EKG leads with pads hanging from IV pole untangled
- SpO2 probe attached; BP cuff (adult regular, size 11) attached
- NMT, arterial line, temperature cables present and nicely tucked away

OR Table:
- Plugged in, on, and at lowest position.
- Arm board attached on side opposite of patient entrance.
- Blue ramp on OR bed, placed under hovermat.
- All chairs removed from anesthesia area

:

Difficult Airway Equipment:
- Glidescope plugged in.
- Glidescope 3 and 4 blades, stylet, 6.5 ETT, 10 mL syringe in basket – everything unopenedLMA 3.0, 4.0, 5.0 in anesthesia cart.
- Ambu disposable fiber screen plugged in; large, regular, and slim scopes on back of cart

Emergency Medication/Anesthesia Cart:
- Sealed anesthesia medication trays in anesthesia cart
- In 4th drawer for drawn up meds, check phenylephrine & succinylcholine available and not expired; Toss out any old drawn up medicationsCart locked and no medications out (such as on top of cart) while unattended.

IV Line:
- IV start kit on cart; pigtail and flush syringe NOT opened or attached
- 2 syringe pumps; 1 Sigma Spectrum pump

Neuraxial Kits:
- On bottom shelf of anesthesia "Mayo Stand," at least two of each:
  - Epidural kit (arrow or medline)
  - Spinal kit

Substerile Room, H2214C Checklist
- Belmont Rapid Infuser – Plugged in and components hanging on Belmont IV pole (250 mL NS bag, Belmont tubing, extension x1 – everything unopened)
- Arterial Line Setup – Unspiked A-line transducer kit (500 mL NS bag, pressure bag, A-line transducer – everything unopened) hanging from Belmont

- Hotline setup – unspiked hotline kit (1000mL plasmalyte, Y-connector, Hotline tubing, stopcock x2, IV extension – eveyrthing unopened) hanging from the Belmont
- Ultrasound – Ultrasound plugged in; Probes and probe holders clean; "CLEAN" tag attached to probes

Sign off that you checked the above on the "OB Anesthesia OR Checklist Sign Off" on the wall in OB OR B, H2214B.
~~Keep it as you would like to find it for a STAT C-section~~

~~Anesthesia Machine:~~
- ~~Machine check per protocol.~~
- ~~Suction functional.~~
- ~~Restart computer.~~

~~Monitors:~~
- ~~EKG leads with pads untangled on OR table.~~
- ~~SpO2 probe attached.~~
- ~~Adult Regular, size 11 BP cuff present.~~
- ~~NMT, arterial line, temperature cables present in drawer of anesthesia machine.~~

~~OR Table:~~
- ~~Plugged in, on, and at lowest position.~~
- ~~Arm board attached on side opposite of patient entrance.~~
- ~~Blue ramp on OR bed, placed under hovermat.~~

~~Intubation Equipment in Airway Tray:~~
- ~~Single use laryngoscopes, Miller 2 and 3, Macintosh 3 and 4. Do NOT open.~~
- ~~Oral and nasal airways. Do NOT open.~~

~~ETT (dated and initialed - good for 1 month after opening):~~
- ~~6.5 and 7.0 ETT with stylets, syringes attached.~~

~~Difficult Airway Equipment:~~
- ~~Glidescope plugged in.~~
- ~~Glidescope blade 3 functional.~~
- ~~Backup Glidescope 4 blade functional.~~
- ~~LMA 3.5, 4.5 in anesthesia cart.~~

~~Emergency Medication/Anesthesia Cart:~~
- ~~Sealed anesthesia medication trays in anesthesia cart; no medications out.~~
- ~~Cart locked while unattended.~~

~~Arterial Line Setup:~~
- ~~A-line start kit on back table.~~
- ~~A-line setup package in clear bag on back table (500 mL NS bag, pressure bag, A-line transducer – everything unopened).~~

~~IV Line:~~

- ~~IV start kit on cart.~~
- ~~Hotline setup package in clear bag on back table (1000 mL Plasmalyte, Y-connector, Hotline tubing, Stopcock x 2, IV extension – everything unopened).~~

~~Belmont Rapid Infuser (located in substerile room H2214C):~~

- ~~Plugged in and all components hanging on Belmont IV pole: 250 mL NS bag, bucket, Belmont tubing, extension x 1. Everything unopened or if opened, labeled with 1 month expiration date.~~

~~Neuraxial Kits:~~

- ~~One spinal and one Arrow epidural kit on top of anesthesia machine.~~
- ~~At least one more spinal, Arrow epidural, and Braun epidural kits available in room.~~

~~Sign off that you checked the above on the "OB Anesthesia OR Checklist Sign Off" on the wall in OB OR B, H2214B.~~

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APPENDIX K.2 L&D OB OR AB, H2214A Checklist

Keep it as you would like to find it for a STAT C-section

Anesthesia Machine:
- Machine check per protocol.
- Circuit assembed (with mask available)
- Suction functional.

Monitors:
- EKG leads with pads hanging from IV pole untangledSpO2 probe attached.
- Adult Regular, size 11 BP cuff attached

NMT, arterial line, temperature cables present and nicely tucked away
OR Table:
- Plugged in, on, and at lowest position.
- Arm board attached on side opposite of patient entrance.

All chairs removed from anesthesia area
Difficult Airway Equipment:
- LMA 3.5, 4.5 in anesthesia cart.

Emergency Medication/Anesthesia Cart:
- Sealed anesthesia medication trays in anesthesia cartIn 4th drawer for drawn up meds, check phenylephrine & succinylcholine available and not expired; toss out any old drawn up medications

Cart locked and no medications out (such as on top of cart) while unattended.
IV Line:
- IV start kit on anesthesia cart; pigtail and flush syringe NOT opened or attached
- 2 syringe pumps; 1 Sigma Spectrum pump

Neuraxial Kits:
- On bottom shelf of anesthesia "Mayo Stand" at least two of each:
  - Epidural kit (arrow or medline)
  - Spinal kit

~~Anesthesia Machine:~~
- ~~Machine check per protocol.~~
- ~~Suction functional.~~
- ~~Restart computer.~~

~~Monitors:~~
- ~~EKG leads with pads untangled on OR table.~~
- ~~SpO2 probe attached.~~
- ~~Adult Regular, size 11 BP cuff present.~~
- ~~NMT, arterial line, temperature cables present in drawer of anesthesia machine.~~

~~OR Table:~~
- ~~Plugged in, on, and at lowest position.~~
- ~~Arm board attached on side opposite of patient entrance.~~

~~Intubation Equipment in Airway Tray:~~
- ~~Single use laryngoscopes, Miller 2 and 3, Macintosh 3 and 4. Do NOT open.~~
- ~~Oral and nasal airways. Do NOT open.~~

~~ETT (dated and initialed – good for 1 month after opening):~~
- ~~6.5 and 7.0 ETT with stylets, syringes attached.~~

~~Difficult Airway Equipment:~~
- ~~Glidescope in OB OR B~~
- ~~LMA 3.5, 4.5 in anesthesia cart.~~

~~Emergency Medication/Anesthesia Cart:~~
- ~~Sealed anesthesia medication trays in anesthesia cart; no medications out.~~
- ~~Cart locked while unattended.~~

~~Arterial Line Setup:~~
- ~~A-line start kit on back table.~~
- ~~A-line setup package in clear bag on back table (500 mL NS bag, pressure bag, A-line transducer – everything unopened).~~

~~IV Line:~~
- ~~IV start kit on cart.~~
- ~~Hotline setup package in clear bag on back table (1000 mL Plasmalyte, Y-connector, Hotline tubing, Stopcock x 2, IV extension – everything unopened).~~

~~Neuraxial Kits:~~
- ~~One spinal and one Arrow epidural kit on top of anesthesia machine.~~
- ~~At least one more spinal, Arrow epidural, and Braun epidural kits available in room.~~

Sign off that you checked the above on the "OB Anesthesia OR Checklist Sign Off" on the wall in OB OR B, H2214B

~~Appendix L: ZSFG Fire Safety in the OR Guidelines~~

Commented [AA50]: Is this required in anesthesia R&R? I'm sure there is an OR fire safety policy.

~~**The acronyms RACE and PASS are used to describe actions to be taken in the event of an OR fire.**~~

- ~~R-Remove immediate danger~~
- ~~A-Announce the fire by pulling alarm and dial 9-911.~~
- ~~C-Contain the fire by closing the doors~~
- ~~E-Extinguish the fire if safe to do so.~~

- ~~P-Pull the pin~~
- ~~A-Aim at the base of fire~~
- ~~S-Squeeze the handle~~
- ~~S-Sweep back and forth~~

~~Risk Reduction Strategies~~

~~Each member of the surgical team - surgeon, anesthesiologist, nurse - controls an element of the fire triangle:~~

- ~~Oxygen source~~

- ~~Heat~~
- ~~Fuel~~

~~Oxygen source~~

- ~~Both O2 and N2O support combustion. Be aware of possible enriched O2 and N2O atmospheres near the surgical site under the drapes, especially during head and neck surgery.~~
- ~~Use air or FiO2 30% for open delivery.~~
- ~~Minimize O2 and N2O buildup beneath surgical drapes; tent drapes to dissipate gases.~~
- ~~Use an incise drape to isolate head and neck incisions from O2 and alcohol vapors.~~

~~Fuel and Heat~~

~~When using electrosurgery, electrocautery, or lasers:~~

- ~~Coat facial hair near the surgical site with water-soluble surgical lubricating jelly to make it nonflammable.~~
- ~~Do not drape patient until all flammable preps have fully dried.~~
- ~~Wet gauze or sponges used with uncuffed tracheal tubes to minimize leakage of O2 into the oropharynx; keep them wet.~~
- ~~Moisten sponges, gauze, and pledgets (and their strings) to render them ignition resistant.~~
- ~~Scavenge the oropharynx with separate suction.~~
- ~~Stop supplemental O2 at least one minute before and during use of the unit, if possible. (Surgical team communication is essential.)~~
- ~~Activate the ESU (laser) when the active tip is in view (especially if looking through a microscope).~~
- ~~Deactivate the unit BEFORE the tip leaves the surgical site.~~
- ~~Place electrosurgical electrodes in a holster or off of the patient when not in active use (i.e., when not needed within the next few moments).~~
- ~~Place lasers in standby when not in active use.~~
- ~~Do not place red rubber catheter sleeves over electrosurgical electrodes.~~
- ~~Fiberoptic light sources CAN start fires.~~
- ~~Complete all cable connections before activating the source.~~
- ~~Place source in standby when disconnecting cables.~~

~~Roles and Responsibilities~~

~~Whoever discovers the fire, call 9-911.~~

- ~~Airway Fire:~~
  1. ~~Disconnect circuit from fresh-gas source~~
  2. ~~Remove ET tube and/or debris~~
  3. ~~Squirt saline into field~~
  4. ~~Ventilate by mask~~
  5. ~~Reintubate trachea/bronchoscopy~~

- ~~Drapes on Fire~~
  1. ~~Remove to the floor and smother using:~~
  2. ~~Saline solution~~

3. Sheet/blanket technique
4. Appropriate extinguisher
    - CO2 BC in each OR
    - Chemical ABC in hallways
5. Use a slow sweeping motion

- Fire in OR

Anesthesiologist:

1. Shut off anesthesia machine. Disconnect circuit and ventilate patient with Ambu Bag.
2. Administer IV meds to maintain anesthetic state.
3. Unlock OR table.

Charge Nurse:

1. Ensure O2 is shut down.

Scrub person:

1. Take instruments to stabilize/close patient.

Surgeon:

1. Protect surgical wound site.
2. Make final decision to evacuate OR

Circulator:

1. Clear operative zone to door.
2. Help anesthesiologist transport patient from OR.
3. Close door to contain fire.

Receiving Area:

1. Set up and prepare to receive patients.

Note: The applicability of these recommendations must be considered separately for each patient, consistent with their needs.

Commented [AA51]: Appendix L deleted because Operating Room Department Policy 36: Fire Safety in the Perioperative Environment is the hospital policy which addresses this issue, which extends beyond anesthesia providers alone.

Appendix M1 Clinical Service Privilege Form

Commented [AA52]: From 2018. Is there a newer version?

Anesthesia ANESTHESIA & PERIOPERATIVE CARE 2018

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

6.10 CORE PRIVILEGES
Preoperative evaluations of patients at all levels of American Society of Anesthesia classification including emergencies (inclusive of anesthesia privilege 6.11). Management of procedures for rendering these patients insensible to pain and emotional stress before, during and after surgical, obstetric and certain medical interventions. These procedures include all anesthetic and sedative techniques inducing local infiltration, regional anesthesia and general anesthesia. They also include special skills necessary for support of life functions during an anesthetic, in the post anesthesia care unit, and elsewhere in the hospital. These include airway management, including direct laryngoscopy and fiberoptic laryngoscopy, hemodynamic monitoring, including insertion of arterial lines, central lines, and pulmonary artery catheters, and mechanical ventilation and resuscitation.

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

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 10 anesthetics

6.11 PREOPERATIVE EVALUATION PRIVILEGES
Preoperative evaluation of patients at all levels of American Society of Anesthesiologists classification, inclusive of emergencies, to include: Assessment of, consultation for, and preparation of patients for anesthetist; Determination of the patient's mental status, development of a plan and obtaining consent for anesthetic care.

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

PROCTORING: 5 reviewed cases

REAPPOINTMENT: Review of 5 cases

6.20 SPECIAL PRIVILEGES

6.21 INTENSIVE CARE
Evaluation and management of Critical Care Unit patients

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia with special qualifications in Critical Care Medicine. Under special circumstances, the recommendation of the Chief of Anesthesia and Perioperative Care may be required

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 30 patients

6.22 TRANSESOPHAGEAL/TRANSTHORACIC ECHOCARDIOGRAPHY FOR PERIOPERATIVE MONITORING
Transesophageal echocardiography (TEE)/Transthoracicechocardiography (TTE) for perioperative monitoring of wall motion, volume status and pericardial fluid

Privilege	Status	

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia and documentation of competency from a residency or fellowship program, or completion of the ZSFG department of anesthesia TEE/TTE training course.

PROCTORING: Proctoring will consist of three (3) direct observations (patient or simulator) by a medical staff member who has either 6.22 or 6.23 privilege and has successfully completed proctoring. A minimum of one each, TEE/TTE, is required for proctoring. A summary monitoring report will be sent to the Clinical Service Chief at the completion of successful proctoring.

REAPPOINTMENT: Performance of a minimum of 5 (five) TEE or TTE exams (patient or simulator) for monitoring of wall motion abnormalities, volume status, or pericardial fluid every two (2) years is required for reappointment. A minimum of one each, TEE/TTE, is required for reappointment. Physician specific peer review data must include information regarding cases in which transesophageal or transthoracic echocardiography was utilized for perioperative monitoring.

6.23 TRANSESOPHAGEAL/TRANSTHORACIC ECHOCARDIOGRAPHY FOR PERIOPERATIVE COMPREHENSIVE EXAMINATION
Transesophageal/Transthoracic echocardiography monitoring ofperioperative patients for comprehensive examination.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia. Successful completion of the Perioperative Transesophageal Echocardiography Certification Examination administered (PTEeXAM) by the National Board of Echocardiography (NBE testamur status).

PROCTORING: Proctoring will consist of five (5) direct/observations by a medical staff member who has 6.23 privilege and has successfully completed proctoring. A minimum of one each, TEE/TTE, is required for proctoring. A summary monitoring report will be sent to the Clinical Service Chief at the completion of successful proctoring.

REAPPOINTMENT: Performance of a minimum of 5 (five) complete TEE/TTE exams every two (2) years is required for reappointment. A minimum of one each, TEE/TTE, is required for reappointment. Physician specific peer review data must include information regarding cases in which transesophageal or transthoracic echocardiography was utilized for a comprehensive examination.

6.24 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH
Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____
CTSI Medical Director Date

6.25 PAIN MEDICINE
Interventional Procedures For The Management Of Acute Or Chronic Pain Syndromes

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

6.10 CORE PHYSICIAN PRIVILEGES ___

Preoperative evaluations of patients at all levels of American Society of Anesthesia classification including emergencies (inclusive of anesthesia privilege 6.11). Management of procedures for rendering these patients insensible to pain and emotional stress before, during and after surgical, obstetric and certain medical interventions. These procedures include all anesthetic and sedative techniques inducing local infiltration, regional anesthesia and general anesthesia. They also include special skills necessary for support of life functions during an anesthetic, in the post anesthesia care unit, and elsewhere in the hospital. These include airway management, including direct laryngoscopy and fiberoptic laryngoscopy, hemodynamic monitoring, including insertion of arterial lines, central lines, and pulmonary artery catheters, and mechanical ventilation and resuscitation.

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

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 10 anesthetics

6.101 CORE CRNA PRIVILEGES ___

Preoperative evaluations of patients at all levels of American Society of Anesthesia classification including emergencies. Management of procedures for rendering these patients insensible to pain and emotional stress before, during and after surgical, obstetric and certain medical interventions under medical direction of an attending anesthesiologist. These procedures include all anesthetic and sedative techniques including local infiltration, regional anesthesia and general anesthesia. They also include special skills necessary for support of life functions during an anesthetic, in the post anesthesia care unit, and elsewhere in the hospital. These include airway management, including direct laryngoscopy and fiber optic laryngoscopy, hemodynamic monitoring, including insertion of arterial lines, central lines, and mechanical ventilation and resuscitation.

PREREQUISITES: Successful completion of CRNA program and board admissible (for initial appointment) or current certification by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 10 anesthetics

6.11 PREOPERATIVE EVALUATION PRIVILEGES ___

Preoperative evaluation of patients at all levels of American Society of Anesthesiologists classification, inclusive of emergencies, to include: Assessment of, consultation for, and preparation of patients for anesthetist; Determination of the patient's mental status, development of a plan and obtaining consent for anesthetic care.

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

PROCTORING: 5 reviewed cases

REAPPOINTMENT: Review of 5 cases

6.20 SPECIAL PRIVILEGES ___

6.21 INTENSIVE CARE ___

Evaluation and management of Critical Care Unit patients

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia with special qualifications in Critical Care Medicine. Under special circumstances, the recommendation of the Chief of Anesthesia and Perioperative Care may be required

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 30 patients

6.22 TRANSESOPHAGEAL/TRANSTHORACIC ECHOCARDIOGRAPHY FOR PERIOPERATIVE MONITORING ___

Transesophageal echocardiography (TEE)/Transthoracic echocardiography (TTE) for perioperative monitoring of wall motion, volume status and pericardial fluid

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia and documentation of competency from a residency or fellowship program, or completion of the ZSFG department of anesthesia TEE/TTE training course.

PROCTORING: Proctoring will consist of three (3) direct observations (patient or simulator) by a medical staff member who has either 6.22 or 6.23 privilege and has successfully completed proctoring. A minimum of one each, TEE/TTE, is required for proctoring. A summary monitoring report will be sent to the Clinical Service Chief at the completion of successful proctoring.

REAPPOINTMENT: Performance of a minimum of 5 (five) TEE or TTE exams (patient or simulator) for monitoring of wall motion abnormalities, volume status, or pericardial fluid every two (2) years is required for reappointment. A minimum of one each, TEE/TTE, is required for reappointment. Physician specific peer review data must include information regarding cases in which transesophageal or transthoracic echocardiography was utilized for perioperative monitoring.

6.23 TRANSESOPHAGEAL/TRANSTHORACIC ECHOCARDIOGRAPHY FOR PERIOPERATIVE COMPREHENSIVE EXAMINATION ___
Transesophageal/Transthoracic echocardiography monitoring of perioperative patients for comprehensive examination.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia. Successful completion of the Perioperative Transesophageal Echocardiography Certification Examination administered (PTEeXAM) by the National Board of Echocardiography (NBE testamur status).

PROCTORING: Proctoring will consist of five (5) direct/observations by a medical staff member who has 6.23 privilege and has successfully completed proctoring. A minimum of one each, TEE/TTE, is required for proctoring. A summary monitoring report will be sent to the Clinical Service Chief at the completion of successful proctoring.

REAPPOINTMENT: Performance of a minimum of 5 (five) complete TEE/TTE exams every two (2) years is required for reappointment. A minimum of one each, TEE/TTE, is required for reappointment. Physician specific peer review data must include information regarding cases in which transesophageal or transthoracic echocardiography was utilized for a comprehensive examination.

6.24 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH ___
Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____
CTSI Medical Director Date

6.25 PAIN MEDICINE ___
Interventional Procedures For The Management Of Acute Or Chronic Pain Syndromes

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in Anesthesiology with special qualifications in Pain Medicine by the American Board of Anesthesiology and documentation of competency from a residency and fellowship program accredited by the Accreditation Council on Graduate Medical Education.

PROCTORING: Proctoring will consist of direct observations by a medical staff member who has 6.25 privilege and has successfully completed proctoring. A minimum of two (2) direct observations of each of three categories of interventional pain procedures listed below is required for proctoring.

REAPPOINTMENT: Performance and peer review of a minimum of four (4) cases in each of the three categories of procedures listed below every two (2) years is required for reappointment. Physician specific peer review data must include information regarding cases in which interventional procedures were used for management of acute or chronic pain syndromes.

PRIVILEGE DESCRIPTIONS:
- Fluoroscopy based injections/neuromodulation/neurolysis of the spinal column, peripheral nerves, ganglia, joints, or bursa sacs. NB-fluoroscopy must be performed by individual licensed to use fluoroscopy (may include: privilege 6.26, radiology technician, provider with other ZSFG fluoroscopy privilege)
- Ultrasound based neuromodulation/neurolysis of the spinal column or peripheral nerves and injection/neuromodulation/neurolysis of the ganglia, joints, or bursa sacs
- Chemodenervation (botulinum toxin) or local anesthetic injection of trigger points, scar, pericranial muscles (for migraine), or neuroma

6.26 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Anesthesiology. A current x-ray/Fluoroscopy Certificate is required.

PROCTORING: Presentation of valid California Fluoroscopy certificate

REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.

I hereby request clinical privileges as indicated above.

_____

Applicant Date

APPROVED BY

_____

Division Chief Date

_____

Service Chief Date

Privilege	Status

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in Anesthesiology with special qualifications in Pain Medicine by the American Board of Anesthesiology and documentation of competency from a residency and fellowship program accredited by the Accreditation Council on Graduate Medical Education.

PROCTORING: Proctoring will consist of direct observations by a medical staff member who has 6.25 privilege and has successfully completed proctoring. A minimum of two (2) direct observations of each of three categories of interventional pain procedures listed below is required for proctoring.

REAPPOINTMENT: Performance and peer review of a minimum of four (4) cases in each of the three categories of procedures listed below every two (2) years is required for reappointment. Physician specific peer review data must include information regarding cases in which interventional procedures were used for management of acute or chronic pain syndromes.

PRIVILEGE DESCRIPTIONS:
- Fluoroscopy based injections/neuromodulation/neurolysis of the spinal column, peripheral nerves, ganglia, joints, or bursa sacs. NB-fluoroscopy must be performed by individual licensed to use fluoroscopy (may include: privilege 6.26, radiology technician, provider with other ZSFG fluoroscopy privilege)
- Ultrasound based neuromodulation/neurolysis of the spinal column or peripheral nerves and injection/neuromodulation/neurolysis of the ganglia, joints, or bursa sacs
- Chemodenervation (botulinum toxin) or local anesthetic injection of trigger points, scar, pericranial muscles (for migraine), or neuroma

6.26 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Anesthesiology. A current x-ray/Fluoroscopy Certificate is required.

PROCTORING: Presentation of valid California Fluoroscopy certificate

REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.

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1001 Potrero Avenue
San Francisco, CA 94110

Appendix M Nurse Practitioner Privilege Form

AFF_2020 Anesthesia 2020

CORE STANDARDIZED PROCEDURES

HEALTH CARE MANAGEMENT, PRIMARY CARE / SPECIALTY CLINICS / INPATIENT UNITS

REQUIREMENT: Active California license, Board certification,(staff hired prior to Board requirement will be "grandfathered " in at reappointment), Basic Life Support (BLS) from an approved provider, Advanced Cardiac Life Support (ACLS) for noted procedures, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP, PNP or PA.

PROCTORING: A minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures demonstrate clinical competence or as noted in each special protocol.

REAPPOINTMENT: 5 chart reviews every 2 years. Charts can include reviews completed for special procedure reviews.

PRE-OP SCREENING OF ADULTS

REQUIREMENT: Active California license, Board certification, Basic Life Support (BLS) from an approved provider, possession of a Medicare/Medical Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP or PNP.

PROCTORING: 3 months in length. Presentation of 5 adult cases with chart review of the same 5 cases.

REAPPOINTMENT: Review of 3 adult cases every 2 years.

PRE-OP SCREENING OF CHILDREN

REQUIREMENT: Active California license, Board certification, Basic Life Support (BLS) from an approved provider, possession of a Medicare/Medical Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP or PNP.

PROCTORING: 3 months in length. Presentation of 5 pediatric cases with chart review of the same 5 cases.

REAPPOINTMENT: Review of 3 pediatric cases every 2 years.

FURNISHING MEDICATIONS AND DRUG ORDERS

REQUIREMENT: Active California license, Board certification,(staff hired prior to Board requirement will be "grandfathered " in at reappointment), Basic Life Support (BLS) from an approved provider, Advanced Cardiac Life Support (ACLS) for noted procedures, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP, PNP or PA.

PROCTORING: A minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures demonstrate clinical competence or as noted in each special protocol.

REAPPOINTMENT: 5 chart reviews every 2 years. Charts can include reviews completed for special procedure reviews.

SPECIAL STANDARDIZED PROCEDURES

eCONSULT

REQUIREMENT: 6 months of experience in the specific specialty and are providing care to patients in the area they are reviewing, understanding of algorithms or referral guidelines used for screening, triaging and prioritizing of patients.

PROCTORING: Concurrent review of the first 20 EConsult consultation decisions during the first 3 months.

REAPPOINTMENT: 5 eConsult consultations every 2 years.

MANAGEMENT OF NEURAXIAL/NERVE CATHETERS FOR PAIN CONTROL

REQUIREMENT: On site training by a privileged provider or documentation of previous training.

PROCTORING: A minimum of 2 observations by a qualified anesthesia attending of each of the following: clinical assessment of patient in relation to pain management, assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter.

REAPPOINTMENT: 2 observations of clinical assessment of patient in relation to pain management, assessment of catheter site, setup infusion pump, selection/administration of infusion medications and removal of catheter.

TRIGGER POINT INJECTIONS

REQUIREMENT: Training will be provided on site by an experienced provider.

PROCTORING: New Practitioner, 2 successful observed demonstrations of the procedure. Experienced, 1 successful observed demonstration of the procedure. Chart review of all observed cases.

REAPPOINTMENT: Performance of at least 2 injections every 2 years. 1 chart review every 2 years.

Appendix N Anesthesia OPPE Definition of Thresholds

Commented [AA53]: Are these updated? I recall including completion of training modules, note completion, etc.

Anesthesia OPPE Metrics

• Metric 1 – Significant incidents, Cases of concern
ACGME Core Competency: Patient Care
Medical Staff, CRNAs, and NPs
Data Source: SAFE Reports/M&M Database
○ 1 = Acceptable: 0–1
○ 2 = Marginal: 2, or any w/significant concern
○ 3 = Unacceptable: >2, or any with major concern

• Metric 2 – Death
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: Epic, M&M
○ 1 = Acceptable: 0, or any non-preventable
○ 2 = Marginal: >1, possibly preventable
○ 3 = Unacceptable: >1, probably preventable

• Metric 3 – Cardiac Arrest/ MI
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: M&M
○ 1 = Acceptable: 0, or any non-preventable
○ 2 = Marginal: >1, possibly preventable
○ 3 = Unacceptable: >1, probably preventable

• Metric 4 – Medication Error
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: M&M, SAFE Reports
○ 1 = Acceptable: 0–2
○ 2 = Marginal: 3
○ 3 = Unacceptable: >3; or with any significant error

• Metric 5 – Perioperative Temperature Management [>65% with monitoring for >1h anes]
ACGME Core Competency: Patient Care
Medical Staff & CRNAs
Data Source: Epic
○ 1 = Acceptable: >50% of pts w/GA or neuraxial with temp monitoring
○ 2 = Marginal: 30–50% of pts w/GA or neuraxial with temp monitoring
○ 3 = Unacceptable: <30% of pts w/GA or neuraxial without temp monitoring

• Metric 6 – Board Certification/Recertification
ACGME Core Competency: Medical/Clinical Knowledge
Medical Staff
Data Source: Medical Staff Office
○ 1 = Acceptable: Active/Current
○ 2 = Marginal: Received letter that boards are due at next reappointment
○ 3 = Unacceptable: Administrative suspension from medical staff during the 6-month reporting period for lack of board certification

• Metric 7 – California License
ACGME Core Competency: Medical/Clinical Knowledge
Medical Staff
Data Source: Medical Staff Office
○ 1 = Acceptable: Licensed
○ Marginal: n/a
○ 2 = Unacceptable: Not licensed

• Metric 8 – Attendance at Huddles
ACGME Core Competency: Practice-Based Learning and Improvement
Medical Staff & CRNAs
Data Source: ABO Tracking
○ 1 = Acceptable: Attendance at least 1 huddle/month
○ 2 = Marginal: Less than once a month attendance at huddles
○ 3 = Unacceptable: No huddles attended

• Metric 9 – Completion of ZSFG Required Annual Hospital Training Modules
ACGME Core Competency: Practice-Based Learning & Improvement
Medical Staff & CRNAs
Data Source: Hydra ZSFG Active Compliance Report
○ 1 = Acceptable: Current
○ Marginal: n/a
○ 2 = Unacceptable: Not Current

• Metric 10 – Absence of UOs
ACGME Core Competency: Interpersonal & Communication Skills
Medical Staff, CRNAs, and NPs
Data Source: SAFE Reports, Risk Management Committee
○ 1 = Acceptable: 0–2
○ 2 = Marginal: 3 or any w/significant concern
○ 3 = Unacceptable: >3 or any with major concern

• Metric 11 – Absence of Issues in this Area as Reported by Peers
ACGME Core Competency: Interpersonal & Communication Skills
Medical Staff, CRNAs, and NPs
Data Source: Any documented communication with leadership team
○ 1 = Acceptable: 0–1
○ 2 = Marginal: 2–3 or any with significant concern
○ 3 = Unacceptable: >3 or any with major concern

• Metric 12 – Faculty Meeting Attendance
ACGME Core Competency: Professionalism
Medical Staff
Data Source: ABO Tracking
○ 1 = Acceptable: >50%
○ 2 = Marginal: 30–50%
○ 3 = Unacceptable: <30%

• Metric 13 – Absence of UOs & Complaints in This Area
ACGME Core Competency: Professionalism
Medical Staff, CRNAs, and NPs
Data Source: Any documented communication with the leadership team
○ 1 = Acceptable: 0–2
○ 2 = Marginal: 3 or any w/significant concern
○ 3 = Unacceptable: >3 or any with major concern

• Metric 14 – Intraoperative Handoff
ACGME Core Competency: Systems-Based Practice
Medical Staff & CRNAs
Data Source: Epic
○ 1 = Acceptable: >75% of cases
○ 2 = Marginal: 25–75% of cases
○ 3 = Unacceptable: <25% of cases

• Metric 15 – Percentage of all attributable notes closed in 3 days
ACGME Core Competency: Systems-Based Practice
Medical Staff, CRNAs, and NPs
Data Source: Epic data entered by Medical Staff Office
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <80%

• Metric 16 – Percentage of AVS Completed for In-Person Visit
ACGME Core Competency: Patient Care
NP
Data Source: Epic
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <79%

• Metric 17 – Percentage of Preop Visits Completed within 30 Days of Procedure Date
ACGME Core Competency: Patient Care
NP
Data Source: Epic
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <79%

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

• Metric 18 – Attendance at Weekly Clinic Meeting
ACGME Core Competency: Professionalism
NP
Data Source: Preop Clinic Director
○ Acceptable: >90%
○ Marginal: 80–90%
○ Unacceptable: <79%

~~1. Deaths~~

- ~~*Acceptable*: Any non-preventable deaths (e.g., trauma patients with non-survivable injuries) will be considered acceptable.~~
- ~~*Marginal:* One or more deaths that are deemed possibly preventable would be considered marginal performance.~~
- ~~*Unacceptable:* One or more preventable deaths (e.g. mismanagement by the anesthesia provider) are considered unacceptable.~~

~~2. Cardiac Arrest / MI~~

- ~~*Acceptable*: Any non-preventable cases (e.g. patient is medically optimized, cardiac evaluation and risk is clearly documented and anesthetic plan is tailored to minimize cardiac impact) are considered acceptable.~~
- ~~*Marginal:* One or more cardiac events that are deemed possibly preventable would be considered marginal performance (e.g., cardiac risk not well documented / recognized by provider resulting in management decisions that fail to minimize cardiac risk).~~
- ~~*Unacceptable:* One or more preventable cardiac events are considered unacceptable (mismanagement by the anesthesia provider, e.g., prolonged period of untreated hypotension or unaddressed tachycardia).~~

~~3. Unrecognized Difficult Airway~~

- ~~*Acceptable*: 0-2 cases with full documentation of airway exam, reflecting that the standard of care for airway assessment has been met.~~
- ~~*Marginal:* 1-2 cases with incomplete documentation of airway exam~~
- ~~*Unacceptable:* > 2 cases with incomplete documentation of airway exam or 1 case without documentation of airway exam. Without documentation of the airway exam, standard of care for airway assessment has not been met.~~

~~*Note: None of the components of the airway exam have high positive predictive value. Difficult airways scenarios occur despite appropriate assessment and planning. If appropriate steps in assessment and planning are taken the management will be considered acceptable.*~~

~~4. Unplanned Re-intubation~~

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- *Acceptable*: Non-preventable cases are re-intubations that are clinically indicated by patient factors. All appropriate assessment and treatment was completed prior to extubation (adequate minute ventilation, responding to commands, neuromuscular blockade reversed/resolved).
- *Marginal*: 1-2 preventable re-intubations (patient with residual neuromuscular blockade, poor respiratory mechanics prior to extubation, hypoxia prior to extubation)
- *Unacceptable:* Greater than 2 preventable re-intubations. See definitions above.

5. Medication Error

- *Acceptable*: 0-2
- *Marginal*: 3
- *Unacceptable:* ≥ 4

Note: Assessments of medication errors should include evaluation of severity of outcome, appropriate recognition of error and measures taken to mitigate any possible harm.

6. Perioperative Aspiration

- *Acceptable*: 0-1 cases of pulmonary aspiration requiring escalation in level of care (unplanned admission or ICU) in elective cases. Trauma patients and emergency cases with intra-abdominal processes are at a higher risk of aspiration and will be considered differently.
- *Marginal:* 1-2 cases defined as above
- *Unacceptable:* ≥ 3

7. Dental Trauma

- *Acceptable*: 0-3 Dental trauma is a known risk of general anesthesia and intubation, which is included in the informed consent process. Appropriate documentation should include a dental exam that indicates increased risk if poor dentition is present.
- *Marginal*: 3-4 with appropriate documentation. 2-3 cases may be considered marginal if documentation is incomplete; reflecting that appropriate assessment may not have been completed.
- *Unacceptable:* ≥5

8. Peripheral Nerve Injury

- *Acceptable*: 0-1
- *Marginal*: 2
- *Unacceptable:* ≥ 3

9. Problem Transfusions

- *Acceptable*: 0-2 cases with appropriate documentation of blood transfusion protocols (e.g., 2 providers check the blood against the patient information including blood type, check expiration and sign the slip)
- *Marginal*: 1 case without appropriate documentation.
- *Unacceptable:* ≥ 2 cases without appropriate documentation

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Note: There may be circumstances in trauma resuscitation that prevent the provider from completing all documentation prior to hanging the blood (e.g. signing the provider line with time and date the blood is administered). Therefore, 1 case will be considered marginal rather than unacceptable.

10. Clinical Cases, UO, Complaints, Risk Management Cases, Professionalism, Cases of Concern

- *Acceptable*: 0-1
- *Marginal*: 2
- *Unacceptable:* ≥ 3

Note: Given the diversity of type and severity of issues that may be raised via case review, patient complaints, U/Os and sentinel events, the specifics of the incident are important in determining whether the performance is acceptable, marginal or unacceptable

NURSE PRACTITIONERS ONLY;

11. Allergy list review/update

- *Acceptable*: >90%
- *Marginal*: 80-90%
- *Unacceptable:* <80%

12. Medication list review/update

- *Acceptable*: >90%
- *Marginal*: 80-90%
- *Unacceptable:* <80%

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Location: *

I. Policy statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators, and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept electronically and on file in the Medical Staff Office and the office of the Department Chief or Medical Director.

II. Functions to be performed

The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians and registered nurses.

A. Performing patient assessment

B. If applicable, ordering and interpreting drug therapy-related tests

C. If applicable, referring patients to other health care providers

D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy; the patient's treating prescriber may prohibit any adjustment or change in the patient's drug regimen by the clinical pharmacist.

F. As appropriate in the area of practice, communicate drug therapy changes to the care team.

G. Administering drugs and biologicals pursuant to a prescriber’s order (the administration of immunizations under the supervision of a prescriber may also be performed outside of a licensed health care facility).

H. If applicable, initiating and administering vaccine listed on the routine immunization schedules recommended by the federal Advisory Committee on

Immunization Practices (ACIP) or California Department of Public Health (CDPH), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC)

I. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

III. Circumstances under which a clinical pharmacist may function

A. Setting

The clinical pharmacist may perform the following standardized procedure functions in the listed clinics consistent with their experience and training.

B. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer, and the medical directors or chiefs of service of clinics or departments where they provide clinical pharmacist services.

2. If applicable, University of California-San Francisco pharmacists practicing in SFHN clinics are under the direct supervision of the clinic medical director. They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent with the needs and expectations of the DPH and SFHN. Performance appraisals and other professional oversight are the responsibility of the clinic medical director.

3. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the clinical pharmacist, available by phone, in person or other electronic means at all times

4. Provider consultation is to be obtained under the following circumstances:

    a) Medical conditions requiring prompt medical intervention
    b) Acute decompensation of a patient
    c) Medical problems not resolving as anticipated
    d) Unexpected historical, physical or laboratory findings
    e) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
    f) Early requests for controlled substance refills based upon pain agreement between a provider and the patient
    g) Upon request of patient, provider or clinical pharmacist
    h) Violent or verbally abusive patient behavior

IV. Requirements for the clinical pharmacist

A. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

   Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

   (Two years of verifiable post-graduate work experience performing clinical functions in medication management may be substituted for the one year residency or fellowship experience requirement)

3. If applicable, completion of immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education if initiating or administering vaccines under section II, G

4. If applicable for a specialty SP, completion of a specialty pharmacy residency or fellowship related to the area of practice (e.g. emergency, hematology/oncology, pain, infectious disease, critical care, etc.) OR three or more years of verifiable post-graduate work experience performing clinical functions in the specialty area medication management which may include board certification in the specialty area.

5. Completion of an annual relevant competencies associated with the pharmacist's professional practice

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B. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Chief Pharmacy Officer or designee will assess the clinical pharmacist's ability to practice under the scope of this SP ~~utilizing feedback from consulting providers,~~ and review 10 charts or 10 direct observations that include medication changes made by the clinical pharmacist. Documentation will be reviewed and signed off by the clinic medical director, chief of service, or designee.

Commented [AM2]: Verify this number with CIDP

2. Annual: Chief Pharmacy Officer or designee will evaluate the clinical pharmacist's competence by reviewing 5~~five~~ chart reviews or 5~~five~~ direct observations every 2 years to align with the reappointment window for Medical Staff Office credentialing. Documentation of these evaluations will

be reviewed and signed off by the clinic medical director, chief of service, or designee.

3. Follow-up: Aareas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief Pharmacy Officer or designee at appropriate intervals until acceptable skill level is achieved.

V. Development and approval of standardized procedure

A. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians and pharmacists, and conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

B. Approval

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

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C. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

D. Revisions

All changes or additions to the standardized procedures are to be approved the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee, and Joint Conference Committee prior to their implementation.

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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

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.Aspericueta@sfdph.org).*

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP: 10/1/25	
Person completing this form: Anusha M.	
Standardized Procedure Title:	All Pharmacy SPs
Department:	Pharmacy
Dept Chief:	David Smith
SP Author(s):	Anusha McNamara, Tamara Lenhoff, Curtis Geier, Taylor Yasunaga, and Ed Lor
Update #1:	Update all preambles to be consistent between all pharmacy SPs
Reason/Explanation for Revision:	• Added "if applicable" for any statements that only apply to one service • Standardized 10 chart reviews or direct observations for initial credentialing, and 5 chart reviews or direct observations for renewal
Update #2:	Add MXM to Ambulatory Care SP
Reason/Explanation for Revision:	MXM will now have a clinical pharmacist, and since it is under CPC, the pharmacist should practice under the same SP.
Update #2:	Added link to list of clinics in the Ambulatory Care SP so the list would only need to be updated in one place in the document
Reason/Explanation for Revision:	To improve efficiency and maintain consistency, reducing redundancy and the risk of outdated or conflicting information.

*Include additional rows to table, if needed

Medical Staff Services Department
San Francisco General Hospital Medical Center
1001 Potrero Avenue ◦ Suite 2A5 ◦ San Francisco, CA 94110
Telephone (415) 206-3517 ◦ Fax (415) 206-3434

Section II: Standardized Revisions

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. *Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure*. (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)

San Francisco Health Network

SF HEALTH NETWORK

San Francisco Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE FOR EMERGENCY MEDICINE CLINICAL PHARMACIST

1. Policy statement

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G. Administering drugs and biologicals pursuant to a prescriber's order (the administration of immunizations under the supervision of a prescriber may also be performed outside of a licensed health care facility).

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D. Experience and education

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1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

   Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

   (Two years of verifiable post-graduate work experience performing clinical functions in medication management may be substituted for the one year residency or fellowship experience requirement)

3. If applicable, completion of immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education if initiating or administering vaccines under section II, G

4. If applicable for a specialty SP, completion of a specialty pharmacy residency or fellowship related to the area of practice (e.g. emergency, hematology/oncology, pain, infectious disease, critical care, etc.) OR three or more years of verifiable post-graduate work experience performing clinical functions in the specialty area medication management which may include board certification in the specialty area.

A. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Chief Pharmacy Officer or designee will assess the clinical pharmacist's ability to practice under the scope of this SP and review 10 charts or 10 direct observations that include medication changes made by the clinical pharmacist. Documentation will be reviewed and signed off by the clinic medical director, chief of service, or designee.

2. Annual: Chief Pharmacy Officer or designee will evaluate the clinical pharmacist's competence by reviewing 5 chart reviews or 5 direct observations every 2 years to align with the reappointment window for Medical Staff Office credentialing. Documentation of these evaluations will be reviewed and signed off by the clinic medical director, chief of service, or designee.

3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief Pharmacy Officer or designee at appropriate intervals until acceptable skill level is achieved.

5. Development and approval of standardized procedure

E. Method of development

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F. Approval

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G. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

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All changes or additions to the standardized procedures are to be approved the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee, and Joint Conference Committee prior to their implementation.

~~**I. Policy statement**~~

~~A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists, of Nurse Practitioners, Registered Nurses, Physicians, Pharmacists, Administrators and other Affiliated Staff~~

~~B. A copy of the signed procedures will be kept in the Medical Staff Office, Emergency Department Clinical Pharmacist Office and the Hospital Pharmacy Administration operational manual.~~

~~**II. Functions to be performed**~~

~~The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a licensed health care facility as part of a multidisciplinary team that includes physicians, physician assistants, nurse practitioners, and registered nurses.~~

~~A. Perform drug therapy related patient assessment~~

~~B. Ordering and interpreting drug therapy-related laboratory tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies.~~

~~C. Administering drugs and biologicals orally, by injection, or transdermally pursuant to a prescriber's order~~

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D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy in consultation with the provider or team caring for the patient

F. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention

III. Circumstances under which a clinical pharmacist may perform function

B. Setting

The clinical pharmacist may perform the following standardized procedure functions in the ZSFG emergency department setting consistent with their experience and training.

C. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer and under the direct supervision of the Emergency Department Medical Director(s). They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent with the needs and expectations of the DPH and SFHN.

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d) Unexplained historical, physical or laboratory findings
e) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
f) Upon request of patient, physician or clinical pharmacist
g) Violent or verbally abusive patient behavior
h) Need for prior authorization for outpatient prescriptions

IV. Requirements for the clinical pharmacist

D. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree

3. Completion of a specialty residency or fellowship in emergency medicine pharmacotherapy, critical care pharmacotherapy, toxicology; OR

Three or more years of verifiable post-graduate work experience performing clinical functions in emergency medicine

4. Relevant experience in Clinical Pharmacy in a hospital setting. Ability to work in an interdisciplinary setting as determined by DPH Chief Pharmacy Officer

5. Completion of annual pediatric and/or geriatric competency relevant to the pharmacist's professional practice

A. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Emergency Department Medical Director(s) or designee will assess the clinical pharmacist's ability to practice utilizing feedback from consulting providers, and review ten charts or medication orders, or the equivalent number of direct observations. Documentation will be reviewed and signed off by the service medical director or designee.

2. Biennial Reappointment: every 2 years the Emergency Department Medical Director(s) or designee will evaluate the clinical pharmacist's competence and documentation by reviewing five charts, or the equivalent number of direct observations.

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

V. Development and approval of standardized procedure

E. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians, pharmacists, and registered nurses, and should conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

F. Approval

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

G. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

H. Revisions

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

Protocol #1 EMERGENCY MEDICINE CLINICAL PHARMACIST

A. Definition: This protocol describes the procedure for entering medication and laboratory orders for patients who are being treated in the ZSFG Emergency Department Area.

B. Assessment

1. Subjective
   a. Chief complaints
   b. History of present illness including relevant medication history
   c. Signs and symptoms related to the patient's medication therapy or underlying illnesses
   d. Medication reconciliation, adherence and concordance
   e. History of allergy and medication intolerance

2. Objective
   a. Physical assessment if appropriate and available including vital signs
   b. Drug-therapy related test results (serum levels, culture data)
   c. Medication coverage based on insurance or other coverage plan

C. Evaluation

1. Evaluate medication response to prescribed drug therapy (example: response to prescribed intravenous blood pressure medication while in the ED).

2. Evaluate response to medication therapy for outpatients previously seen in the ED

3. Evaluate the appropriateness of drug therapy for provider's diagnosis, side effects, drug interactions, and allergies

4. Evaluate the need for physician consultation as outlined under section III, B, 3.

D. Management

1. For inpatient medication and laboratory orders, discuss with the primary team or provider caring for the patient prior to entering or modifying a medication or laboratory order.

2. For outpatient medication prescriptions or clarifications, verify the original prescriber's diagnosis and intended treatment plan and choose appropriate medication therapy for the diagnosis based on insurance coverage, pharmacy availability or laboratory/culture data as appropriate.

3. The pharmacist will educate patients or family members on any new or adjusted medication therapy if available.

4. Refer patients to other members of the multidisciplinary team for additional services or consultation as needed, such as social worker services.

5. Consult with the provider as outlined under section III, B, 3.

E. Record keeping

~~1. Progress notes are completed in the electronic medical record if any laboratory tests are ordered inpatient or medications are ordered outpatient.~~

~~2.~~1. All drug therapy initiations, adjustments and discontinuations are entered in the electronic medical record

~~3.~~2. All prescription clarifications are entered in the electronic medical record.

Medical Director or Division Chief Approval or Service Chief Approval

Christopher Coswell, MD	Josephine Lai, PharmD
Chief of Emergency Medicine	Director Pharmacy ZSFG

Author: Curtis Geier, PharmD Emergency Medicine Clinical Pharmacist
Reviewed: 6/3/2020, ~~7/23/25~~10/1/2025
CIDP Approval Date: 6/03/2020
Credentials Approval Date: 7/06/2020
MEC Approval Date: 7/15/2020
Gov. Body Approval Date: 7/28/2020

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Zuckerberg San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

CLINICAL SERVICE: **EMERGENCY MEDICINE CLINICAL PHARMACIST**

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET	COMMENTS
CORE				
Emergency Medicine	10 charts or medication orders, or the equivalent number of direct observations and documentation review.	5 charts, or the equivalent number of direct observations		

_____ _____

Chief of Service 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.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Title: Medicine Pain Service - Clinical Pharmacist

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, Certified Nurse Midwives, Physician Assistants, Registered Nurses, Physicians, Pharmacists, Administrators and other Affiliated Staff and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. A copy of the signed procedures will be kept in Hospital Pharmacy Administration, and on file in the Medical Staff Office.

II. Functions to be performed

The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians and registered nurses.

Commented [KA1]: add advanced pracctitioners?

A. Performing patient assessment

B. Ordering and interpreting drug therapy-related tests

C. Referring patients to other health care providers

D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy; the patient's treating prescriber may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the clinical pharmacist.

F. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

III. Circumstances Under Which a Clinical Pharmacist May Perform Function

A. Setting

The Clinical Pharmacist may perform the following standardized procedure functions with the Medicine Pain Service in both the Inpatient and Outpatient areas consistent with their experience and training.

B. Scope of Supervision Required

1. The Clinical Pharmacist is responsible and accountable to the Medicine Pain Service Medical Director or physician designee.

2. Overlapping functions are to be performed in areas which allow for a consulting physician to be available to the Clinical Pharmacist by phone or in person, including but not limited to the clinical area.

3. Physician consultation will be obtained as specified in the protocols and under the following circumstances:
   a) Acute decompensation of the patient
   b) Pain which is not resolved as anticipated
   c) Upon request of the patient, pharmacist or physician

Commented [KA2]: could consider adding (continuity with other pharm D SPs)
medical conditions requiring prompt medical intervention
unexplained historical, physical or laboratory findings
violent or verbally abusing patient behavior

IV. Requirements for the Clinical Pharmacist

A. Experience and Education

1. Active California Registered Pharmacist license
2. Possession of a Doctor of Pharmacy degree, and completion of a one year American Society of Health-Systems Pharmacy accredited pharmacy residency program; OR

Possession of a Doctor of Pharmacy degree and completion of a one year pharmacy fellowship program; OR

Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management.

(Two years of verifiable post-graduate work experience performing clinical functions in medication management, or certification as Board Certified Pharmacotherapy Specialist may be substituted for the one year residency or fellowship experience requirement)

B. Special Training

1. Previous work experience in interdisciplinary pain consultation.

Commented [MA3]: Include number of years?

Commented [MA4R3]: Per Ed Lor: >5 years? Defer to Dr. Brody

C. Evaluation of Clinical Pharmacist (CP) competence in performance of standardized procedures:

1. Initial: at the conclusion of the standardized procedure training the Medical Director or physician designee will assess the Clinical Pharmacist's ability to practice. Method of proctoring will be direct observation of 5 patients utilizing the Medicine Pain Service.
2. Annual: Medical Director or physician designee along with Pharmacy Administration will evaluate the Clinical Pharmacists competence through an annual performance appraisal and appropriate competency validation for the setting. Competency validation review will include direct observation of 5 patients on the Medicine Pain Service.
3. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director or physician designee and Pharmacy Administration at appropriate intervals until acceptable skill level is achieved.

V. Development and Approval of Standardized Procedure

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

B. Approval
All standardized procedures must be approved by the CIDP, Credentials Committee, Medical Executive Committee and Governing Body prior to use.

C. Review Schedule
The standardized procedure will be reviewed every three years by the practitioner and medical director and as practice changes.

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

Commented [MA5]: Any documentation review?

Commented [KA6R5]: review 5 charts or equivalent number of direct observations?

Commented [MA7R5]: Per Ed Lor: Yes, include doc review

Commented [KA8]: Annual or Biennial? (Heme Onc is annual, ED is bienniel). Usually the reviews are chart reviews. are there particular reasons that direct observation is needed for the pain service?

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San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Health Network of San Francisco Committee on Interdisciplinary Practice

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STANDARDIZED PROCEDURE FOR PAIN MEDICINE CLINICAL PHARMACIST

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1. Policy statement

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A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators, and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept electronically and on file in the Medical Staff Office and the office of the Department Chief or Medical Director.

2. Functions to be performed

The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians and registered nurses.

A. Performing patient assessment

B. If applicable, ordering and interpreting drug therapy-related tests

C. If applicable, referring patients to other health care providers

D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy; the patient's treating prescriber may prohibit any adjustment or change in the patient's drug regimen by the clinical pharmacist.

F. As appropriate in the area of practice, communicate drug therapy changes to the care team.

G. Administering drugs and biologicals pursuant to a prescriber's order (the administration of immunizations under the supervision of a prescriber may also be performed outside of a licensed health care facility).

H. If applicable, initiating and administering vaccine listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP) or California Department of Public Health (CDPH), in compliance with individual ACIP vaccine recommendations, and

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published by the federal Centers for Disease Control and Prevention (CDC)

I. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

3. Circumstances under which a clinical pharmacist may function

B. Setting

The clinical pharmacist may perform the following standardized procedure functions in the listed clinics consistent with their experience and training.

C. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer, and the medical directors or chiefs of service of clinics or departments where they provide clinical pharmacist services.

2. If applicable, University of California-San Francisco pharmacists practicing in SFHN clinics are under the direct supervision of the clinic medical director. They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent with the needs and expectations of the DPH and SFHN. Performance appraisals and other professional oversight are the responsibility of the clinic medical director.

3. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the clinical pharmacist, available by phone, in person or other electronic means at all times

4. Provider consultation is to be obtained under the following circumstances:

h) Medical conditions requiring prompt medical intervention
h) Acute decompensation of a patient
h) Medical problems not resolving as anticipated
h) Unexpected historical, physical or laboratory findings
h) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
h) Early requests for controlled substance refills based upon pain agreement between a provider and the patient
h) Upon request of patient, provider or clinical pharmacist
h) Violent or verbally abusive patient behavior

4. Requirements for the clinical pharmacist

D. Experience and education

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1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

   Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

   (Two years of verifiable post-graduate work experience performing clinical functions in medication management may be substituted for the one year residency or fellowship experience requirement)

3. If applicable, completion of immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education if initiating or administering vaccines under section II, G

4. If applicable for a specialty SP, completion of a specialty pharmacy residency or fellowship related to the area of practice (e.g. emergency, hematology/oncology, pain, infectious disease, critical care, etc.) OR three or more years of verifiable post-graduate work experience performing clinical functions in the specialty area medication management which may include board certification in the specialty area.

A. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Chief Pharmacy Officer or designee will assess the clinical pharmacist's ability to practice under the scope of this SP and review 10 charts or 10 direct observations that include medication changes made by the clinical pharmacist. Documentation will be reviewed and signed off by the clinic medical director, chief of service, or designee.

2. Annual: Chief Pharmacy Officer or designee will evaluate the clinical pharmacist's competence by reviewing 5 chart reviews or 5 direct observations every 2 years to align with the reappointment window for Medical Staff Office credentialing. Documentation of these evaluations will be reviewed and signed off by the clinic medical director, chief of service, or designee.

3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief Pharmacy Officer or designee at appropriate intervals until acceptable skill level is

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achieved.

5. Development and approval of standardized procedure

E. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians and pharmacists, and conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

F. Approval

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

G. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

H. Revisions

All changes or additions to the standardized procedures are to be approved the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee, and Joint Conference Committee prior to their implementation.

VI. Protocol for Medicine Pain Service

A. Definitions: This protocol describes the procedure for the Clinical Pharmacist with the Inpatient Medicine Pain Service and Pain Clinic
1. The patient must be referred for the management of pain
2. Standardized Procedure functions will be performed only when a consulting physician is available in person or by phone to the clinical pharmacist.
3. Conditions requiring consultation with the Medicine Pain Service physician.
~~4. Referral by medical team for patients with unrelieved pain.~~

B. Assessment
1. Subjective
   a. Chief complaint or present status of pain
   b. Medication reconciliation, adherence, and concordance, including specifically including pain medications, medications for constipation, psychoactive medications and other treatments for pain
   c. Other symptoms

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d. History of present illness, including relevant past medical history, pain history, substance use disorder and review of systems

2. Objective
   a. Vitals
   b. Drug-related therapy test results, such as renal and/or hepatic function. CBC, Urine toxicology
   c. ~~gy~~

Other laboratory tests as per physician order

d.

~~b.~~ Medication coverage based on insurance or other coverage plan.

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C. Evaluation

1. Evaluate patient's response to medications prescribed in relation to pain,
2. Evaluate the appropriateness of patient's drug therapy, side effects, drug interactions, allergies and adherence
3. Evaluate the need for physician consultation as outlined under section III, B, 3.
4. Evaluation to ensure that, whenever relevant, prescribed or recommended medications are consistent with the patient's insurance or medication plan coverage.

D. Management

1. Initiate, adjust or discontinue pain medication regimens or pain-related medication regimens to enhance medication adherence and efficacy, decrease risk for adverse effects and drug interactions as indicated by the patient's condition. This will be done by either writing recommendations to the Primary Team or writing orders after consultation with the Primary Team or physician. When writing orders, the name of the Primary Care team member who concurs with the order will be included in the medication order.
2. Educate patient on the medication therapy including indications, efficacy, side effects, and dosing schedules.
3. Order test for monitoring and managing drug therapy for chronic illnesses, requiring long-term treatment with pain medications.

E. Record keeping

1. All consultations will be written in the clinical progress note section of the chart and must be completed within 24 of the patient encounter. ~~.~~
2. Medical records will be kept on all patients seen by the clinical pharmacist and will include pain history, diagnosis, therapy prescribed or maintained, and follow-up using "pain scale" as appropriate.
3. Progress notes are completed in the electronic medical record by the Clinical Pharmacist within 24 hours of the patient encounter.
4. All drug therapy initiations, adjustments and/or discontinuations made by the Clinical Pharmacist will be entered in the electronic medical record.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

~~**Reviewed:** 2021, 7/25,~~
~~**Reviewed by:**~~**ZSFG 2025 Clinical Pharmacist Pain Standardized Procedures**
Medical Director or Division Chief Approval or Service Chief Approval:
David Smith, PharmD, Director of Pharmacy
Author Name: Ed Lor
CIDP Approval Date: 10/1/2025
Credentials Approval Date:
MEC Approval Date:
Gov. Body Approval Date:

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San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

CLINICAL SERVICE: PHARM D

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET	COMMENTS
CORE				
Medicine: Medicine Pain Service	5 direct observations of 5 patients utilizing the Pain Consultation Service	Direct observation of 5 patients on the Pain Consultation Service annually.		

_____ _____

Chief of Service 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.

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE FOR HEMATOLOGY/ONCOLOGY CLINICAL PHARMACIST

~~I. Policy statement~~

~~A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively by health professionals, including physicians, pharmacists, physician assistants, nurse practitioners, and registered nurses.~~

~~B. A copy of the signed procedures will be kept in the Medical Staff Office and the respective clinics.~~

~~II. Functions to be performed~~

~~The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians, physician assistants, nurse practitioners, and registered nurses.~~

~~A. Performing patient assessment~~

~~B. Ordering and interpreting drug therapy-related tests~~

~~C. Referring patients to other health care providers~~

~~D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers~~

~~E. Initiating, adjusting, or discontinuing drug therapy; in consultation with the oncology provider or, if unavailable, the on-call hematology/oncology fellow or attending physician.~~

~~F. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.~~

~~III. Circumstances under which a clinical pharmacist may perform function~~

~~B. Setting~~

The clinical pharmacist may perform the following standardized procedure functions in the hematology/oncology clinics, infusion center, and inpatient wards consistent with their experience and training.

C. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer and the medical directors of the service where they provide clinical pharmacist services consistent with the needs and expectations of the DPH and SFHN. The clinical pharmacists are under the direct supervision of the service medical director.

2. Overlapping functions are to be performed in areas which allow for a consulting physician to be available to the clinical pharmacist, available by phone, in person or other electronic means at all times

3. Physician consultation is to be obtained under the following circumstances:

a) Medical conditions requiring prompt medical intervention
b) Acute decompensation of a patient
c) Medical problems not resolving as anticipated
d) Unexplained historical, physical or laboratory findings
e) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
f) Early requests for controlled substance refills based upon pain agreement between a provider and the patient
g) Upon request of patient, physician or clinical pharmacist
h) Violent or verbally abusive patient behavior

IV. Requirements for the clinical pharmacist

D. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of a one year pharmacy residency program; OR

3. Possession of a Doctor of Pharmacy degree and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management.

(Two years of verifiable post-graduate work experience performing clinical functions in medication management, or certification as Board Certified Pharmacotherapy Specialist may be substituted for the one year residency or fellowship experience requirement.)

4. Completion of a specialty residency or fellowship in Hematology/Oncology Pharmacotherapy OR three or more years of verifiable post-graduate work experience

performing clinical functions in oncology-related medication management with certification as a Board Certified Oncology Pharmacist

A. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Service Medical Director or designee will assess the clinical pharmacist's ability to practice utilizing feedback from consulting providers, and review ten charts for the oncology protocol and five charts for the hematology protocol, or the equivalent number of direct observations. Documentation will be reviewed and signed off by the service medical director or designee.

2. Reappointment: Service Medical Director or designee will evaluate the clinical pharmacist's competence and documentation by reviewing five charts for the oncology protocol and three charts for the hematology protocol, or the equivalent number of direct observations.

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

V. Development and approval of standardized procedure

E. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians, pharmacists, and registered nurses, and should conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

F. Approval

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

G. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

H. Revisions

All changes or additions to the standardized procedures are to be approved prior to use.

VI. Protocol for Oncology

A. Definition: This protocol describes the procedure for clarifying cancer treatment orders for patients who are being treated by ZSFG Hematology/Oncology Service Providers. This protocol also describes the procedure for the provision of related medications (including

anti-emetics, growth factor support, supportive care, and suppressive therapy for prophylaxis) and anticoagulation.

B. Assessment

1. Subjective
   a. Chief complaints
   b. History of present illness including relevant medication history
   c. Signs and symptoms related to the patient's medication therapy or underlying illnesses
   d. Medication reconciliation, adherence and concordance
   e. History of allergy and medication intolerance

2. Objective
   a. Physical assessment
   b. Drug-therapy related test results
   c. Medication coverage based on insurance or other coverage plan.

C. Evaluation

1. Evaluate medication response in relation to pertinent diagnosed malignancy

2. Evaluate patient's tolerance of prescribed chemotherapy, in context of current and potential supportive therapies

3. Evaluate the appropriateness of patient's drug therapy, side effects, drug interactions, allergies and adherence

4. Evaluate the need for physician consultation as outlined under section III, B, 3.

5. Evaluation to ensure that, whenever possible, prescribed or recommended medications are consistent with the patient's insurance or medication plan coverage.

D. Management

1. Educate patient on the medication therapy including indications, efficacy, side effects, and dosing schedules.

2. For existing chemotherapy orders, provide clarification to chemotherapy orders with regards to schedule or dose changes; weight/BSA changes; or diluent choice, volume or infusion rate.

3. For related medications hematology/oncology medication orders, modify therapy to increase chemotherapy tolerability, increase medication adherence and efficacy, decrease risks for adverse effects and drug interactions, and to meet formulary requirements with respect to the patient's pharmacy benefits, with consideration of the most recent edition of SFDPH-based and/or nationally recognized guidelines, including (but not limited to):

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4. ~~Recommend over-the-counter medications to patients to address signs and symptoms experienced by the patient to address the disease state or side effects of treatments provided.~~

5. ~~Educate on self-management techniques to improve treatment tolerability~~

6. ~~Order tests for monitoring and managing drug therapy, in coordination with the patient's hematology/oncology provider.~~

7. ~~Refer patients to other members of the multidisciplinary team for additional services or consultation as needed, such as nutritional consults and social worker services.~~

8. ~~Schedule follow-up appointments with patient's hematology/oncology providers or the infusion center.~~

9. ~~Consult with the oncology provider or, if unavailable, the on-call hematology/oncology fellow or attending physician, as outlined under section III, B, 3.~~

E. ~~Record keeping~~

1. ~~Progress notes are completed in the electronic medical record within 72 hours of patient visits.~~

2. ~~All drug therapy initiations, adjustments and discontinuations are entered in the medical record within 24 hours.~~

3. ~~All prescriptions, including those also requiring a paper prescription, are entered in the electronic medical record.~~

1. Policy statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators, and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept electronically and on file in the Medical Staff Office and the office of the Department Chief or Medical Director.

2. Functions to be performed

The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians and registered nurses.

A. Performing patient assessment

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B. If applicable, ordering and interpreting drug therapy-related tests

C. If applicable, referring patients to other health care providers

D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy; the patient's treating prescriber may prohibit any adjustment or change in the patient's drug regimen by the clinical pharmacist.

F. As appropriate in the area of practice, communicate drug therapy changes to the care team.

G. Administering drugs and biologicals pursuant to a prescriber's order (the administration of immunizations under the supervision of a prescriber may also be performed outside of a licensed health care facility).

H. If applicable, initiating and administering vaccine listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP) or California Department of Public Health (CDPH), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC)

I. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

3. Circumstances under which a clinical pharmacist may function

B. Setting

The clinical pharmacist may perform the following standardized procedure functions in the listed clinics consistent with their experience and training.

C. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer, and the medical directors or chiefs of service of clinics or departments where they provide clinical pharmacist services.

2. If applicable, University of California-San Francisco pharmacists practicing in SFHN clinics are under the direct supervision of the clinic medical director. They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent with the needs and expectations of the DPH and SFHN. Performance appraisals and other professional oversight are the responsibility of the clinic medical director.

3. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the clinical pharmacist, available by phone, in person or other electronic means at all times

4. Provider consultation is to be obtained under the following circumstances:

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h) Medical conditions requiring prompt medical intervention
h) Acute decompensation of a patient
h) Medical problems not resolving as anticipated
h) Unexpected historical, physical or laboratory findings
h) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
h) Early requests for controlled substance refills based upon pain agreement between a provider and the patient
h) Upon request of patient, provider or clinical pharmacist
h) Violent or verbally abusive patient behavior

4. Requirements for the clinical pharmacist

D. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

   Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

   (Two years of verifiable post-graduate work experience performing clinical functions in medication management may be substituted for the one year residency or fellowship experience requirement)

3. If applicable, completion of immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education if initiating or administering vaccines under section II, G

4. If applicable for a specialty SP, completion of a specialty pharmacy residency or fellowship related to the area of practice (e.g. emergency, hematology/oncology, pain, infectious disease, critical care, etc.) OR three or more years of verifiable post-graduate work experience performing clinical functions in the specialty area medication management which may include board certification in the specialty area.

A. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Chief Pharmacy Officer or designee will assess the clinical pharmacist's ability to practice under the scope of this SP and review 10 charts or 10 direct observations that include medication changes made by the clinical pharmacist. Documentation will be reviewed and signed off by the clinic medical director, chief of service, or designee.

2. Annual: Chief Pharmacy Officer or designee will evaluate the clinical pharmacist's competence by reviewing 5 chart reviews or 5 direct observations every 2 years to align

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with the reappointment window for Medical Staff Office credentialing. Documentation of these evaluations will be reviewed and signed off by the clinic medical director, chief of service, or designee.

3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief Pharmacy Officer or designee at appropriate intervals until acceptable skill level is achieved.

5. Development and approval of standardized procedure

E. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians and pharmacists, and conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

F. Approval

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

G. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

H. Revisions

All changes or additions to the standardized procedures are to be approved the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee, and Joint Conference Committee prior to their implementation.

~~VII.~~ 6. Protocol for Non-Malignant Hematologic Disorders

A. Definition: This protocol describes the pharmacist management of patients who are being treated by ZSFG Hematology Service Providers for non-malignant hematologic disorders.

B. Assessment

1. Subjective
   a. Chief complaints
   b. History of present illness including relevant medication history
   c. Signs and symptoms related to the patient's medication therapy or underlying illnesses
   d. Medication reconciliation, adherence and concordance
   e. History of allergy and medication intolerance

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2. Objective
   a. Physical assessment
   b. Drug-therapy related test results
   c. Medication coverage based on insurance or other coverage plan.

C. Evaluation

1. Evaluate medication response in relation to the non-malignant hematologic disorder

2. Evaluate the appropriateness of patient's drug therapy, drug interactions, allergies and adherence

3. Evaluate the need for physician consultation as outlined under section III, B, 3.

~~4.~~2. Evaluation to ensure that, whenever possible, prescribed or recommended medications are consistent with the patient's insurance or medication plan coverage.

D. Management

1. Educate patient on the pathophysiology of the non-malignant hematologic disorder, and medication therapy including indications, efficacy and side effects.

2. Initiate, adjust or discontinue medication(s) based on lab and monitoring parameters, according to prescribing, patient's history of response to the medication, or the most recent edition of SFDPH-based and/or nationally recognized guidelines or published articles.

3. Order tests for monitoring and managing drug therapy, in coordination with the patient's primary care provider or specialty providers.

4. Schedule follow-up appointments with patient's hematologist or infusion center.

5. Consult with the oncology provider or, if unavailable, the on-call hematology/oncology fellow or attending physician, as outlined under section III, B, 3.

B. Record keeping

1. Progress notes are completed in the electronic medical record within 72 hours of patient visits.

2. All drug therapy initiations, adjustments and discontinuations are entered in the medical record within 24 hours.

3. All prescriptions, including those also requiring a paper prescription, are entered in the electronic medical record.

Author Name: Taylor Yasunaga~~; Catharine Pang, PharmD~~
CIDP Approval Date: 1~~2/04/2019~~ **0/1/2025**
Credentials Approval Date: ~~1/06/2020~~
MEC Approval Date: ~~01/16/2020~~
Gov. Body Approval Date: ~~01/28/2020~~

San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

CLINICAL SERVICE: PHARM D

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET	COMMENTS
CORE				
Medicine: Oncology/Hematology	10 chart reviews of oncology patients and 5 charts of hematology patients.	~~10~~ 5 chart reviews of oncology patients ~~and~~ ~~6~~and 3 chart reviews of hematology patients every 2 years.		

_____ _____

Chief of Service 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.

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE FOR AMBULATORY CARE CLINICAL PHARMACIST

Medication Therapy Management Clinics at:

Anticoagulation Clinic
Cardiology Clinic
Castro Mission Health Center
Children's Health Center
Chinatown Health Center
Community Health Programs for Youth
Curry Senior Center
~~Ocean Park Health Center~~
Family Health Center
Maxine Hall Health Center
Maria X Martinez Health Resource Center
~~Curry Senior Center~~
Ocean Park Health Center
Positive Health Program
Potrero Hill Health Center
Richard Fine People's Clinic
Silver Avenue Family Health Center
Southeast Health Center
Tom Waddell Urban Health Center
~~Family Health Center~~
~~Richard Fine People's Clinic~~
~~Positive Health Program~~
~~Children's Health Center~~
~~Community Health Programs for Youth~~
Special Programs for Youth
~~Maria X Martinez Health Resource Center~~

I. Policy statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators, and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept electronically and on file in the Medical Staff Office and the office of the Department Chief or Medical Director.

II. Functions to be performed

The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians and registered nurses.

A. Performing patient assessment

B. If applicable, ordering and interpreting drug therapy-related tests

C. If applicable, referring patients to other health care providers

D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy; the patient's treating prescriber may prohibit any adjustment or change in the patient's drug regimen by the clinical pharmacist.

F. As appropriate in the area of practice, communicate drug therapy changes to the care team.

G. Administering drugs and biologicals pursuant to a prescriber's order (the administration of immunizations under the supervision of a prescriber may also be performed outside of a licensed health care facility).

H. If applicable, initiating and administering vaccine listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP) or California Department of Public Health (CDPH), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC)

I. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

III. Circumstances under which a clinical pharmacist may function

A. Setting

The clinical pharmacist may perform the following standardized procedure functions in the listed clinics consistent with their experience and training.

B. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer, and the medical directors or chiefs of service of clinics or departments where they provide clinical pharmacist services.

2. If applicable, University of California-San Francisco pharmacists practicing in SFHN clinics are under the direct supervision of the clinic medical director. They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent with the needs and expectations of the DPH and SFHN. Performance appraisals and other professional oversight are the responsibility of the clinic medical director.

3. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the clinical pharmacist, available by phone, in person or other electronic means at all times

4. Provider consultation is to be obtained under the following circumstances:

   a) Medical conditions requiring prompt medical intervention
   b) Acute decompensation of a patient
   c) Medical problems not resolving as anticipated
   d) Unexpected historical, physical or laboratory findings
   e) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
   f) Early requests for controlled substance refills based upon pain agreement between a provider and the patient
   g) Upon request of patient, provider or clinical pharmacist
   h) Violent or verbally abusive patient behavior

IV. Requirements for the clinical pharmacist

A. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

   Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

   (Two years of verifiable post-graduate work experience performing clinical functions in medication management may be substituted for the one year residency or fellowship experience requirement)

3. If applicable, completion of immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education if initiating or administering vaccines under section II, G

4. If applicable for a specialty SP, completion of a specialty pharmacy residency or fellowship related to the area of practice (e.g. emergency, hematology/oncology, pain, infectious disease, critical care, etc.) OR three or more years of verifiable post-graduate work experience performing clinical functions in the specialty area medication management which may include board certification in the specialty area.

B. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Chief Pharmacy Officer or designee will assess the clinical pharmacist's ability to practice under the scope of this SP and review 10 charts or 10 direct observations that include medication changes made by the clinical pharmacist. Documentation will be reviewed and signed off by the clinic medical director, chief of service, or designee.

2. Renewal~~Annual~~: Chief Pharmacy Officer or designee will evaluate the clinical pharmacist's competence by reviewing 5 chart reviews or 5 direct observations every 2 years to align with the reappointment window for Medical Staff Office credentialing. Documentation of these evaluations will be reviewed and signed off by the clinic medical director, chief of service, or designee.

3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief Pharmacy Officer or designee at appropriate intervals until acceptable skill level is achieved.

V. Development and approval of standardized procedure

A. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians and pharmacists, and conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

B. Approval

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

C. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

D. Revisions

All changes or additions to the standardized procedures are to be approved the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee, and Joint Conference Committee prior to their implementation.

~~I. Policy statement~~

~~A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively by health professionals, including physicians, pharmacists, and registered nurses.~~

B. A copy of the signed procedures will be kept in the Medical Staff Office and the respective clinics.

II. Functions to be performed

The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians and registered nurses.

A. Performing patient assessment

B. Ordering and interpreting drug therapy-related tests

C. Referring patients to other health care providers

D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy; the patient's treating prescriber may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the clinical pharmacist.

F. Administering drugs and biologicals by injection pursuant to a prescriber's order (the administration of immunizations under the supervision of a prescriber may also be performed outside of a licensed health care facility).

G. Initiating and administering vaccine listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC)

H. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

III. Circumstances under which a clinical pharmacist may function

A. Setting

The clinical pharmacist may perform the following standardized procedure functions in the listed clinics consistent with their experience and training.

B. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer, and the medical directors of clinics where they provide clinical pharmacist services.

2. University of California San Francisco pharmacists practicing in SFHN clinics are under the direct supervision of the clinic medical director. They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent

with the needs and expectations of the DPH and SFHN. Performance appraisals and other professional oversight are the responsibility of the clinic medical director.

3. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the clinical pharmacist, available by phone, in person or other electronic means at all times

4. Provider consultation is to be obtained under the following circumstances:

a) Medical conditions requiring prompt medical intervention
b) Acute decompensation of a patient
c) Medical problems not resolving as anticipated
d) Unexpected historical, physical or laboratory findings
e) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
f) Early requests for controlled substance refills based upon pain agreement between a provider and the patient
g) Upon request of patient, provider or clinical pharmacist
h) Violent or verbally abusive patient behavior

IV. Requirements for the clinical pharmacist

A. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

(Two years of verifiable post-graduate work experience performing clinical functions in medication management may be substituted for the one year residency or fellowship experience requirement)

3. Completion of immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education if initiating or administering vaccines under section II, G

4. Completion of an annual geriatric competency relevant to the pharmacist's professional practice

B. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Chief Pharmacy Officer or designee will assess the clinical pharmacist's ability to practice utilizing

feedback from consulting providers, and review ten charts or 10 direct observations that include medication changes made by the clinical pharmacist. Documentation will be reviewed and signed off by the clinic medical director or designee.

2. Annual: Chief Pharmacy Officer or designee will evaluate the clinical pharmacist's competence by reviewing 5 chart reviews or 5 direct observations every 2 years to align with the 2 year reappointment window for Medical Staff Office credentialing. Documentation will be reviewed and signed off by the clinic medical director or designee.

3. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief Pharmacy Officer or designee at appropriate intervals until acceptable skill level is achieved.

Commented [DJ(1]: Changed to 5

Commented [AM2]: It says 5 charts for amb care in the other document

Commented [AEK3R2]: Agree with 5 chart reviews or direct observations to align with amb care

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V. Development and approval of standardized procedure

A. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians, pharmacists, and registered nurses, and should conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

B. Approval

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

C. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

D. Revisions

All changes or additions to the standardized procedures are to be approved prior to use.

VI. Standardized procedures in Medication Therapy Management Clinic

A. Definition: This protocol describes the pharmacist management of patients referred to medication therapy management clinic at one or more of the ~~following~~ clinics listed on ~~:~~ ~~Anticoagulation Clinic, Cardiology Clinic, Castro Mission Health Center, Chinatown Public Health Center, Ocean Park Health Center, Maxine Hall Health Center, Curry Senior Center, Potrero Hill Health Center, Silver Avenue Family Health Center, Southeast Health Center, Tom Waddell Urban Health Center, Family Health Center, Richard Fine People's Clinic, and Positive Health Program, Children's Health Center, Community Health Programs for Youth, Special Programs for Youth (see page 1)~~.

The patient must meet the following criteria:

a. is a registered patient at the clinic

b. has previously been evaluated by a DPH/UCSF licensed provider or contracted provider

B. Assessment

1. Subjective
   a. Chief complaints
   b. History of present illness including relevant medication history
   c. Signs and symptoms related to the patient's medication therapy or underlying illnesses
   d. Medication reconciliation, adherence and concordance
   e. History of allergy and medication intolerance

2. Objective
   a. Physical assessment
   b. Drug-therapy related test results
   c. Medication coverage based on insurance or other coverage plan.

C. Evaluation

1. Evaluate medication response in relation to pertinent diagnosed chronic diseases

2. Evaluate patient's understanding of chronic diseases and therapy

3. Evaluate the appropriateness of patient's drug therapy, drug interactions, allergies and adherence

4. Evaluate the need for provider consultation as outlined under section III, B, 3.

5. Evaluation to ensure that, whenever possible, prescribed or recommended medications are consistent with the patient's insurance or medication plan coverage.

D. Management

1. Educate patient on the pathophysiology of chronic diseases, and medication therapy including indications, efficacy and side effects.

2. Initiate, adjust or discontinue medication(s) for documented diagnosed chronic conditions to enhance medication adherence and efficacy, decrease risks for adverse effects and drug interactions, and to meet formulary requirements with respect to the patient's pharmacy benefits, with consideration of the most recent edition of SFDPH-based and/or nationally recognized guidelines.

3. Recommend over-the-counter medications based on signs and symptoms.

4. Educate on self-management techniques to improve chronic disease management.

5. Order tests for monitoring and managing drug therapy, in coordination with the patient's primary care provider or specialty providers.

6. Refer patients to other members of the multidisciplinary team for additional services or consultation as needed, such as nutritional consults and behavioral health services.

7. Schedule follow-up appointments with patient's primary care provider or specialty providers

8. Schedule follow-up appointments to medication therapy management clinics based upon patient's treatment plan.

9. Consult with provider as outlined under section III, B, 4.

E. Record keeping

1. Progress notes are completed within 72 hours of patient visits.

2. All drug therapy initiations, adjustments and discontinuations are entered in the electronic health record within 24 hours.

3. Vaccinations are entered in the electronic health record within 24 hours.

4. All prescriptions, including those requiring a paper prescription, are entered in the electronic medical record.

ZSFG 2025 Clinical Pharmacist Ambulatory Care Standardized Procedures
Medical Director or Division Chief Approval or Service Chief Approval:
David Smith, PharmD, Director of Pharmacy
Author Name: Anusha McNamara
CIDP Approval Date: 10/1/2025
Credentials Approval Date:
MEC Approval Date:
Gov. Body Approval Date:

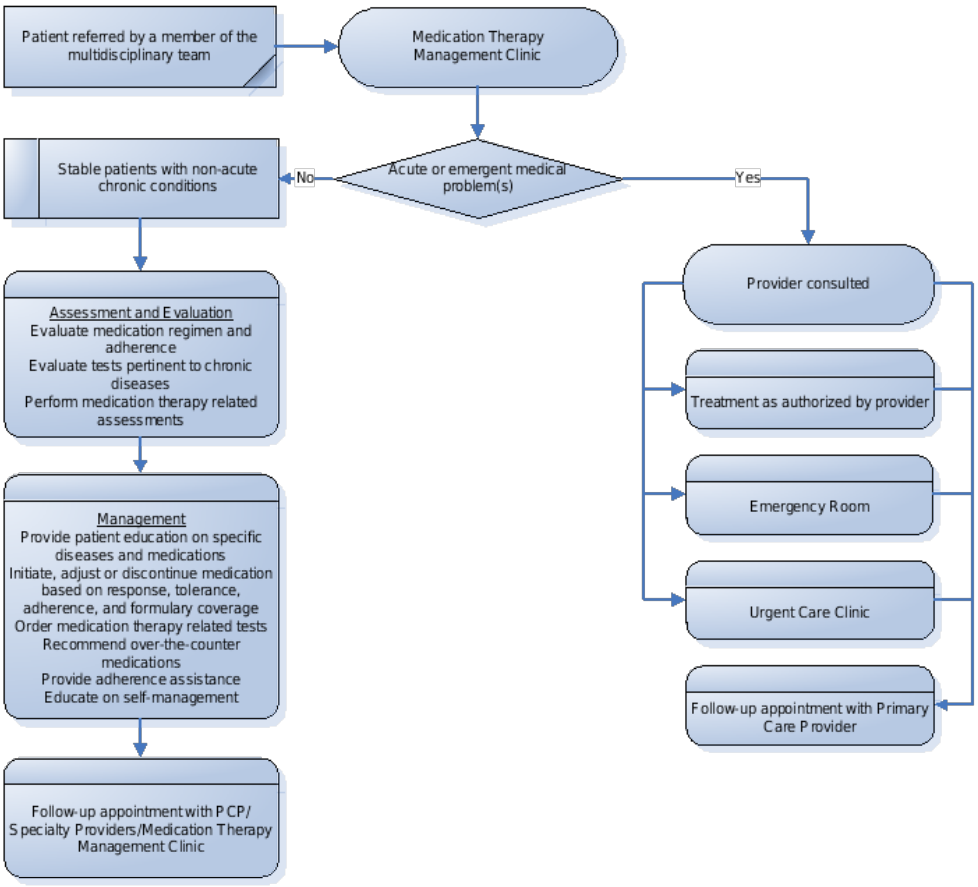
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Figure 1

Medication Therapy Management Clinic



San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

CLINICAL SERVICE: PHARM D

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET	COMMENTS
CORE				
Ambulatory Care	10 charts or the equivalent number of direct observations that include medication changes made by the clinical pharmacist.	~~5~~Review of 10- charts, or the equivalent number of direct observations every 2 years.		

_____ _____

Chief of Service 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

2023~~1~~

~~INPATIENT~~ACUTE CARE CLINICAL PHARMACIST STANDARDIZED PROCEDURE

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ZSFG Clinical Services:

- Family Medicine Inpatient Service
- Internal Medicine
- Neonatology and Pediatrics
- Psychiatry
- Trauma
- Critical Care
- Cardiology
- Obstetrics and Gynecology

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~~Title: Family Medicine Inpatient Service – Clinical Pharmacist~~

I. Policy Statement

A. It is the policy of the Community Health Network and Zuckerberg San Francisco General Hospital Medical Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Registered Nurses, Physicians, Pharmacists, Administrators, and other Affiliated Staff

B. A copy of the signed procedures will be kept in an operational manual in Hospital Pharmacy Administration, and on file in the Medical Staff Office

II. Functions to be performed

The Clinical Pharmacist, in accordance to the California Business and Professions Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a licensed health care facility as part of a multidisciplinary team, including physicians, physician assistants, nurse practitioners, and registered nurses

A. Perform drug therapy-related patient assessment

B. Order and interpret drug therapy-related laboratory tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies

C. Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers

D. Initiate, adjust, or discontinue drug regimen and/or PPN/TPN order of a patient in consultation with the ~~Family Medicine~~ clinical service provider

E. Provide consultation, training, and education to patients about drug therapy, disease management, and disease prevention

III. Circumstances under Which a Clinical Pharmacist May Perform Function

A. Setting:

The Clinical Pharmacist may perform the following standardized procedure functions in the medical and psychiatric emergency units and the inpatient units at ~~**inpatient Family Medicine Service at**~~ Zuckerberg San Francisco General Hospital consistent with their experience and credentialing, including but not limited to, ordering and interpreting drug therapy related tests, initiating, adjusting or discontinuing medications or TPNs/PPNs after discussion with a ~~provider~~Physician.

B. Scope of Supervision Required

1. Clinical Pharmacists are responsible and accountable to the Chief Pharmacy Officer and under the direct supervision of ~~-~~ their clinical service Medical Director~~the Inpatient Family Medicine Medical Director~~. They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent with the needs and expectations of the DPH and SFHN

2. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the Clinical Pharmacist by phone, in person or other electronic means at all times

3. Provider consultation is to be obtained under the following circumstances~~, in addition to when medication orders are being entered:~~

   a. Medical conditions requiring prompt medical intervention
   b. Acute decompensation of a patient
   c. Medical problems not resolving as anticipated
   d. Unexplained historical, physical or laboratory findings
   e. Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy
   f. Upon request of patient, provider, or other Clinical Pharmacist
   g. Violent or verbally abusive patient behavior

IV. Requirements for the Clinical Pharmacist

A. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of a one-year pharmacy residency program; OR

   Possession of a Baccalaureate of Pharmacy degree, completion of a one-year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

   (Two years of verifiable post-graduate work experience performing clinical functions in medication management, or certification as Board Certified Pharmacotherapy Specialist may be substituted for the one-year residency or fellowship experience requirement.)

3. Relevant experience in Clinical Pharmacy in a hospital setting. Ability to work in an interdisciplinary setting as determined by DPH Chief Pharmacy Officer

~~-~~Completion of the following competencies during orientation and annually: pediatric competency, geriatric competency, vancomycin per pharmacy/renal dose adjustment competency, anticoagulation monitoring competency, and/or parenteral nutrition competency relevant to the pharmacist's professional practice

~~4. annual pediatric and/or geriatric competency relevant to the pharmacist's professional practice~~

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B. Evaluation of Clinical Pharmacist competence in performance of standardized procedures:

1. Initial: at the conclusion of the standardized procedure training the Medical Director or physician designee will assess the Clinical Pharmacist's ability to practice. Method of proctoring will be chart review or medication orders, or the equivalent number of direct observations and documentation review of 5~~10~~ patients on the inpatient clinical service.~~Family Medicine Service~~ Assessment of the clinical pharmacist's ability to manage and make recommendations based on evidence-based medication therapy shall be made, including initiation, modification, or discontinuation of therapy based on patient's response, change in condition, or concomitant therapy in order to optimize outcomes.

2. Reappointment every 2 years will include chart reviews of 5 patients or the equivalent number of direct observations on the inpatient ~~Family Medicine~~clinical Service.

3. Follow-up: areas requiring increased proficiency as determined by the initial or reappointment evaluation will be re-evaluated by the Medical Director or physician designee and Pharmacy Administration at appropriate intervals until acceptable skill level is achieved.

V. Development and Approval of Standardized Procedure

A. Method of Development

Standardized procedures are developed collaboratively by the Clinical Pharmacist, physicians, and administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474

B. Approval

All standardized procedures must be approved by CIDP, Credentials Committee, Medical Executive Committee and the Joint Conference Committee prior to use

C. Review Schedule

The standardized procedure will be reviewed every three years by the provider and medical director and as practice changes

D. Revisions

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

VI. Protocol: Clinical Pharmacist with a ZSFG~~the~~ Inpatient ~~Family Medicine~~Clinical Service

A. Definitions: Scope of Practice of the Clinical Pharmacist with the Inpatient ~~Family Medicine~~Clinical Service

1. Patient must be admitted to the clinical service that the clinical pharmacist is assigned.~~inpatient Family Medicine Service~~

2. Standardized Procedure functions will be performed only when a consulting physician is available in person or by phone to the Clinical Pharmacist

B. Assessment

1. Subjective

a. Chief complaints
b. History of present illness including relevant medication history
c. Signs and symptoms related to patient's medication therapy or underlying illness
d. Medication reconciliation, adherence, and concordance
e. History of allergy and medication intolerance

2. Objective

a. Physical assessment
b. Drug-therapy related test results
c. Medication coverage based on insurance or other coverage plan

C. Evaluation

1. Evaluate the appropriateness of patient's drug therapy, adverse reactions, drug interactions, allergies, and adherence
2. Evaluate the need for physician consultation as outlines under section III, B
3. Evaluate to ensure that, whenever possible, prescribed or recommended medications are consistent with the patient's insurance or medication plan coverage

D. Management

1. Order laboratory tests for monitoring and managing drug therapy, in coordination with the patient's ~~patient's~~ clinical service provider~~inpatient Family Medicine provider~~
2. Initiate, adjust, or discontinue medication(s) for conditions discussed with inpatient ~~Family Medicine~~clinical service physicians to enhance medication adherence and efficacy, decrease risk for adverse effects and drug interactions, and/or to meet formulary requirements with respect to the patient's pharmacy benefits, with consideration of the most recent edition of SFDPH-based and/or nationally recognized guidelines
3. Consult with inpatient clinical service ~~Family Medicine~~ provider, as outlined under section III, B
4. This protocol does not supersede existing hospital policies regarding medications requiring approval, for example chemotherapy or non-formulary medications.

E. Record keeping

1. Progress notes are completed in the electronic medical record by the Clinical Pharmacist
2. All drug therapy initiations, adjustments and/or discontinuations made by the Clinical Pharmacist will be entered in the electronic medical record
3. Documentation of discussion will be noted in the provider's daily progress note by the notation of "Drug dosing and labs discussed with clinical pharmacist" by the inpatient ~~Family Medicine~~clinical service provider

202531 ~~Family Medicine~~ Inpatient ~~Service~~ Clinical Pharmacist Standardized Procedures	
Author: ~~Tamara Lenhoff~~Tamara Lenhoff, PharmD, Mark Jones, PharmD	Supervising Pharmacist: Mark Jones, PharmD
CIDP	~~8/04/2021~~

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Credentials Committee	~~9/07/2021~~
Medical Executive Committee	~~9/16/2021~~
Governing Body (JCC)	~~9/28/2021~~

San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

CLINICAL SERVICE: ACUTE CARE PHARM D

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET	COMMENTS
CORE				
Family Medicine Inpatient Service	10 charts or medication orders, or the equivalent number of direct observations and documentation review, including at least 2 medication starts, 2 medication changes, and 2 medication discontinuations.	5 charts, or the equivalent number of direct observations		

Commented [EK1]: Initiation, changes and discontinuation is mentioned in SP, but the #2 of each not specified.

_____ _____

Chief of Service 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

Emergency Department

Emergency Department Registered Nurse

Standardized Procedures and Protocols

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Zuckerberg San Francisco General Hospital and Trauma Center
Emergency Department

Emergency Department Registered Nurse
Standardized Procedures and Protocols Manual

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Distribution List:

Copy 1:	Telemetry Room
Copy 2:	CIDP committee
Electronic copy 3:	ED CNS office, ED Director's Office
Master copy:	Medical Staff Office

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Christopher B Colwell, MD Date
Chief, Emergency Medicine

Gillian Otway RN CNL (I can't get the underline off)
Nursing DIrectorDirector, Emergency Department
Chief Nursing Officer

Matthew Talmadge MSN, FNP-BC, PHN
Erinn Darmstadt, RN Date
Interim
Lead Nurse Manager, Emergency Department

Robbie Gnat RN, NP

Brian Cross, BSN, RNDate
Nurse Manager, Emergency Department

Meghan Koch RN, BSN

Elvina Hewitt, MSN, RN Date
Meghan Koch RN, BSN Date
Interim Nurse Manager, Emergency Department

David Staconis, RN, MSN, NP Date
Interim Nursing Director, Emergency Department

List updated 9/35/2025/3/20259/28/2021

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Zuckerberg San Francisco General Hospital and Trauma Center

Emergency Department

Standardized Procedures:
Emergency Department Registered Nurse

Introduction

The following protocols are the policies and guidelines for the care provided to patients at Zuckerberg San Francisco General Hospital (ZSFG) Emergency Department (ED) by the Registered Nurse (RN). Since it is impossible to anticipate every clinical situation or presenting chief complaint that may arise, it is expected that Attending Physician consultation may be warranted. The RN will consult the Attending Physician by using their nursing clinical judgment. In general, the RN shall function within the scope of practice as specified in the State of California Nurse Practice Act. Every patient presenting to the Emergency Department is evaluated by a provider (MD/NP/PA) regardless of the initiation of a standardized procedure by the RN. All Standard Procedures are intended for adult patients >18 years, unless otherwise indicated. When the Standardized Procedure is initiated and any diagnostic test is ordered (blood tests, radiologic exams as listed in the procedure), the Attending in Charge will be listed as the ordering provider.

The Standardized Procedures were developed with assistance from the following:

1. Implementation of Standardized Procedures. Position Statement of the California Nurse Association
2. Standardized Procedure Work Sheet, State of California Board of Registered Nursing, Department of Consumer Affairs.

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

STANDARDIZED PROCEDURE Registered Nurse Order Entry in the Emergency Department

Title: Registered Nurse in the Emergency Department

I. Purpose of Policy

To expedite patient care by initiating evidence-based interventions by Registered Nurses based on patient complaint and acuity. These medical staff approved procedures and protocols are intended to be a guide for RNs to initiate basic interventions in the Emergency Department.

II. Policy Statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Registered Nurses, Physicians, Administrators and other Affiliated Staff and conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, a copy of the signed procedures will be kept in an operational manual in the Emergency Department, and on file in the credentialing liaison Medical Staff Office.

II. Functions to be performed

The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. The RN provides interdependent functions that overlap the practice of medicine. These overlapping functions require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the RN to seek provider consultation.

III. Circumstances Under Which RN May Perform Function

A. Setting
The Registered Nurse may perform the following standardized procedure functions in the Emergency Department consistent with their experience and training.

B. Scope of Supervision Required
1. The RN is responsible and accountable to the Emergency Department Nurse Manager and Medical Director or physician designee.
2. Overlapping functions are to be performed in areas, which allow for a consulting Emergency Department provider to be available to the RN, by phone or in person, including but not limited to the clinical area.
3. Provider consultation is to be obtained as specified in the protocols and under the following circumstances:
   a) Emergency conditions requiring prompt medical intervention
   b) Upon the request of the patient, registered nurse, or provider
4. Every patient who presents to the Emergency Department is evaluated by a provider, regardless of the initiation of a Standardized Procedure by the RN.

IV. Requirements for the Registered Nurse

A. Experience and Education
1. Active California Registered Nurse license
2. Current Basic Life Support certification
3. Current Advanced Cardiac Life Support certification
4. Current Emergency Nurse Pediatric Course certification

B. Special Training
1. Enrollment in the Emergency Department orientation program by the Emergency Department Nurse Manager
2. Successful completion of the orientation program, including protocol specific training, requirements described by the *Guidelines for Emergency Nursing Practice*

C. Evaluation of the Registered Nurse competence in performance of standardized procedures
1. Initial: at the conclusion of the standardized procedure training the Nurse Manager or designee will assess the RN's ability to perform the procedures.
   a. Successful completion of the RN orientation program

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b. Successful completion of a review of accuracy and completeness of documentation for actual patient cases (minimum of ten the first year, then five thereafter)

2. Annual: Nurse Manager or designee will evaluate the RN's competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation and/ or chart review.
3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, or designee at appropriate intervals until acceptable skill level is achieved. This evaluation may include chart reviews.

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V. Development and Approval of Standardized Procedure

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

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

C. Review Schedule
The standardized procedures will be reviewed every three years by the registered nurses, nurse manager, nurse director and medical director and as practice changes.

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

Protocol #1
Assessment and Management of Abdominal Pain

Protocol: Infestation

A. Definition: This protocol covers the initial assessment and management of patients with abdominal pain seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Generalized abdominal pain
- Reliable history of abdominal pain

Exclusions
- Gastrointestinal bleeding, vomiting and diarrhea, vaginal bleeding, suspected renal colic, sickle cell crisis

B. Data Base

1. Subjective Data

• Review history and signs and symptoms related to abdominal pain.
- Date of last menstrual period in women age <50 years

• Pertinent past medical history; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (cramping, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to abdominal pain
- Measure vital signs every 30 minutes x2.
- Level of consciousness (may use Glascow Coma Scale)
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Laboratory and imaging evaluation
   - CBC, BMP, LFT, Lipase
   - Urinalysis, urine culture, stat POCT urine pregnancy test for women < age 50 years
   - Stat 12-lead ECG if concern for cardiac ischemia. Show to Attending MD when completed.

2. Start IV (20-gauge or larger). Draw full tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Patient education and counseling appropriate to disease process
.

4. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
     Altered mental status with GCS <13

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Protocol #2
Assessment and Management of Acute Allergic Reaction

Protocol: Acute Allergic Reaction

A. Definition: This protocol covers the initial assessment and management of patients with acute allergic reaction seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Respiratory distress with history of provoking allergenic exposure prior to symptoms or
- Vital signs suggesting hemodynamic instability (HR >120 or SBP <110)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of acute allergic reaction

- Onset, Provoking Factor/Exposure prior to symptoms
- History of past allergic reactions
- History of anaphylaxis or anaphylactic shock

• Pertinent past medical history; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to allergic reactions

• Measure vital signs

• Place on pulse oximetry and measure SpO_2

• Check skin signs for color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula or non-rebreather mask. Titrate to maintain SpO_2 >94%.

2. Start IV (18-gauge or larger). Draw full tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Administer nebulized duoneb (albuterol sulfate 2.5 mg and ipratroprium bromide 0.5 mg in 3 mL saline solution) x 1 dose if wheezing

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - Altered mental status with GCS <13
   - Signs & Symptoms of Anaphylactic Shock

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Protocol #3
Assessment and Management of Agitation/Hallucinations

Protocol: Agitation/Hallucinations

A. Definition: This protocol covers the initial assessment and management of patients with agitation and/or hallucinations seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Agitated behavior or hallucinations and any of the following:
  1. History of psychiatric disorders, IDDM, or IVDU,
  2. Decrease or cessation of alcohol or sedative intake
  3. Drug intoxication
  4. Sepsis/CNS infection
  5. Vital signs suggesting hemodynamic instability HR > 120 or SBP < 90, or temperature >38.5C

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B. Data Base

1. Subjective Data

• Review history and signs and symptoms of agitation and/or hallucinations

- Sequence of preceding events
- Duration and frequency of present symptoms
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to agitation/hallucinations

- Observe for signs of injury, needle marks, and characteristic breath odor

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2.

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Restrain Limbs per *Use of Restraints in the ED* policy.
2. Ask provider for sedation order.
3. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%
4. Obtain POCT fingerstick glucose.
5. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dl, followed by 0.9% NS flush 10ml with medication administration.
6. Notify provider and recheck POCT fingerstick glucose in one hour.
7. Patient education and counseling appropriate to disease process
8. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

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Protocol #4
Assessment and Management of Suspected Alcohol Withdrawal

Protocol: Suspected Alcohol Withdrawal

A. Definition: This protocol covers the initial assessment and management of patients with suspected alcohol withdrawal seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- History of alcohol withdrawal with a decrease or cessation of alcohol, and
- Vital signs suggesting hemodynamic instability HR > 120 or SBP < 90, or temperature >38.5C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of alcohol withdrawal
- History of daily alcohol intake and last drink
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to alcohol withdrawal
- Observe for tremors, tongue wag, hallucinations, seizure-like activity, and altered mental status (CIWA-Ar scale)
- Observe for signs of injury, needle marks, and characteristic breath odor

• Level of consciousness (may use Glasgow Coma Scale)
• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- 12-lead ECG for HR > 120, show to Attending MD when completed
- Portable chest x-ray if indicated by symptoms or history

C. Diagnosis
a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. Plan

1. Start saline lock IV for HR >120 or SBP <90. Draw full tubes. Administer 1L NS IVF bolus if HR >120 or SPB <90. May repeat x 1 if HR >120 after 1st liter bolus unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC, basic metabolic panel, and liver function tests.

3. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

4. Obtain POCT fingerstick glucose.

5. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dl. Notify provider and recheck POCT fingerstick glucose in one hour.

6. Restrain Limbs per *Use of Restraints in the ED* policy.

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13
- Seizure-like activity

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Protocol #5
Assessment and Management of Altered Mental Status

Protocol: Altered Mental Status

A. Definition: This protocol covers the initial assessment and management of patients with altered mental status seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Altered mental status and
- History of seizure disorders, IDDM, trauma, Infection, psychiatric disorders, stroke, or
- Decrease, cessation, or overdose of alcohol or drug intake

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of altered mental status

- History of seizure disorders, diabetes, trauma, infection, psychiatric disorders, stroke
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to altered mental status

- Assess for and maintain airway patency. Insert oral or nasal airway as needed.

• Level of consciousness (may use Glasgow Coma Scale) and pupillary response.

• Measure vital signs every 30 minutes x2.

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• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- 12-lead ECG, show to Attending MD when completed
- Portable chest x-ray

C. Diagnosis
a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. Plan

1. Start saline lock IV for HR > 120 or SBP <90. Draw full tubes. Administer 1000 mL NS IVF Bolus if HR >120 or SPB <90, unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC, basic metabolic panel, liver function tests, and urinalysis.

3. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

4. Obtain POCT fingerstick glucose.

5. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dl. Notify provider and recheck POCT fingerstick glucose in one hour.

6. Obtain and send urine toxicology. Split and hold sample for urine culture.

7. Restrain Limbs per *Use of Restraints in the ED* policy.

8. Patient education and counseling appropriate to disease process

9. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13

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Protocol #6
Assessment and Management of Cardiac Catheterization Lab Preparation

Protocol: Cardiac Catheterization Lab Preparation

A. Definition: This protocol covers the initial assessment and management of patients being prepped for the Cardiac Cath Lab seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Known or suspected STEMI with need to go to the Cardiac Cath Lab

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of ischemia

- Chest discomfort with STEMI
- Pain spreading to shoulders, neck, arms, or jaw, or pain in back
- Associated lightheadedness, fainting, diaphoresis, or nausea
- Shortness of breath
- Global feeling of distress, anxiety, or impending doom

• Pertinent past medical history, current medications and allergies

• Characteristics of pain (PQRST); location, quality, and intensity (1-10)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to chest pain/cardiac disease

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG, show to Attending MD when completed
- Repeat EKG 15 minutes after the initial EKG
- Right Sided EKG (if inferior ST elevation)
- Posterior EKG (if septal or anterior ST depression)
- Portable CXR

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger). Draw full blood tubes. Send CBC, basic metabolic panel, liver function tests, troponin I, BNP, PT/PTT/INR, and type and screen. Start a second saline lock IV. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Administer Aspirin 325 mg PO/PR x1 (if no contraindications or not administered prior to arrival)

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%

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Protocol #7
Assessment and Management of Chest Pain

Protocol: Chest Pain

A. Definition: This protocol covers the initial assessment and management of patients with suspected ischemic chest discomfort seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Suspected ischemic chest discomfort

Exclusions

- Acute chest trauma or suspected musculoskeletal pain
- Fever > 38 ° C (100.4 ° F)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of ischemia

- Retrosternal chest discomfort
- Pain spreading to shoulders, neck, arms, or jaw, or pain in back
- Associated lightheadedness, fainting, diaphoresis, or nausea
- Shortness of breath
- Global feeling of distress, anxiety, or impending doom

• Pertinent past medical history, current medications and allergies

• Characteristics of pain (PQRST); location, quality, and intensity (1-10)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to chest pain/cardiac disease

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs at least every two-hours, or more frequently,

as needed

- Skin signs: color, temperature, moisture, and capillary refill

3. Interventions once patient is placed in an exam room

- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

- Place on pulse oximetry and measure SpO_2

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger). Draw full tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Patient education and counseling appropriate to disease process

4. Laboratory and ECGs:
   - Stat 12-lead ECG, show to Attending MD when completed
   - Initiate and send High-Sensitivity Troponin Care Path in EMR
     - Ensure 0-hour gold top lab tube is labeled specifically with the 0-hour specimen lab label, not a generic patient label

5. Consultation with physician as needed, or:
   - HR >120
   - SBP <90

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- RR >28
- SpO_2 <92%

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Protocol #8
Assessment and Management of Dislocation/Deformity/Injury of Extremity

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Protocol: Dislocation/Deformity/Injury of Extremity

A. Definition: This protocol covers the initial assessment and management of patients with a dislocation, deformity, or injury of extremity seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

i. Obvious dislocation, deformity, or injury of extremity

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of dislocation, deformity, or injury of extremity

- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications, and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to dislocation, deformity, or injury of extremity

- Assess circulation, movement, and sensation distal to injury

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• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:

- X-ray affected extremity per protocol

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C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start IV Saline Lock. Draw full blood tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer Td/Tdap 0.5 mL IM x 1, if immunization status not up to date and an open wound is present (hold if contraindicated).

3. If open fracture, cover wound with sterile dressing and notify provider immediately.

4. Place sling/splint on effected extremity if applicable.

5. Patient education and counseling appropriate to disease process.

6. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Temp > 39°C (102.2°F)

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Protocol #9
Assessment and Management of Dysuria/Suspected Pyelonephritis

Protocol: Dysuria/Suspected Pyelonephritis

A. Definition: This protocol covers the initial assessment and management of patients with vomiting and diarrhea seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

ii. Dysuria or

iii. History of a urinary tract infection

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of pyelonephritis

- Frequency, amount, and color of urine
- Onset and duration of symptoms
- Actions that relieve symptoms

• Pertinent past medical history, CHF or renal failure; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (abdominal pain, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to urinary disorders

• Measure vital signs

• Check skin signs for color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start IV Saline Lock if HR >120 or SBP <90. Draw full tubes. Administer 1000 mL NS IV bolus for HR > 120 or temp >38.5F if no history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and Basic Metabolic Panel if CVA tenderness, vomiting, and/or temp > 38.5.

3. Obtain and Send Urinalysis; Hold specimen for Urine Culture

4. Obtain POCT urine pregnancy for women < age 50 years.

5. Administer acetaminophen 1000~~975~~ mg PO x 1 for temp ≥ 38.5C if not contraindicated.

6. Notify provider if acetaminophen was administered by the ED nurse.

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - History of CHF or renal failure

Protocol #10
Assessment and Management of Gastrointestinal Bleeding

Protocol: Gastrointestinal Bleeding

A. Definition: This protocol covers the initial assessment and management of patients with gastrointestinal (GI) bleeding seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

iv. Subjective history of:
1. Blood or coffee-ground emesis, or
2. Melena, or
3. Rectal bleeding (more than spotting on tissue), and Vital sign abnormality suggesting hemodynamic instability (HR >100 or SBP < 110)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of GI bleeding
- As noted above
- Amount, type, and frequency of blood in emesis or stools and other associated symptoms (abdominal pain, fatigue, syncope)

• Pertinent past medical history, including history of ulcer, coagulopathies, esophageal varices, CHF or renal failure; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to gastrointestinal disorders

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill; petechiae, purpura, or ecchymosis

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start IV NS (18-gauge or larger). Draw full blood tubes. Obtain stat HCT POCT. Administer 1000 mL NS IV bolus (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Start 2nd IV (18-gauge or larger) if HR >110, SBP <120, conjunctiva pale, or history of esophageal variceal bleeding

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Massive hematemesis bleeding (with potential airway compromise)
   - Altered mental status with GCS <14
   - History of CHF or renal failure

Protocol #11
Assessment and Management of Adult Patient with Generalized Medical Illness and Abnormal Vital Signs

Protocol: Adult Patient with Generalized Medical Illness and Abnormal Vital Signs

A. Definition: This protocol covers the initial assessment and management of adult patients with generalized medical illness and abnormal vital signs seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

v. History of generalized medical illness and
vi. Vital signs suggesting hemodynamic instability HR > 120 or SBP < 90

B. Data Base

1. Subjective Data

• Review history and signs and symptoms generalized medical illness
- Sequence of preceding events
- Actions that relieve symptoms
- Observe for signs of injury, needle marks, and characteristic breath odor

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to generalized medical illness

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Check skin signs for color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG for HR > 120. Show to Attending MD when completed

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV for HR > 120 or SBP <90. Draw full tubes. Send CBC and basic metabolic panel. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Obtain stat POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Send urinalysis.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms

Protocol #12
Assessment and Management of Head Trauma

Protocol: Head Trauma

A. Definition: This protocol covers the initial assessment and management of patients with head trauma seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

vii. Blunt or penetrating trauma to the head and
viii. Vital signs suggesting hemodynamic instability (HR >120 or SBP <90)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of head trauma
- Sequence of preceding events
- Actions that relieve symptoms
- History of patient's baseline neurological function

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, seizure, or amnesia)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to head trauma
- Assess for and maintain airway patency. Insert oral or nasal airway as needed and if not contraindicated.
- Observe for periorbital ecchymosis, battle's sign, and drainage from nose or ears
- Apply direct pressure to areas of active bleeding
- Assess neurological status: determining gross motor strength and lateralization of limbs

• Level of consciousness (may use Glasgow Coma Scale) and pupillary response.

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias if GCS <13

• Place on pulse oximetry and measure SpO_2 if GCS <13

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock if GCS <13. Draw full blood tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send Trauma Panel for 900 Trauma: CBC with platelets, basic metabolic panel, PT/PTT/INR, ethanol level, and type and screen.

3. Obtain and send urine toxicology per Head Injury Panel (HIP) order set.

4. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

5. Patient education and counseling appropriate to disease process

6. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #13
Assessment and Management of Hyperglycemia

Protocol: Hyperglycemia

A. Definition: This protocol covers the initial assessment and management of patients with hyperglycemia seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Documented elevated glucose

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of hyperglycemia

- Diabetic history and medication regiment
- History of trauma, or infection
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, CHF or renal failure, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to hyperglycemia

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock. Draw full blood tubes. Send CBC and basic metabolic panel. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Obtain stat VBG with potassium POCT.

3. Obtain POCT fingerstick glucose.

4. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

5. Obtain and send urinalysis.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fingerstick blood glucose <60 mg/dL or >400 mg/dL
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13
   - VBG potassium level > 5mEq/L

Protocol #14
Assessment and Management of Hyperthermia
Temperature ≥ 41 degrees C (105.8 degrees F)

Protocol: Hyperthermia Temperature ≥ 41 degrees C

A. Definition: This protocol covers the initial assessment and management of a patient with hyperthermia (temperature ≥ 41C) seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

ix. Temperature ≥ 41C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of hyperthermia
- History of infectious process or hyperthermic episode
- Sequence of preceding events and symptoms
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, back pain, rash)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to hyperthermia

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock IV. Draw full tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and basic metabolic panel. Obtain and hold blood cultures x 2. Obtain stat lactic acid POCT (if meets sepsis protocol criteria).

3. Administer acetaminophen ~~975~~ 1000 mg PO/PR x 1, if not contraindicated.

4. Obtain and send urinalysis and urine culture.

5. Place indwelling urinary catheter with temperature sensor.

6. Initiate cooling measures.

7. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

8. Patient education and counseling appropriate to disease process

9. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Temp > 41
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #15
Assessment and Management of Hypoglycemia

Protocol: Hypoglycemia

A. Definition: This protocol covers the initial assessment and management of patients with hypoglycemia seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Documented low glucose level

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of hypoglycemia

- History of hypoglycemia
- History seizure disorders, trauma, or infection
- History of diabetes and medication regiment
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to hypoglycemia

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock. Draw full blood tubes. Send basic metabolic panel. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if fingerstick blood glucose <60 mg/dl. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Patient education and counseling appropriate to disease process

6. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fingerstick blood glucose <60 mg/dl after glucose administered by ED nurse
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #16
Assessment and Management of Hypothermia
Temperature ≤ 35 degrees C (95 degrees F)

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Protocol: Hypothermia Temperature ≤ 35 degrees C

A. Definition: This protocol covers the initial assessment and management of a patient with hypothermia (temperature ≤ 35C) seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

x. Temperature ≤ 35 degrees C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current symptoms
- Hypothermic episode or pertinent medical history
- History of infectious process
- History of immunocompromising disease processes
- Social history (homeless)
- Sequence of preceding events and symptoms
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to Hypothermia
- Observe for shivering (usually stops about 31°C)

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmia
• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG. Show to Attending MD when completed.

C. Diagnosis
a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. Plan

1. Start saline lock IV. Draw full blood tubes. Administer 1000 mL NS IVF bolus via fluid warmer (Hotline™ or Level 1) , unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and basic metabolic panel. Obtain stat lactic acid POCT.

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Consider placing indwelling urinary catheter with temperature sensor.

6. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

7. Use Bair Hugger™.

8. If using warm blankets, place over torso only if temperature ≤ 33C degrees.

9. Patient education and counseling appropriate to disease process

10. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- Temp <32 or >38.5
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #17

Assessment and Management of Immunocompromised Patient with a Temperature ≥38.5C

Protocol: Immunocompromised Patient with a Temperature ≥38.5C

A. Definition: This protocol covers the initial assessment and management of an immunocompromised patient with a temperature ≥ 38.5C seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

xi. History of temperature ≥ 38.5C and
xii. History of immunocompromised illness

B. Data Base

1. Subjective Data

• Review history and signs and symptoms surrounding fever
- History of immunocompromised disease
- Sequence of preceding events and symptoms
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, back pain, chest pain)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to an immunocompromised patient with a Temp ≥ 38.5C

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- 12-lead ECG, show to Attending MD when completed
- Portable chest x-ray

C. Diagnosis
a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. Plan

1. Start saline lock IV. Draw full blood tubes. Administer 1000 mL NS IVF Bolus for HR >120 or SBP <90, unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC, basic metabolic panel, liver function tests, blood cultures x 2. Obtain stat VBG with lactic acid POCT.

3. Administer acetaminophen 1000 mg~~975 mg~~ PO x 1 for temp ≥ 38.5, if not contraindicated

4. Obtain and send urinalysis and urine culture

5. Obtain POCT urine pregnancy for women < age 50 years

6. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- Temp > 39°C (102.2°F)
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #18
Assessment and Management of Infestation

Protocol: Infestation

A. Definition: This protocol covers the initial assessment and management of patients with infestation seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

xiii. Visible bed bugs, lice, and/or scabies or

xiv. Exposure to bed bugs, lice, and/or scabies with concurrent symptoms

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of an infestation
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to an infestation
- Assess patient safety needs as pertains to showering with or without staff member assistance.
- Itchiness, multiple generalized body scratch marks.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Properly contain all contaminated clothing items and provide instructions for proper handling and cleaning of contaminated clothing.

2. Provide patient directions with shower instructions. Providing soap, towels, and clean clothes for after showering.

3. Apply Permethrin 5% cream to hair x 1 for presence of lice.

4. Apply Permethrin 1% lotion to skin x1 post showering with soap and water.

5. Patient education and counseling appropriate to disease process

6. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Altered mental status with GCS <13

Protocol #19
Influenza Vaccine

A. **DEFINITION**: This protocol covers the administration of the influenza vaccine to patients being discharged from the Emergency Department (ED) by Registered Nurses (RN). Once a discharge order has been placed by the provider, the RN caring for the patient will perform the Influenza Screening in the electronic health record (EHR). The ED RN will use the screening to document the patient decision to be vaccinated and that there are no contraindications to administration.

1. Indications: Annually during Flu season any patient older than 18 years of age seen at ZSFG will be offered the inactivated influenza vaccine unless there are documented contraindication(s) and/or a documented immunization for that year.

2. Precautions:
    - Utilize standard precautions for medication administration by intramuscular injection

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

4. Procedure
    - Screen Patient for Influenza Vaccination at ED prior to discharge
        - Review chart for documented objective contraindications
        - Review temperature documented for this emergency department visit in the patient's chart or take the patient's temperature
        - Talk to patient/decision maker for subjective contraindications
        - For patients that qualify, offer vaccination and document accepts or declines vaccination in the screen.
        - For patients that are not responsive, unable to engage, the screener may answer "No" to the first screening question "Are you able to assess patient at this time?" and be done

- Patient conditions requiring Physician Consultation
  - Questions regarding interpretation of a contraindication
  - Patient questions unable to be addressed by nursing expertise
- Education
  - Prior to vaccination, patients/decision maker will be provided education via Vaccine Information Sheets (VIS)
- Administration of Vaccination
  - RN to enter appropriate order for Influenza Vaccination using the mode "per protocol no co-sign required" for patients that qualify and accept vaccination and do not require further physician consultation.
    - Inactivated Influenza vaccine (IIV) is given IM. There is no upper age limit. IIV is the preferred formulation for influenza vaccination
  - Timing of administration will occur prior to discharge.
  - RNs are not authorized to place orders for Live Attenuated Influenza Vaccine
- RECORD KEEPING
  - Vaccination lot number, expiration date, and location of injection will be documented in the medical record

B. **DATA BASE/ DOCUMENTATION OF PROCEDURE**

Subjective Data (Adult ≥ 18 years)

a. Patient/decision maker declaration of previous administration of Influenza vaccine during existing Flu season.
b. Patient/decision maker declaration of prior reaction to vaccination or component.
c. Patient/decision maker declaration of history of Guillain Barre Syndrome

Objective Data (Adult ≥ 18 years)

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

C. **SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY**

Prerequisite: a. Completion of a training module on flu vaccination b. Review of Protocol
Proctoring Period: a. For RNs in orientation: observe placement of order in EHR for "ordered per protocol, no signature required" b. Designated RN Preceptor will provide supervision
Annual Competency Documentation: a. Annual performance appraisal b. Nurse Manager or their designee will be the evaluator
Any additional comments:

Protocol #20
Assessment and Management of IVDU with a Temperature ≥ 38.5C

Protocol: IVDU with a Temperature ≥ 38.5C

A. Definition: This protocol covers the initial assessment and management of IVDU with a temperature ≥ 38.5 seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

xv. Temperature ≥ 38.5C and
xvi. History of IVDU

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current drug use and fever
- Sequence of preceding events and symptoms
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, back pain, chest pain)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to IVDU with a Temp ≥ 38.5C

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- 12-lead ECG, show to Attending MD when completed
- Portable chest x-ray

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

C. Plan

1. Start saline lock IV. Draw full blood tubes. Administer 1000 mL NS IVF Bolus for HR >120 or SBP <90, unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

4. Send CBC, basic metabolic panel, blood cultures x 3. Obtain stat VBG with lactic acid POCT.

3 Administer acetaminophen 1000~~975~~ mg PO x 1 for Temp ≥ 38.5, if not contraindicated (e.g. liver disease)

4 Obtain POCT urine pregnancy for women < age 50 years.

5 Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

6 Patient education and counseling appropriate to disease process

7 Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #21
Assessment and Management of Missed Dialysis/Renal Failure

Protocol: Missed Dialysis/Renal Failure

A. Definition: This protocol covers the initial assessment and management of patients who have missed dialysis or have renal failure seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- History of missed dialysis/renal failure or
- Predetermined hyperkalemia with a history of dialysis

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of missed dialysis/renal failure history

- Dialysis/renal failure history
- Dialysis type and schedule
- Onset and duration of symptoms
- Actions that relieve symptoms

• Pertinent past medical history, CHF; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (chest pain, palpitations, shortness of breath)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to dialysis/renal failure

• Measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat POCT venous blood gas (VBG) with a potassium level
- Stat 12-lead ECG, show to Attending MD when completed
- Portable chest x-ray

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Patient education and counseling appropriate to disease process

3. Consultation with provider as needed, or:
- VBG potassium level >5 mEq/L
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%
- Fever > 39 ° C (102.2 ° F)
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #22
Assessment and Management of Intentional Overdose

Protocol: Overdose

A. Definition: This protocol covers the initial assessment and management of patients with overdose seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Intentional overdose

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of an overdose
- History of psychiatric disorders
- History of past accidental or suicidal ingestion
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to an overdose
- Assess for and maintain airway patency. Insert oral or nasal airway as needed.

• Level of consciousness (may use Glasgow Coma Scale) and pupillary response.

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG, show to Attending MD when completed

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock IV. Draw full tubes. Send CBC, basic metabolic panel, liver function tests, acetaminophen level, and salicylate level. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Initiate 5150 or ”At Risk” precautions

6. Obtain and send urine toxicology

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #23
Assessment and Management of a Pediatric Patient with a Temperature ≥ 38.5 degrees C

Protocol: Pediatric Patient with a Temperature ≥ 38.5 degrees C

A. Definition: This protocol covers the initial assessment and management of pediatric patients with a temperature ≥ 38.5C seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Temperature ≥ 38.5C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current pediatric illness
  - Sequence of preceding events and symptoms
  - Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (age appropriate pain scale) and associated symptoms (headache, crying, irritability, decreased appetite, tachycardia)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to pediatric temperature ≥ 38.5C
  - Observe for signs of injury, infection, rash, sepsis, and characteristics of meningococcal meningitis

• Level of consciousness (may use Pediatric Glasgow Coma Scale)

• Obtain core temperature, measure vital signs per *Guidelines for Emergency Nursing Practice*, assess central and peripheral pulses

• Obtain patient's weight in kg

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill (central and peripheral)

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via blow by if SpO_2 <94%

2. Administer acetaminophen 15 mg/kg PO/PR x 1 for Temp ≥38.5, if not contraindicated or if not previously administered within 4 hours.

3. Administer Ibuprofen 10 mg/kg PO x1 for Temp ≥39.0 only in children older than 6 months, if not contraindicated or if not previously administered within 6 hours.

4. Notify physician if anti-pyretics were administered by the ED nurse.

5. Send urinalysis. Hold specimen for urine culture. Anticipate collection of urine by catheterization for any male child less than 6 months old that is circumcised, any male child less than 12 months old that is uncircumcised, or any female child who is less than 24 months old.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
   - Abnormal vital signs based on patient's age. See addendum for table.
   - SpO_2 <92%
   - New onset focal neurological symptoms, rash
   - New onset listlessness, irritability, or change in Pediatric Glascow Coma scale

Protocol #24
Assessment and Management of Suspected Renal Colic

Protocol: Suspected Renal Colic

A. Definition: This protocol covers the initial assessment and management of patients with suspected renal colic seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Hematuria or
- Flank pain or
- History of renal colic, with or without
- Vomiting more than two times today

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of renal colic
  - Frequency, amount, and color of urine
  - Onset and duration of symptoms
  - Actions that relieve symptoms

• Pertinent past medical history, CHF or renal failure; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (flank pain, abdominal pain, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to renal disorders

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start IV Saline Lock. Draw full blood tubes. Administer 1000 mL NS IV bolus for HR > 120 or temp >38.5C (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and Basic Metabolic Panel.

3. Obtain and Send Urinalysis, split for urine culture if ordered

4. Obtain POCT urine pregnancy for women < age 50 years.

5. Administer ondansetron 4 mg IV/PO/SL x 1, if patient is nauseous and not contraindicated

6. Administer ketorolac 30 mg IV x 1 for pain, if not contraindicated (renal disease, hx GIB, allergy) If patient <50kg and or >65 years old, administer ketorolac 15 mg IV x1.

7. Notify provider if ondansetron and/or ketorolac was administered by the ED nurse.

8. Patient education and counseling appropriate to disease process

9. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - History of CHF or renal failure
   - Uncontrolled vomiting or pain not relieved by ondansetron and/or ketorolac

Protocol #25
Assessment and Management of Active Seizure

Protocol: Seizure

A. Definition: This protocol covers the initial assessment and management of patients with a seizure seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Witnessed or suspected seizure

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of seizure

- History of seizure disorders & type of seizure-like activity
- History of post-ictal state
- History of diabetes, alcohol withdrawal, head trauma, drug effects, stroke, infection, or CNS lesion
- Description of onset and duration of event
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to seizure

- Assess for and maintain airway patency. Carefully suction as needed.

• Level of consciousness (may use Glasgow Coma Scale), pupillary response

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock. Draw full blood tubes. Send CBC, basic metabolic panel, liver function tests, and specimen for drug levels as appropriate: Dilantin level, Tegretol level, Valproic Acid level, Phenobarbital level. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94% NRB.

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Administer lorazepam 2 mg IV x 1 for seizure activity (if not contraindicated) and notify provider.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #26
Assessment and Management of Severe Sepsis

Protocol: Sever Sepsis

A. Definition: This protocol covers the initial assessment and management of patients with suspected severe sepsis seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Confirmed or suspected infection with two ***OR*** more of the following SIRS criteria:
- Heart Rate > 90
- Respiratory Rate > 20 (or $PaCO_2$ <32)
- Temperature ≥ 38 º C (100.4 º F)
- Temperature ≤ 36 º C (96.8 º F)
- WBC > 12 or < 4 or > 10% bands (if available)

Exclusions

- None

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of infection

• Pertinent past medical history, current medications and allergies

• Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to infection
- Level of consciousness (may use Glasgow Coma Scale)
- Measure vital signs every 30 minutes x2
- Attach cardiac monitor, assess rhythm, and monitor for arrhythmias
- Place on pulse oximetry and measure SpO_2

- Skin signs: color, temperature, moisture, and capillary refill

- Laboratory and imaging evaluation:
    - POCT VBG with lactate

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Initiate the following:
    - Check POCT VBG with lactate
    - Administer oxygen in order to maintain SpO_2 >94%
    - Start saline lock IV (18-gauge or larger). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration
    - Draw full blood tubes.
    - Draw and hold blood cultures x 2
    - Obtain UA and split for culture

2. Additionally, if POCT Lactate $\geq$ 3 ***OR*** Systolic BP < 90 (MAP < 65):
    - Notify charge nurse and provider
    - Send blood cultures
    - Administer 0.9% NS IV fluid bolus of 30 mL/kg (each liter over 30 min)

3. Patient education and counseling appropriate to disease process

4. Consultation with provider as needed

Protocol #27
Assessment and Management of Shortness of Breath with Wheezes (Asthma/COPD)

Protocol: Shortness of Breath with Wheezes

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath with wheezes seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Shortness of breath with confirmed wheezing and history of asthma/COPD

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of asthma/COPD

• Pertinent past medical history, current medications and allergies

• Characteristics of shortness of breath (PQRST) and associated symptoms (cough, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to respiratory disease

- Auscultate lung sounds bilaterally
- Note respiratory rate, depth, and work of breathing
- Stridor or audible wheezing

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Measure vital signs every 30 minutes x2

• Measure peak flow before and after 1st nebulized treatment

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation
- None

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger) and draw full blood tubes if, and Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.
- RR >40
- Peak flow <150
- SpO_2 <94%

3. Administer nebulized duoneb (combination albuterol sulfate 2.5 mg and ipratropium bromide 0.5 mg per 3 mL saline) x3 doses every 1 hour.

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%

Protocol #28
Assessment and Management of Shortness of Breath Without Wheezes

Protocol: Shortness of Breath without Wheezes

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath without wheezes seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Chief complaint of shortness of breath
- Absence of wheezes, and
- RR >24, or
- RA SpO_2 <94%

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of shortness of breath

• Pertinent past medical history, hospitalizations for respiratory disease, current medications and allergies

• Characteristics of shortness of breath (PQRST) and associated symptoms (cough, fever, chills, chest pain, ankle edema)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to respiratory disease
    - Auscultate lung sounds bilaterally
    - Note respiratory rate, depth, and work of breathing
• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Obtain 12-lead ECG. Show to Attending MD when completed
- Obtain portable CXR or send for PA and lateral CXR if:
  - SpO_2 >94% on oxygen
  - RR <24
  - ECG cleared by provider
  - Patient is alert and cooperative

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (20-gauge or larger). Draw full blood tubes, including BNP, and hold. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Draw and hold first set of blood cultures if fever > 38 ° C (100.4 ° F)

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%

Protocol #29
Assessment and Management of Sickle Cell Crisis

Protocol: Sickle Cell Crisis

A. Definition: This protocol covers the initial assessment and management of a patient with sickle cell crisis seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- History of sickle cell disease and
- Severe and uncontrolled sickle cell pain (as described by the patient)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of sickle cell crisis

- Determine precipitating factors: illness, dehydration, stress, cold, or pregnancy
- History of therapeutic interventions for pain
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to a sickle cell crisis

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Provide large pitcher of water and encourage oral hydration.

3. Start saline lock IV. Draw full blood tubes. Administer 1000 mL NS IV bolus if unable to tolerate oral hydration (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

4. Send CBC, basic metabolic panel, and reticulocyte count.

5. Obtain and send urinalysis.

6. Obtain POCT pregnancy for women < age 50 years.

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%

Protocol #30
Assessment and Management of Surface Trauma

Protocol: Surface Trauma

A. Definition: This protocol covers the initial assessment and management of patients with surface trauma seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Trauma resulting in abrasions, lacerations, contusions, puncture wounds, avulsions, and bites

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of surface trauma
- History of Tetanus immunization status
- For bites: obtain history including species of animal, location of animal, time of trauma and vaccination status
- Time of occurrence of surface trauma to ensure lacerations are repaired within the appropriate time frame (6 hours for extremity, 12 hours for face and head)
- Sequence of preceding events
- Actions that relieve symptoms

• Pertinent past medical history, current medications, and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to surface trauma
- Assess circulation, movement, and sensation distal to injury
- Apply direct pressure to areas of active bleeding

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer Td/Tdap 0.5 mL IM x 1, if immunization status not up to date or contraindicated.

2. Patient education and counseling appropriate to disease process.

3. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Temp > 39°C (102.2°F)

Protocol # 31
Assessment and Management of Syncope
(Abrupt and Transient Loss of Consciousness)

Protocol: Syncope

A. Definition: This protocol covers the initial assessment and management of patients with syncope seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Reliable history of syncope or near-syncope

B. Data Base

1. Subjective Data

• Review history and signs and symptoms related to loss of consciousness

- Sequence of preceding events
- Duration of episode
- Actions that relieve symptoms
- Observe for signs of injury, needle marks, and characteristic breath odor

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to syncope

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG, show to Attending MD when completed
- Portable CXR

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger). Draw full blood tubes. Send CBC and basic metabolic panel. Administer 1000 mL NS IV bolus if HR >100 or SBP <120 (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Obtain stat fingerstick glucose. Obtain POCT urine pregnancy test for women < age 50 years.

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms

Protocol #32
Trauma Laboratory Tests Order Set

A. **DEFINITION**: This protocol covers the initial laboratory tests for trauma patients seen by Registered Nurses (RN) in the Emergency Department (ED). On the arrival of an injured patient, who is ≥ 11 years of age and meets Trauma Team Activation (TTA) criteria, the RN caring for the patient will draw blood and obtain the urine samples as defined by the specific TTA "Trauma Laboratory Order Set". The pediatric lab order set (patients < 11 years of age) will be determined by the Trauma Team with consultation from the pediatric service.

For the **900 TTA Trauma Lab Order Set** the following samples will be obtained and sent to the laboratory for processing:

- Type and Screen
- ABO/Rh Recheck
- CBC
- Basic metabolic panel
- Coagulation panel (PT, PTT, INR)
- Ethanol
- Urinalysis
- Urine drugs of abuse screen
- POCT Urine pregnancy (females)
- POCT VBG with hematocrit, potassium, lactic acid

1. Performance of procedure:

   Indications: Injured patients with 900 Trauma Team Activation (TTA)

   Exclusions: Patients deemed by the Resuscitation Team (Trauma Attending, Emergency Medicine Attending, Anesthesia Attending) to be stable and not requiring lab panel processing

2. Precautions:
   - Utilize standard precautions for specimen collection and handling

3. Contraindications:
   - None

For the **911 TTA Trauma Lab Order Set** the following samples will be obtained and sent to the laboratory for processing

- CBC
- Basic metabolic panel
- Coagulation panel (PT, PTT, INR)
- Ethanol
- Urinalysis
- Urine drug of abuse screen
- POCT Urine pregnancy (females)

1, Performance of procedure:

Indications: Injured patients with a 911 Trauma Team Activation (TTA)

Exclusions: Patients deemed by the Emergency Provider /Resuscitation Team to be stable and not requiring lab order set processing

2. Precautions:
   - Utilize standard precautions for specimen collection and handling

3. Contraindications:
   - None

B. **DATA BASE/ DOCUMENTATION OF PROCEDURE**

Documentation of the Trauma Lab Order Set procurement or provider's decision not to obtain lab samples will be recorded in the ED medical record.

C. **SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY**

The prerequisites and proctoring are the same as RN's approved to care for trauma patients in the ED

Protocol #33
Assessment and Management of Vaginal Bleeding

Protocol: Vaginal Bleeding

A. Definition: This protocol covers the initial assessment and management of patients with vaginal bleeding seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Vaginal bleeding, and
- Known or suspected pregnancy, and
- Age < 50 years

B. Data Base

1. Subjective Data

• Review history and signs and symptoms related to gynecological emergency

- Gravida, para, abortions
- Date of last menstrual period; duration and amount of flow, length of time for pad/tampon saturation, presence of clots or tissue
- Pregnancy suspected or confirmed. If confirmed, expected date of confinement (EDC)
- If patient is postpartum: date of delivery, complications

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (abdominal cramping, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to vaginal bleeding

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
    - Obtain POCT urine pregnancy for women < age 50 years.

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Prepare patient for pelvic exam. Patient should empty bladder prior to exam.

2. If urine pregnancy test is positive OR known to be pregnant: Start IV NS (18-gauge or larger). Draw full blood tubes. Obtain stat HCT POCT. Send CBC, Type and Screen, serum B-HCG, and urinalysis (by quick-cath if more than spotting). Administer 1000 mL NS IV bolus if HR >100 or SBP <120 (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Start a second IV if SBP <90.

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
    - HR >120
    - SBP <90
    - RR >28
    - SpO_2 <92%
    - Fever > 39 ° C (102.2 ° F)
    - Pad soaked more than one per hour

Protocol #34
Assessment and Management of Vomiting and Diarrhea

Protocol: Vomiting and Diarrhea

A. Definition: This protocol covers the initial assessment and management of patients with vomiting and diarrhea seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Vomiting more than two times today or diarrhea/loose stool more than four times today, PLUS
- Vital signs suggesting hemodynamic instability (HR >100 or SBP <110), or orthostatic vital signs or dizzy when standing

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of volume loss
- Frequency, amount, and color of emesis
- Frequency, amount, and color of stool

• Pertinent past medical history, CHF or renal failure; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (abdominal pain, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to gastrointestinal disorders

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer ondansetron 4 mg IV/PO/SL x 1 if emesis x2 while in ED and not contraindicated. Notify provider if ondansetron is administered by the ED nurse.

2. If HR >100 or SBP <100 or orthostatic, start IV (18-gauge or larger). Draw full blood tubes. Administer 1000 mL NS IV bolus (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Send CBC and Basic Metabolic Panel with Magnesium and Phosphorous for persistent vomiting

4. Obtain and Send Urinalysis

5. Obtain POCT urine pregnancy for women < age 50 years.

6. Save stool sample if diarrhea

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - Altered mental status with GCS <13
   - History of CHF or renal failure
   - Vomiting more than two times in ED prior to being seen by provider

Protocol #35
ABO/Rh Recheck Test

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A. **DEFINITION**: This protocol covers the second blood bank test for a recheck of patient's blood type for which a non-emergency blood transfusion has been ordered by a provider. Upon notification from the Blood Bank that an ABO/Rh Recheck is required, the RN caring for the patient will place an order for an ABO/Rh Recheck, draw blood and send it Blood Bank.

1. Performance of procedure:

Indications: Notification from Blood Bank that the patient requires an ABO Recheck

Exclusions: None

2. Precautions:
   - Utilize standard precautions for specimen collection and handling

3. Contraindications:
   - None

B DATA BASE/ DOCUMENTATION OF PROCEDURE

Documentation of the ABO/Rh Recheck will be recorded in the ED medical record as appropriate.

C. **SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY**

The prerequisites and proctoring are the same as RN's approved to care for patients in the ED.

Protocol #36
Ordering Xrays in Triage

Protocol: Ordering xrays in triage

A. Definition: This protocol covers the initial assessment and management of patients with injuries to body sites seen by Registered Nurses (RN) in the Emergency Department (ED).
   1. Location to be performed: ED Triage
   2. Performance of procedure:

      a. Indications: See "presentation" column in table below"
      b. Precautions: LIST See "note" column
      c. Contraindications:

B. Data base
   1. Subjective Data
      a. History and review of symptoms (see "Common History" column in table
      b. Pertinent past medical history, surgical history, family history, hospitalizations
   2. Objective Data
      a. Physical Exam appropriate to the procedure to be preformed

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

D. Plan
   See "Order" column in table

SITE OF INJURY	COMMON HISTORY	PRESENTATION Subjective/objective	Diagnosis/Plan: ORDER	NOTE
Clavicle	Fall on arm or shoulder. Direct lateral trauma.	Point tenderness and pain. Inability to raise arm. Swelling, deformity and/or crepitus may be present.	Clavicle	If subcutaneous emphysema (crepitus) is present, the patient should be moved directly to the treatment area. Clavicle film should be ordered only when the injury is felt to be confined to the clavicle.
Shoulder	Direct trauma. Fall on arm.	Point tenderness and pain. Inability to raise	Shoulder OR	If severe deformity, pain or neurovascular

	Sudden deformity and pain.	arm. Swelling and/or deformity may be present.	Shoulder with dislocation	compromise is seen patient should be moved to treatment area.
Upper Arm	Direct trauma. Fall on arm. Pathological fractures of the elderly.	Point tenderness. Inability to move. Pain on movement. Swelling	Humerus	May be associated with shoulder fracture of dislocation. Humeral fractures in mid to distal area may damage radial nerve. Check distal sensation on back of hand. If unable to straighten arm or if any deformity is seen move directly to treatment area.
Elbow	Fall on outstretched arm. Fall on flexed elbow.	Pain and point tenderness. Usually significant swelling. Possible deformity and discoloration.	Elbow	Associated with a significant incidence of brachial artery laceration and/or ulnar/radial nerve injury. Check for wrist pulses and sensation in hand for each nerve. If unable to straighten arm. Or if any deformity is seen, move to treatment area.
Proximal to wrist/distal to elbow	Fall on extended arm. Direct trauma.	Pain and point tenderness. Deformity and angulation usually evident. Occasionally shortening.	Forearm	If severe deformity, angulation or shortening is noted that patient should be moved directly to the treatment area.
Wrist	Fell on extended arm. Direct trauma	Pain and point tenderness. Swelling, deformity and/or discoloration may be present.	Wrist 1-2 views OR Wrist with navicular view	If navicular tenderness is noted on palpation order "navicular view" also. Be specific about point tenderness since there are many small bones in the wrist. Wrist dislocation is associated

				with a significant incidence of neurovascular comprise and/if such is noted expedite to treatment area.
Hand	Impactive closed fist trauma (Boxers fx) Direct trauma. Fall on outstretched hand.	Pain and point tenderness. Swelling, deformity and/or discoloration may be present.	Hand PA lateral oblique minimum 3 views OR Hand with wrist	If a wrist fracture is suspected "wrist" must also be ordered (Hand with wrist)
Chest	Cough. Fever. TB screening	Cough, fever, decreased or abnormal breath sounds	Chest 2 view	Portable chest xray if patient is unable to stand or in patient room.
Knee	Direct trauma Impactive trauma.	Pain and point tenderness at joint. Swelling, deformity and/or discoloration may be present.	Knee OR Knee with patella	Special attention to lower leg for associated fracture or patella if direct trauma. Dislocation is associated with a significant incidence of vascular compromise. Pulses in foot should be specifically checked. If absent, of if motion or sensation are not normal, move directly to treatment area.
Proximal to ankle Distal to knee	Direct trauma.	Pain and inability to bear weight. Point tenderness. Swelling, deformity and/or discoloration may be present.	Tibia Fibula	A compartment syndrome may develop secondary to the large amount of soft tissue swelling and hemorrhage. The triage sheet must contain documentation of foot

				pulses and ability to dorsiflex the foot. Fibular fx by itself is a rare injury which manifests as point tenderness and pain.
Ankle	Frequently an athletic injury. Lateral stresses.	Pain and point tenderness. Swelling, deformity and/or dislocation may be present. Dislocation may present as "locked joint".	Ankle	Patient with single malleolar fx's will frequently walk in c/o severe pain. The bi- and tri-malleolar fx's are more dramatic and present with unstable ankles, unable to bear weight. Be specific about point tenderness since are many small bones of the ankle. Dislocation is associated with a significant incidence of neurovascular compromise and/if such is noted expedite to treatment area. Special attention to the knee for associated injury.

E. DOCUMENTATION/RECORD KEEPING

- Documentation of x=ray will be recorded in the medical record as appropriate

F. SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY

The prerequisites and proctoring are the same as RN's approved to care for patients in the ED.

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Protocol # 37
Assessment and Management of a Pediatric Patient with vomiting

Protocol: Pediatric Patient with > 2 episodes of vomiting within 24 hours, with most recent episode < 4 hours prior to presentation

A. Definition: This protocol covers the initial assessment and management of pediatric patients with vomiting seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Weight ≥ 8 kg
- Vomiting with past four hours
- Not tolerating liquids per history
- No antiemetic use with four hours
- No history of cardiac arrhythmia

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current pediatric illness
    - Sequence of preceding events and symptoms
    - Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (age appropriate pain scale) and associated symptoms (headache, crying, irritability, decreased appetite, tachycardia)

• Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to pediatric vomiting
    - Observe for signs of abdominal pain, injury, headache, dehydration, surgical abdomen (bilious vomiting, severe pain, distension, right lower quadrant tenderness)

• Level of consciousness (may use Pediatric Glasgow Coma Scale)
• Obtain core temperature, measure vital signs per *Guidelines for Emergency Nursing Practice*, assess central and peripheral pulses

• Obtain patient's weight in kg

• Obtain full vital signs including temperature and blood pressure

• Skin signs: color, temperature, moisture, and capillary refill (central and peripheral)

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer ondansetron oral dissolving tablet
a. 8-15kg patient: 2mg PO/SL
b. >15kg patient: 4 mg PO/SL

2. Notify physician if anti-emetic was administered by the ED nurse.

3. If patient has no abdominal pain, give oral liquids to allow patient to slowly hydrate 15 minutes after administration of antiemetic

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
    - Abnormal vital signs based on patient's age. See addendum for table.
    - New onset focal neurological symptoms or altered mental status
    - Severe abdominal pain
    - Focal right lower quadrant pain

- New onset listlessness, irritability, or change in Pediatric Glascow Coma scale

Protocol # 38
Syphilis screening and Laboratory Test Order set

A. DEFINITION

This protocol covers the syphilis screening and laboratory test for patient populations within one of the following categories below seen by registered nursing (RN) staff in in the Emergency Department (ED) and Adult Urgent Care Center

1.Frequency: Testing for syphilis should be done in any person:

- pregnant who has not had syphilis testing
- requests to be tested
- with signs or symptoms suggestive of syphilis
- with an oral, anal, or vaginal sex partner who has been recently diagnosed with syphilis
- presents with signs and symptoms of syphilis

a. Every three months testing in persons who are:

- On PreP for HIV prevention
- living with HIV and are sexually active
- having unprotected sex and risk factors
- reports that their sex partner has been recently diagnosed with syphilis
- Unstable housing
- Men who have sex with men (MSM)
- Pregnant -
- Sexually active adolescents

b. Every 6-12 months: all others

2. Location to be performed: **Emergency Department and Adult Urgent Care Center**

3. Performance of procedure:
   a. Indications: Patients within special categories listed above who meet subjective/objective data criteria
   b. Exclusions: Patients outside of special categories listed above or who do not meet subjective/objective data criteria
   c. Precautions: Use standard precautions for specimen collection and handling
   d. Contraindications: Patients who do not agree/consent to the test

B. DATA BASE

1. Subjective Data

a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.

- rash, small bumps, sores or ulcers on the genitals, mouth or anus
- genital or anal discharge
- wart-like growth on the genitals or anus
- fatigue, itching, rash on the palms and soles, sore throat, swollen lymph nodes, weight loss, or rectal lining inflammation

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

2. Objective Data
   a. Physical exam consistent with subjective data listed above.
   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

Risk for syphilis infection as indicated by subjective and objective data in persons within the designated categories.

D. PLAN

1. Therapeutic Treatment Plan
   a. Identifying patients that satisfy criteria for syphilis screening
   b. Confirm accurate contact information for the patient
   c. Perform RPR testing per current workflow
   d. If using POCT and the result is positive; send a blood sample to the laboratory for confirmatory testing

2. Patient condition requiring Attending Consultation: Patient questions regarding the test that the nurse is unable to answer

3. Education: Discharge information and instructions.

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

E. RECORD KEEPING

Documentation of the Syphilis Laboratory Test Order Set procurement or patient's declination will be recorded in the electronic medical record as appropriate.

F. Summary of Prerequisites, Proctoring and Competency Documentation

Prerequisite: a. Review of CDC guidelines on syphilis b. Completion of departmental orientation program
Initial Evaluation: Three chart reviews needed to ensure that syphilis screening test was indicated and completed
Annual Competency Documentation: a. Nurse Manager, Medical Director or designated physician will evaluate the RN's competence through an annual performance appraisal and skills competency review. Feedback from colleagues, direct observation and/or chart review may be used. b. The standardized procedures will be a required Unit Based Competency for annual review.
Any additional comments: None

Protocol #39

COVID-19 Antigen (Ag) Point-of-Care-Testing (POCT)

A. Definition: This protocol covers patients requiring a recent COVID-19 Ag test performed by a Registered Nurses (RN) in the Emergency Department (ED).

Indications:

- Triage RN referral of isolated psychological or behavioral health complaint patients to Psychiatric Emergency Services
- Patients being transferred to procedural areas requiring a recent COVID Ag test result
- Patients being transferred to an external facility requiring a recent COVID Ag test result

B. Data Base

1. Subjective Data

- Review history and absence of any COVID-19 signs and symptoms with the patient
- Confirm no recent COVID-19 exposure

2. Objective Data

- Obtain and review vital signs
- Assess for signs of respiratory illness including fever, cough, shortness of breath, fatigue, nausea, vomiting, or any other COVID-19 related symptoms

C. Plan

1. Order the COVID-19 Ag POCT in EPIC using the COVID-19 Ag POCT Standardized Procedure order set

2. Perform COVID-19 Ag POCT and document results in the patient's medical record.

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Protocol #40
ED Stroke Evaluation

- **Definition**: This protocol covers the initial labs and radiologic exams of patients with suspected acute stroke as recognized by Registered Nurses (RN) in the Emergency Department. On the arrival of the acute stroke patient who meets stroke activation or Mission Protocol criteria, the RN will draw blood and order radiologic exams per the **ED Stroke Evaluation** orders in the electronic medical record system.

- For the **ED Stroke Evaluation** order set, the following samples will be obtained and sent to the laboratory for processing:
  - CBC with differential
  - Comprehensive Metabolic Panel
  - Acute Stroke Coagulation panel, PT and PTT
  - Rapid Creatinine with GFR
  - POCT VBG
  - Magnesium
  - Phosphorus
  - Serum HCG for female patients 11-50 years old
  - Urinalysis
  - Urine Toxicology screen
  - ECG 12-lead
  - CXR Portable
  - CT stroke protocol head and neck

- For the suspected stroke patient, the RN will initiate an IV (20-guage or larger), draw full tubes, send **ED Stroke Evaluation** order set labs, give IV push, 0.9% NS flush 10ml PRN for PIV maintenance ~~w~~and with medication administration, and obtain a weight in kg.

- Performance of Procedure
  - **Indications**
    - Any Mission Protocol/ Stroke activation
    - Acute neurological deficit such as:
      - Balance disturbance- dizziness, drifting to one side, unsteady gait
      - Eyes: Blurry vision, double vision, vision loss
      - Face: Uneven smile, facial droop/numbness, sudden severe headache
      - Arms & Legs: weakness, numbness, difficulty walking
      - Speech: slurred, nonsense words, non-verbal
  - **Exclusions:**
    - Patients deemed by the ED team (EM Attending and Resident, Neurology Resident) to not meet criteria to require a stroke activation.

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- **Precautions:**
  - Utilize standard precautions for specimen collection and handling

- **Contraindications:**
  - None

~~ZSFG 2021 ED RN Standardized Procedures~~

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~~**Medical Director or Division Chief Approval or Service Chief Approval**~~
~~Christopher B Colwell, MD~~

~~Author Name: Tina King, NP~~

~~**CIDP Approval Date:** 10/06/2021~~

~~**Credentials Approval Date:** 12/21/21~~

~~**MEC Approval Date:** 12/21/21~~

~~**Gov. Body Approval Date:** 12/28/2021~~

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

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.Aspericueta@sfdph.org).*

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:	
Standardized Procedure Title:	**Protocol #9** **Assessment and Management of Dysuria/Suspected Pyelonephritis**
Department:	ED
Dept Chief:	Otway
SP Author(s):	Perry Limon
Update #1:	Change dose of Tylenol from 975mg PO to 1000mg PO
Reason/Explanation for Revision:	Formulary alignment

*Include additional rows to table, if needed

Standardized Procedure Title:	**Protocol #14** **Assessment and Management of Hyperthermia Temperature ≥ 41 degrees C (105.8 degrees F)**
Department:	ED
Update #1:	Change dose of Tylenol from 975mg PO to 1000mg PO

Reason/Explanation for Revision:	Formulary alignment

Standardized Procedure Title:	**Protocol #17** **Assessment and Management of Immunocompromised Patient with a Temperature ≥38.5C**
Update #1:	Change dose of Tylenol from 975mg PO to 1000mg PO
Reason/Explanation for Revision:	Formulary alignment

Standardized Procedure Title:	**Protocol #20** **Assessment and Management of IVDU with a Temperature ≥ 38.5C**
Update #1:	Change dose of Tylenol from 975mg PO to 1000mg PO
Reason/Explanation for Revision:	Formulary alignment

Standardized Procedure Title:	**Protocol #24** **Assessment and Management of Suspected Renal Colic**
Update #2:	Add method of administration of Zofran 4mg, was just IV, now IV/PO/SL
Reason/Explanation for Revision:	Formulary alignment
Standardized Procedure Title:	**Protocol #34** **Assessment and Management of Vomiting and Diarrhea**
SP Author(s):	Perry Limon
Update #2:	Add method of administration of Zofran 4mg, was just IV, now IV/PO/SL
Reason/Explanation for Revision:	Formulary alignment
Update#3:	**Added protocol# 39 (Covid Testing)**
Reason/Explanation for Revision:	Protocol approved in 2023, needed to be added to document.

Update#4:	**Added protocol# 40 (ED Stroke Management)**
Reason/Explanation for Revision:	Protocol reflects current workflow processes to provide rapid assessment and management for ED patients.

Section II: Standardized Revisions

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. *Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure*. (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)

MS.08.01.03: Summary of Changes

Current	Revision	Explanation for Revision
III. DEFINITIONS: Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures:	**III. DEFINITIONS:** Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures or privileges:	Inclusion of privileges to reflect practice of CRNA's and Optometrists.
Credentialing Item: NPDB Method of Verification: Query	Credentialing Item: NPDB Method of Verification: Enrolled in Continuous Query. Notified of new disclosures as reported, along with monthly report.	Recommendation from Health Plan to include how often the National Provider Databank (NPDB) is monitored.
Appendix F – Ongoing Professional Practice Evaluation (OPPE) Procedure	Appendix E – Ongoing Professional Practice Evaluation (OPPE) Procedure	Appendix E skipped
Appendix F – Credentialing of HIV/AIDS Specialists Procedure	(new document)	Recommendation from San Francisco Health Plan to include the process for which HIV/Aids specialist are identified and credentialed per National Committee for Quality Assurance (NCQA) policy and procedure CR-06.

ZSFG HOSPITAL & TRAUMA CENTER

Medical Staff Organization

Credentialing Manual

Office of Origin: Medical Staff Office (628) 206-2342

I. PURPOSE:

Zuckerberg San Francisco General Hospital (ZSFG) and Clinics ensure that licensed health care providers meet the minimum credentials standards for Medical Staff or Affiliate Staff membership. This Credentialing Manual (with accompanying policies and procedures) and the Appendix, will be reviewed and approved each year by the ZSFG Credentials Committee and Medical Executive Committee.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- Joint Commission Medical Staff Standards
- NCQA Credentialing Standards
- CMS Conditions of Participation
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

III. DEFINITIONS:

Practitioner: Any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, unless otherwise expressly limited.

Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures or privileges: Advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, or CRNA – certified registered nurse anesthetist), PA – physician assistant, PharmD, Optometrists, Genetic Counselor, Acupuncturist and other categories as approved by the Governing Body.

Provider: For purposes of this document, provider means practitioners and affiliates.

Complete Application:

A complete application, at the point that verifications are finished, means the following:

- all information was verified and any missing information is explained or accounted for;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by ZSFG have been resolved.

IV. POLICY:

A. The Medical Staff Office conducts credentialing with confidentiality for all clinical venues within ZSFG and will only delegate credentialing to any outside entities if

needed. Credentialing is performed prior to appointment and reappointment to the ZSFG Medical Staff.

B. Each provider has a confidential credentials file, which contains verification documents. For Medical Staff members, the credentials file includes quality information as described in Appendix A. These files are re-verified at least every two (2) years. Expirable documents are updated on an ongoing basis. All required verifications must be no more than 180 days old at the time of Governing Body review.

C. Credential files are treated as confidential and are kept within file cabinets with access by Medical Staff Office personnel only. These files are protected from discovery pursuant to Evidence Code Section 1156, et seq. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Section 1156, et seq.

1. The credentials file may be reviewed by contracting health plan representatives (pursuant to delegated credentialing agreements), except that information determined to be confidential.

   A provider has the right to review the items in their credentials file, except the following elements: National Practitioner Databank Reports and Letters of Reference. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the credentials file.

2. The quality information may be reviewed by contracting health plan representatives for the following elements: malpractice claims history, disciplinary actions by hospitals, managed care organizations or State Medical Boards and outcomes of those actions. Other quality items are subject to review pursuant to delegated quality agreements or the National Commission on Quality Assurance (NCQA) credentialing standards.

   A provider has the right to review the items in their quality file, except letters of reference or documents related to peer review activities. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the quality file.

D. Provider Rights to obtain Status of Application
Upon request, providers will be notified of the status of their application during the credentialing process.

E. Provider Rights to Amend Application
The provider attests that all information submitted for the credentialing process is accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the provider will be asked (via phone, letter or email) to resolve this discrepancy. The provider will be given opportunity to resolve the discrepancies, with

response to the Credentials Committee Chair. Any attempts to intentionally hide or misrepresent information are addressed during the Credentials Committee review.

F. Notification of Provider Rights: Pursuant to the Medical Staff Bylaws, providers are notified of their rights to:

- review information submitted to support their credentialing application;
- correct erroneous information; and
- be informed of the status of their application upon request.

G. Erroneous Information: The applicant for appointment, reappointment, and/or clinical privileges will be notified by credentialing staff of any conflicting information found in the provider's application and/or any supporting documentation.
Notice will occur by telephone or written request within 10 days of discovery, and will be documented in the provider's credentials file.

- The provider will have 30 days to reconcile and return the application and/or supporting documentation to the credentialing staff
- Acceptable format will be the corrected and signed credentialing application and, as applicable, a written and signed explanation for any discrepancies in the original application
- The Credentials Committee or Credentials Committee Chair will receive a report of any corrected information submitted by the provider.
- The documentation provided by the applicant and any other related documents will be placed in the provider's credentials file along with notation as to the date received.

H. Upon delegation of credentialing activities, audits may be performed by health plan representatives and other payers, based upon the following guidelines:

1. Audits must be scheduled in advance at a time mutually agreed upon by ZSFG and the auditing entity.
2. Selected documents regarding peer review may not be subject to auditing.
3. Auditors may not photocopy or remove documents.

If credentialing is not delegated, the health plan/payer is responsible for credentialing providers for their health plan.

V. PROCEDURE

A. Initial Appointments

1. The following information is required to begin the Initial Appointment process:
    - Request from Department
    - Applicant Name
    - Curriculum Vitae/Resume including all professional work history
    - Faculty Appointment (if applicable)
    - Requested Privileges/Protocols (Standardized Procedures), (when applicable)
    - Requested Start Date for Temporary Privileges/Credentials only
    - ID attestation per Joint Commission guidelines

2. Providers must complete the following items:

- Application for Medical Staff or Affiliate Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges, or for Affiliate, Standardized Procedures.
- Agreement to abide by the Medical Staff Bylaws, Rules and Regulations
- Health Plan Attestation form (as applicable)
- Environmental Safety form

3. In addition to returning the above documents, providers also must submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
    - Copy of California License(s) (an on-line query is acceptable)
    - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
    - Evidence of Current Malpractice Coverage, if applicable
    - Fluoroscopy Certificate as appropriate
    - Current Photo
    - CPR, BLS/ACLS, PALS, NALS, if applicable
    - Current Curriculum Vitae (CV)

4. The Medical Staff Office reviews the documents as follows:
    a. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
    b. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges. The applicant confirms the correctness and completeness of the application.
    c. Clinical venues are specified and appropriate.
    d. Complete addresses, phone and fax numbers as listed for:
        - Medical school, Internships, Residencies, Fellowships;
        - Hospitals and affiliations;
        - Peer references; and
        - Malpractice insurance company(ies)
    e. Privileging forms or Standardized Procedures are completed as appropriate.
    f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
    g. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

5. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

    Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

Verification of provider enrollment screening in the Medicaid Fee-For-Service program. Completion of the Medi-Cal related acknowledgements for health plan specific trainings are required to begin within 10 working days of a new provider becoming active, and may be completed up to 180 days prior to the new being activated/approved.

6. File Triaging:
   Once all of the information is gathered, the applicant's file is triaged by the Medical Staff Office and flagged for potentially adverse information to be carefully evaluated during the Credentials Committee review.

7. Temporary Privileges for Initial Appointments:
   For Initial Appointments involving clinical urgency, a Service Chief may request temporary privileges up to 120 days. Request for Temporary Privileges/Credentials must be approved by the CEO (or authorized designee) on the recommendation of the Chief of Staff (or authorized designee).

   Actions on temporary privileges/credentials are updated in the Medical Staff Office database upon approval and appropriate areas are notified. The Medical Staff Office database updates the applicant's status and privileges/protocols are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

8. Applicants must complete the credentialing process with privileges or standardized procedures (as appropriate) prior to the provision of patient care to ZSFG patients.

B. Reappointments

1. Reappointment Application Packet
   At least five (5) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:
   - Preprinted Reappointment Application
   - Copy of current clinical privileges

2. The provider is required to return the application and supporting documents within thirty (30) days, and include the following:
   - Copy of current DEA Certificate as appropriate
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current CV

3. If the application is not returned within the designated time period, the provider and Department Chair will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment may be deemed to be a voluntary resignation from the Medical Staff, and the provider will be submitted as "resigned"

to the Credentials Committee.

Practitioners/Affiliates who automatically resign shall be required to complete a reinstatement form to reapply for membership. Reinstatement shall be processed in a manner parallel to the reappointment process. Reinstatement application forms shall be accepted within one (1) month from the date the practitioner membership expires.

All Practitioners/Affiliates whose membership has expired longer than one (1) month shall be required to complete the initial appointment process.

4. The Medical Staff Office reviews the documents as follows:
   a. All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant confirms the correctness and completeness of the application.
   c. Privileging forms and Standardized Procedures are completed as appropriate.
   d. Clinical venues are specified and appropriate.
   e. Completed addresses, phone and fax numbers as listed for:
      - Hospitals and affiliations
      - Peer references; and
      - Malpractice insurance company(ies)
   f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
   g. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy) are current.

5. Verification of Information
   Verification of information begins as soon as the application appears complete, and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

   Verification of provider enrollment screening in the Medicaid Fee-For-Service program

6. Reappointment Performance Improvement
   The results of performance monitoring, evaluation, and identified opportunities to improve care and service are documented in this file. Data Summary sheets are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership.

7. Pre Credentials Committee Meeting
   A meeting shall be convened prior to the Credentials Committee meeting date which shall be attended by the Chair of the Credentials Committee and the credentialing staff in order to discuss files of concern and the agenda.

C. Evaluation And Approval Process

1. Clinical Services Evaluation Process
   If an issue is identified, the related documentation is flagged for the Service Chief to review. The complete file (including application, supportive documents, and privileges request form) is sent to the appropriate Service Chief for review and recommendation to the Credentials Committee. If the applicant's file was flagged, the reviewer must document sufficient review to support making a recommendation for appointment/reappointment.

   If the Service Chief is disinclined to make a favorable recommendation based on:
   - a perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or
   - perceived conduct or professional competence which affects or could adversely affect the health or welfare of a patient or patients, the Service Chief drafts a report to the Credentials Committee indicating concerns with the appointment/reappointment.

   After the Service Chief's recommendation, the file is prepared for the monthly Credentials Committee and the applicant is added to the next monthly Credentials Committee Summary Report.

2. Credentials Committee Evaluation Process
   The Credentials Committee reviews the Summary Report and Committee makes a recommendation for appointment/reappointment. File are reviewed in accordance with the File Triaging categories (see Appendix C). Applications deemed '*green'* do not require committee discussion and are approved on the consent agenda. Applications deemed '*yellow'* or *'red*'are discussed in detail by the Credentials Committee for review and recommendation. Applications requiring additional information/clarification may be tabled until sufficient information is gathered to support a recommendation. Discussion is documented in the committee meeting minutes The report with Credentials Committee recommendations is then sent to the Medical Executive Committee (MEC).

3. Medical Executive Committee and Governing Body Evaluation Process
   The Credentials Committee Summary Report is reviewed by the Medical Executive Committee, then the Joint Conference Committee, and then referred to the Health Commission as the Governing Body.

   Actions on appointments/reappointments are updated in the Medical Staff Office database within 10 days of Governing Body approval. The Medical Staff Office database updates are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification of the Governing Body decision is forwarded to the applicant within 30 days.

4. Provider Enrollment
   Upon Governing Body approval, the Credentials Committee Summary Report is sent to the contracted Health Plans.

D. Visiting Privileges

1. In circumstances involving clinical necessity when clinical services require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, visiting privileges may be granted on a case by case basis.

2. The following information is required to begin the Visiting Privileges process:
   - Completed Application
   - Curriculum Vitae/Resume including all professional work history
   - Faculty Appointment (if applicable)
   - Service Chief Recommendation
   - Requested Privileges
   - Requested Start Date

3. Providers must complete the following items:
   - Visiting Application including Confidentiality Statement and Consent to Release Information and Privileges.
   - Review the Medical Staff Bylaws, Rules and Regulations

4. In addition to returning the above documents, providers must also submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
   - Copy of California License(s) (an on-line query is acceptable)
   - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
   - Evidence of Current Malpractice Coverage
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current Curriculum Vitae (CV)

5. The Medical Staff Office reviews the documents as follows:
   - All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   - Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges.
   - Clinical urgency and venues are specified and appropriate.
   - Complete addresses, phone and fax numbers as listed for:
     - Hospitals and affiliations;
     - Peer references; and
     - Malpractice insurance company(ies)
   - Privileging forms are completed as appropriate.
   - California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

6. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

7. The Chief of Staff and the Executive Administrator (or authorized designees) may grant Visiting privileges for a specified period of time after the above information has been evaluated by the applicable service chief and he/she has made an affirmative recommendation.

E. Expirables/Ongoing Monitoring

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods.

F. Resignations

The effective date of the resignation will be the last day of the month in which the provider states that he/she is resigning, or a date indicated by the Chief of Service, and can occur before the Governing Body date. Notice of resignation to the Medical Staff Office may be submitted by the resigning provider or by the Department Chief, or Chief's designee, provided that the resigning provider is copied on the notice.

H. Non-Discriminatory Credentialing and Recredentialing.

The Medical Staff Office monitors and prevents discriminatory credentialing through the following process:

i. Tracking and trending of reasons for denial and / or termination.

ii. Semi-annual audits of files in process for more than six (6) months

iii. The presence of a non-discrimination statement on the Statement of Confidentiality to be signed by members, staff and guests of the Credentials Committee on an annual basis.

iv. The presence of a non-discrimination statement on the Credentials Committee agenda.

v. Documents and / or information, submitted to the Credentials Committee for approval, denial or termination do not designate a practitioner's race, ethnic / national identify, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes. The Credentialing Committee members will sign a non-discrimination agreement that remains in effect during their term as a Committee member. The statement attests that all decisions made by the committee are based on the applicant's credentials and network participation criteria and not the applicant's age, gender, sexual orientation, race, ethnic/national identity, specialization or special services the applicant may provide.

The Medical Staff Office monitors complaints alleging discrimination. Results are reported to the Credentialing Committee bi-annually.

I. Queries: Verification of the following within 180 days of the Governing Body decision date:

- National Practitioner Data Bank (NPDB) (required for all applicants)
- The State Medical Board responsible for issuing the provider licensure
- Medi-Cal and Medicaid Suspended and Ineligible Provider Reports
- Medicare and Medicaid sanctions
- Office of Inspector General
- Board certification
- Work History
- Malpractice insurance coverage and professional liability claims history
- Attestation questions answered in the application

J. System Control Measures (CR 1C & D)

- The purpose of this section is to ensure compliance with the National Committee for Quality Assurance (NCQA) standards.

Part C – System Controls	
1. How primary source verification information is received, dated and stored.	Credentialing applications are received via MD-Staff credentialing database. Supporting documentation such as primary source verifications (PSVs) are either uploaded into the MD-Staff credentialing database or queried directly through the database. All primary source verifications (PSVs) collected as part of the ZSFG credentialing process for initial and reappointment applications are reviewed by the ZSFG credentialing team. Primary source verifications (PSVs) include but are not limited to the following; State licensure, DEA, DEA-X, OIG, SAM/GSA, NPDB, AMA, NPI, Certifacts. PSVs are received or obtained by primary source websites, email, or verbally (over the phone): a. Primary Source Websites – Verifications from primary source websites will show the name of the source, the provider(s) being verified, the type of verification (license, certificate, etc.), and expiration date if applicable. b. Email – Verifications received by email will be from an approved source and verify a provider's name, type of information being verified, and relevant start/end/expiration dates if applicable. c. Verbal – Verifications from verbal sources are recorded electronically and will note the source, date of verification, type of verification, name of the individual verifying the information, their position and any relevant dates (certification, licensure, training, educations, etc.) PSVs are dated automatically via the MD-Staff credentialing database and the

<table>
<tr><td></td><td>dates cannot be changed/modified.

PSVs are stored in the MD-Staff Credentialing database hosted by the vendor.</td></tr>
<tr><td>2. How modified information is tracked and dated from its initial verification.</td><td>PSVs uploaded into the MD-Staff Credentialing database cannot be modified. The ZSFG credentialing team is oriented not to attempt to modify any type of PSV prior to upload within MD-Staff Credentialing database.
If a verification contains discrepant information that requires additional clarification, the credentialing team may include additional information to supplement the original PSV. Supplemental information should include the credentialing team member's name and date additional information was obtained.</td></tr>
<tr><td>3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.</td><td>All users are authorized to review information. No users have ability to modify PSVs uploaded into MD-Staff. Authorized users are instructed to use good judgement and even consult a team member whenever a question arises regarding a need to remove/delete information in MD-Staff.

Access to MD-Staff is role-based and granted based on job function within the Medical Staff Services department or ZSFG facility. Access is reviewed quarterly and adjusted as needed.
<table>
<tr><th>Role</th><th>Access Level</th><th>Permissions</th></tr>
<tr><td>Administrator</td><td>Full Access</td><td>View, add, modify, and delete data; manage user roles, workflows, and audit logs.</td></tr>
<tr><td>Medical Staff Office</td><td>General Access</td><td>View, modify, and delete provider data; upload documents; no deletion rights.</td></tr>
<tr><td>Read-Only User</td><td>View Only</td><td>View provider profiles and non-sensitive documents; no rights to modify or delete.</td></tr>
</table>
Data Deletion Protocols

Authorized users are encouraged to check with their direct manager when a need to delete information presents itself. This includes instances when a PSV may need to be re-run for a provider's profile.

Examples of appropriate modifications to credentialing information include but are not limited to:

• Erroneous Data Entry: Updates to expired licensure or other documents (updating the database data fields to reflect current/accurate information)
• Changes/updates to education, training, or privileges when supporting PSVs are obtained
• Correcting/rectifying any data entry errors
• Addressing/identifying duplicative provider profiles</td></tr>
</table>

	• **Misfiled Documents:** Documents uploaded to incorrectly (*e.g. wrong provider profile)* • **Duplicate Provider Records**: When duplicate profiles are identified, data is consolidated into the correct profile. **Examples of inappropriate modifications to credentialing information include but are not limited to:** • Altering credentialing approval dates unsanctioned by the Joint Conference Committee (JCC) or prior to temporarily approval by the ZSFG clinical leadership while awaiting JCC final approval • Altering dates on verifications cannot be performed • Whited out of dates or signatures on hard copy documents • Unauthorized/inappropriate deletion of provider files or supporting documentation
4. The security controls in place to protect the information from unauthorized modification.	An excerpt from the City of San Francisco Employee Handbook is detailed below (pg 54 of the New Employee Handbook. **Work Site Security** To prevent and discourage unauthorized access to your work site, do not leave your office area unattended. Do not prop open doors or windows that are normally kept locked. Lock all office doors after business hours or when you leave. Prevent and discourage theft by securing your valuables. Work-site keys and passes may not be shared, may not be duplicated without permission and must be returned upon separation. Access to credentialing information is limited to authorized users only. Only authorized users are granted access to the MD-Staff credentialing database based on business need. Authorized users are required to complete Annual Compliance and Privacy Training (DPH) along with Cybersecurity Training to ensure safeguard of credentialing database information. Authorized users should: • Use strong passphrases containing unique combinations of uppercase letters, lowercase letters, numerals and symbols • Refrain from writing down passwords • Only use a unique password for any of their accounts, and not use a password more than once • Update/change their passwords periodically, including when appropriate such as when passwords may be compromised Authorized user's accounts are inactivated upon separation from the organization, and every 30 days from their last login. The MD-Staff credentialing database is only accessible via hospital intranet or VPN access. When the organization inactivates the user's active directory account, the user will no longer have a mechanism/pathway to log-in to MD-Staff for access to credentialing information.

5. The policies and procedures describe the organization's audit process for identifying and assessing risks and ensuring that specified policies and procedures are followed. At a minimum, the description includes: • the audit elements include: • methodology used; • including sampling; • individuals involved in the audit; and • audit frequency. ➢ Oversight of the department responsible for the audit.	Monitoring of our processes must occur at least annually. The audits of our process will be performed by a director in conjunction with selected members of the medical staff office team. The audits may include but are not limited to the following: 1. A description of the system functionality that prevents or disallows modifications of credentialing information. 2. If the CR system allows modifications only under specific circumstances, an annual process for identifying all changes to established policies within the past 12 months and then updating the system controls accordingly. 3. A review of automatic system alerts or flags for modifications or events in real time and a separate process for annually testing the performance of the system's automatic alerts or flags. Primary source documentation uploaded into our MD-Staff credentialing database cannot be modified. An annual review sampling 5% of active records or 50 files will be reviewed at random from our monthly health plan roster (provider universe) and conducted by department management/senior staff to ensure that the provider records are complete and possesses accurate information. When auditing is used as the method for monitoring, sampling using the "5% or 50 files" audit method, with a minimum of 10 credentialing files and 10 recredentialing files shall occur. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits will audit 100% of the credentialing and recredentialing files. Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements. Monthly, quarterly, semiannual, or annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system's audit trail function reporting capability. Credentialing, privileging, and enrollment are paperless processes that have very limited paper documents due to requirements for wet signatures. For paper documents/files, leadership conducts periodic walk-throughs of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours – i.e., in locked drawers/filing cabinets, not left on workstations, etc. Incorporate review of data modifications/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process. Assess for accuracy, appropriateness, compliance with policies. Findings will be documented and stored in a network folder. Credentialing staff and anyone who has access to credentialing information is required to sign an annual confidentiality form. These forms will be stored in a Medical Staff Services folder.

Part D – Oversight	
1. Identify all modifications to credentialing and recredentialing information that did not meet the organizations policies/procedures for modifications as described in CR 1, Element C, Credentialing System Controls.	At a minimum, an annual monitoring report will be required to show compliance with our Credentialing System Controls policies, procedures shall be reported to the ZSFG MSO and AH Credentials Committee and Medical Executive Committee. The report will need to include: a. A review of all modifications that did not meet the policies and procedures i. Conduct a qualitative and quantitative analysis of all modifications that did not meet policies. ii. Actions taken to address any modifications that did not meet established policy. iii. Implement quarterly monitoring when there are elements that did not meet the policies and procedures and provide written documentation in a report of this review. b. The report shall include the person/role/title of the person performing the monitoring. c. The report shall include the person/role/title of the person who has oversight of the monitoring process if different from who performs monitoring.
2. Document and analyze all modifications that did not meet standards by doing a qualitative and quantitative analysis of all modifications.	**i. Credentialing System Controls Oversight Report** – this template will be included in the request for documents at the time of the annual oversight assessment. **ii. Monitoring and Reporting of Inappropriate Modifications** this template will be included in the request for documents at the time of the annual oversight assessment. ZSFG MSO would need to submit this report if inappropriate modifications were identified. MSS will continue to monitor the report until it demonstrates improvement for three consecutive quarters. If improvement isn't demonstrated for at least one finding, all quarterly reports will be submitted to the MSS Director.
3. Acting on all findings. (Not applicable if no findings above.)	Findings will be acted upon by the ZSFG MSO, if any are identified.

POLICY & PROCEDURE WITH ALL APPENDICIES (A, B, C, D, F)

Added appendix F (changed to appendix E – 11/3/2025)

Approved by Medical Executive Committee – October 17, 2024
Approved by Credentials Committee – September 30, 2024

Added appendices C & D

Approved by Medical Executive Committee – February 15, 2024
Approved by Credentials Committee – February 5, 2024

Added appendices A & B

Approved by Medical Executive Committee – December 15, 2022
Approved by Credentials Committee - December 5, 2022

Approved by Medical Executive Committee – December 16, 2021
Approved by Credentials Committee – December 6, 2021

Approved by JCC – October 22, 2019
Approved by Medical Executive Committee – October 17, 2019
Approved by Credentials Committee – October 8, 2019

A. CREDENTIALS FILE

(available for provider review)

The following documents are kept current and maintained in the Credentials file (as applicable):

1. Application for membership.
2. Delineation of privileges, recommended by the Service Chief in the service which privileges are being requested.
3. Current California State Medical (or other professional) License
4. Valid DEA certification, as applicable
5. Current X-ray Supervisor and Operator Certificate, as applicable
6. Verification of graduation from medical (or other professional) school and completion of residencies and fellowships
7. Verification of previous affiliations prior to SFGH Medical Staff appointment
8. Curriculum Vitae that includes a comprehensive work history
9. Evidence of current, adequate malpractice insurance
10. Professional liability claims history
11. Verification of Board Status Certification or Candidacy, as applicable
12. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
13. California Medical Board Status check for validation of license and sanction activity
14. Continuing Medical Education Compliance
15. Consent to release relevant information
16. Copies of the Governing Body Approval letters confirming Medical Staff appointment and/or approved privileges
17. For Affiliate Staff only: CPR (BLS/ACLS) certification

B. QUALITY FILE

(not available for provider review)

The quality files contain the following historical and current documents (as applicable):

1. Any action taken as a result of a malpractice claim within the previous three (3) years.
2. Reports of disciplinary actions and the outcome of those actions.
3. Results of internal and health plan quality management review such as Peer Review, Surgical Case and Hospital Mortality Review, Transfusion Committee reviews, patient complaints, clinical activity reports, and other quality indicators.
4. State Medical Board reports on any state sanction activity (e.g. 805 reports).
5. Any supplemental information or documentation regarding quality of care including, but not limited to, letters of reference or service.
6. Letters of Reference that attests to clinical competence and ethical character of the applicant.

APPENDIX B – Verification Methods

			CREDENTIALING EVENT				
	CREDENTIALING ITEM	METHOD OF VERIFICATION	INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINT-MENT	UPDATE AS EXPIRES	VISITING / TEMP. PRIVILEGE
1	**License to Practice in California** Includes information related to licensure sanctions monitored monthly	Website as available for the type of provider. If website that is considered prime source verification is not available, credentialer confirms in writing.	X	X	X	X	X
2	**DEA Registration** Provider attests if DEA is not applicable to scope of practice.	Obtain online verification. If website that is considered prime source verification is not available, credentialer confirms in writing.	X	X	X	X	X
3	**Fluoroscopy Certificate** Provider attests if certificate is not applicable to scope of practice.	Obtain on line verification. If website that is considered prime source verification is not available, credentialer confirms in writing.	X	X	X	X	X
4	**Medical School (Domestic Graduates) or Other Professional Schools (non- physician applicants)**	May be obtained (in writing or orally) from the institution(s) where medical school/other professional school completed or the AMA or AOA profile service, as applicable.	X				
5	**ECFMG (Foreign Graduates)** For physicians who enter USA- based internship/ residency programs.	www.ecfmg.org or in writing from ECFMG	X				
6	**Internship /other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X				
7	**Residency/other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X		X *If any new training during the previous appointment period*		
8	**Fellowship/ other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X		X *If any new training during the previous appointment period*		
9	**Board Certification or other professional certification or registration**	CertiFACTS, ABMS compendium, query of the ABMS database, AMA or AOA profile or confirmation	X	X	X	X	X

APPENDIX B – Verification Methods

			CREDENTIALING EVENT				
	CREDENTIALING ITEM	**METHOD OF VERIFICATION**	**INITIAL APPOINTMENT**	**NEW PRIVILEGES**	**REAPPOINT-MENT**	**UPDATE AS EXPIRES**	**VISITING / TEMP. PRIVILEGE**
		(orally or in writing) directly from the certifying organization.					
10	**Healthcare Organization Affiliations**	Confirm in writing or by telephone with affiliation. Confirm dates of affiliation, scope of privileges, restrictions and any disciplinary actions taken during the affiliation. If verification of an affiliation is not obtained after two requests (including a phone call to the facility), this will be noted in the file and the file may then move through the evaluation process without verification of the affiliation.	**X** *Verify all affiliations within the last five years after Medical/ Professional School*	**X** *Verify as necessary to obtain information related to competency*	**X** *Verify current affiliation(s)*		**X** *Verify current affiliation(s)*
11	**Work History (Looking for gaps in training and work history)**	Applicant provides information on application form or curriculum vitae. Additional investigation occurs for 3 months month gaps in work history. Gaps will be documented in the file.	**X** *Verify all affiliations within the last five years after Medical/ Professional School*				**X** *Temps: the last five years Visiting: current affiliation*
12	**Professional Liability Insurance**	Obtain information related to coverage and amounts of coverage directly with carrier. Minimum insurance: $2/million per claim and $6/million annual aggregate coverage.	**X**		**X**		**X**
13	**Professional Liability Claims History:**	Applicant provides information about current and past claims, settlements and judgments; AND write to current carrier; AND request NPDB report.	**X**	**X**	**X**		**X**
14	**Continuing Medical Education**	License attestation					
15	**National Practitioner Data Bank (NPDB)**	Enrolled in Continuous Query. Notified of new disclosures as reported, along with monthly report.	**X**	**X**	**X**		**X**
16	**Medicare Sanctions**	OIG Sanction Report	**X**	**X**	**X**	**Monthly**	**X**
17	**Peer/Professional References/ Recommendations** Peer means an individual in the same professional	Peer references must be from individuals who have recently worked with the applicant, have directly observed his or her	**X** *Obtain 3 Peer References, with at least one from each*	**X** *As necessary to obtain confirmation of clinical*	**X** *Obtain 2 Peer References; If Courtesy appt. with no data*		**X** *One peer reference*

APPENDIX B – Verification Methods

			CREDENTIALING EVENT				
	CREDENTIALING ITEM	METHOD OF VERIFICATION	INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINT-MENT	UPDATE AS EXPIRES	VISITING / TEMP. PRIVILEGE
	discipline (same type of license) or MD for Affiliated Staff as appropriate.	professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, ethical character, health status and ability to work with others. If the applicant has recently completed professional training (resident, fellowship, etc.), a reference from the program director must be requested and references from supervising Attending physicians, rather than co-residents, must be obtained.	*professional position held in the last two years*	*competency*	*summary sheet, one reference must be from a Supervisor at external primary hospital*		
18	**Social Security Death Master File verification** Verification of the SSDMF from NTIS via MD- Staff is required for all initial applicants and then to be verified on an ongoing monthly basis for all actively credentialed providers	Verification of the SSDMF is conducted through the MD-Staff credentialing database and	**X**			**Monthly**	**X**
19	**SAM (GSA/EPLS)**	System for Award Management	**X**		**X**	**Monthly**	**X**
20	**CA DHCS (S&I)**	California Department of HealthCare Services; Sanctions and Ineligible List	**X**		**X**	**Monthly**	**X**

APPENDIX C – File Triaging Categories

TRIAGING CATEGORY	INITIAL APPOINTMENT	REAPPOINTMENT
Green	No issues have been identified with the provider's application, and the file meets the following criteria: • Satisfactory References • No record of malpractice payment or current pending claims • No disciplinary actions • No licensure restrictions • No unexplained time gaps in work history • Current licensure • No problems verifying information • No indication of investigations or potential problems Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified	No issues have been identified with the provider's reappointment, and the file meets the following criteria: • Satisfactory References • No record of malpractice payments since the last appointment or current pending claims • No disciplinary actions • No licensure restrictions • Current licenses • No problems verifying information • No indications of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything by highly qualified • Applicant is not requesting new privileges • Applicant is not requesting a status change • Applicant meets all criteria for privileges requested • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified
Yellow	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • Malpractice claims • Criteria for Privileges requested is not met. • International Medical Graduate	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • Malpractice claims in past 3 years • Health problem identified which will likely have impact on exercise of clinical privileges or standardized procedures. • Lack of clinical activity or difficulty in obtaining monitoring reports
Red	The provider's file shows potentially adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification	The provider's file shows potentially adverse information, including: • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA)

	organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • Any existing information shows a quality of care or competency issue	• Clinical privileges revoked, diminished or altered by another Healthcare organization • New privileges requested outside of normal scope of specialty • Any existing information shows a quality of care or competency issue

APPENDIX D – Sources of Performance Improvement Data

When available, information from these sources is integrated into the credentialing process:

1. **Patient Complaints and Grievances:** Significant issues are forwarded to Quality Improvement and/or Risk Management for further analysis with communication to the Service Chief. If the Service Chief determines immediate action is required, the Chief of the Medical Staff is notified and initiates appropriate resolution.

2. **Clinical Activity Reports:** For monthly reappointment cycles, physician volume statistics and comparative data are gathered by the Medical Staff Office. Providers with no clinical activity may provide supporting information for consideration by the Service Chief to ensure appropriate recommendation of membership/privileges.

3. **Quality Measures:** Physician specific quality data identified for Credentials Committee review as appropriate.

4. **Peer Review:** Individualized profiling information is assessed by the Service Chief.

5. **Medical Record Delinquencies**: The Service Chief reviews and notates as appropriate.

6. **Risk Management/Malpractice Claims:** Risk Management entities report UC Regents and San Francisco City and County claims history. Providers are obligated to disclose past and pending liability actions and provide further details regarding these actions, including specific discussion with the Service/Division Chief. Claims histories also are requested from external professional liability insurance companies, as applicable. Providers with one or more claims are flagged for review by the Service Chief and the Credentials Committee.

7. **Suspensions/Sanctions**: Physicians may be suspended for non-compliance with policies as outlined in the Medical Staff Bylaws, and for infractions, such as a license revocation or other action by the Medical Board or Governing Body (please see the Medical Staff Bylaws for further information). These suspensions are monitored by the Medical Staff Office and identified for Service Chief and Credentials Committee review.

8. **Reporting of Adverse Action to Authorities and Contracted Health Plans**: Adverse action that has been taken against a practitioner which falls under the reporting guidelines for state and federal agencies will be reported as appropriate to the National Practitioner Data Bank, the California Medical or Nursing Board, to the SFDPH Office of Managed Care and to contracted Health Plans. (refer to the ZSFG Medical Staff Bylaws for activities or professional conduct that constitutes a request for investigation).

9. **Service Quality Indicators:** Each clinical service establishes and monitors quality indicators. The Service Chief considers applicable indicators when recommending appropriate membership/privileges and indicates any issues for Credentials Committee consideration.

10. **Provider Directories**: All information required to be published in the practitioner directories of managed healthcare plans per the contractual agreement will be consistent with the information required for the credentialing process.

I. PURPOSE

Ongoing Professional Practice Evaluation (OPPE) is designed to support quality patient care activities and can identify outliers related to clinical performance at Zuckerberg San Francisco General Hospital (ZSFG). OPPE is intended to ensure consistency and to foster a more efficient evidence-based privilege renewal process. The OPPE process focuses on the collection of practitioner-specific, professional practice data related to clinical activities of Medical Staff and Affiliated Medical Staff practitioners at ZSFG. OPPE improves the delivery of quality patient care and is conducted regularly, in accordance with The Joint Commission Medical Staff Standard MS.08.01.03. ZSFG Chiefs (or their designees) are expected to review the data metrics and sign-off the data. When necessary, intervention by the organized medical staff may be required, including but not limited to development and implementation of a Focused Professional Practice Evaluation (FPPE) to address practice that is considered marginal or unacceptable.

II. PROCEDURE

The ZSFG Medical Staff Services Department is required to coordinate the collection, validation, and assessment of practitioner-specific, professional practice data that is relevant to the clinical practices approved by the ZSFG organized medical staff. Continuous monitoring of practitioner's clinical competence metrics will support the ZSFG organized medical staff in the provision of high-quality, safe patient care that is compassionate, appropriate, and effective.

Each practitioner's professional practice metrics will be reviewed by each service Chief or their designee(s) in keeping with the goal of providing high-quality and safe patient care and in accordance with The Joint Commission Standard MS.08.01.03. The practitioner's professional practice evaluation will be documented in the Professional Performance (OPPE) by the Medical Staff Services Department and the timeframe for review of the data cannot exceed 12 months. Management of OPPE is the responsibility of the Medical Staff Services Department. Practitioner's Ongoing professional practice data (OPPE) is privileged, facility specific information protected by California Evidence Codes 1156 and 1157.

Categories of metrics may include the following groups, in accordance with the Accreditation Council for Graduate Medical Education (ACGME) core competencies: Patient Care, Medical/Clinical Knowledge, Practice- Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems- Based Practice. Examples of individual metrics may specifically include data from:

- Administrative Activity
- Case Characteristics and Volume
- Core Competencies
- Inpatient Utilization
- Outpatient Utilization
- Patient Safety and Quality
- Patient Satisfaction
- Patient Relations
- Risk Management

A. DEFINITIONS

Chief of Service – Physician with the ultimate responsibility to review and sign-off on the professional practice information of each practitioner in his/her department. If needed, the Chief of Service may designate a faculty member to review and sign-off on records.

Credentials Committee – The ZSFG Medical Staff Committee is responsible for recommending appointments and reappointments to the Medical Staff, delineation of staff privileges, and application of corrective actions where indicated.

Designee – Physician leader identified by the Service Chief to review a set of practitioners.

OPPE – the Ongoing Professional Performance Evaluation system is designed to aggregate practitioner-specific data from a variety of sources and display this information on a secure password protected website. All the information is stored on the city's secure network under ZSFG IT Security Policy.

Practitioner – Member of the ZSFG Medical Staff or Affiliate Medical Staff

B. CONFIDENTIALITY

Professional practice evaluation information is privileged and confidential in accordance with ZSFG Medical Staff Bylaws and California state evidence codes (including 1157) pertaining to confidentiality and non- discoverability.

All staff, committee members, and other practitioners involved in review and evaluation of performance will hold information in strict confidence, make no voluntary disclosures of such information, and agree to complete a confidentiality acknowledgement related to their handling of Professional Practice Evaluation information under this procedure.

A confidentiality acknowledgment will be completed at initial participation and at least every two years thereafter.

Security practices must be maintained to protect the integrity and confidentiality of OPPE at ZSFG. As OPPE reports are facility-specific, the information contained within are considered proprietary and thus only intended to be viewed by those directly involved in the OPPE process at ZSFG.

OPPE data may be directly shared with other facilities outside of ZSFG (1) Upon special request to the current Chief of Staff, or (2) as requested by another facility under a current, executed Memorandum of Understanding or Peer Review Sharing Agreement.

C. CONFLICTS OF INTEREST

A medical staff member asked to perform professional practice evaluation may have a conflict of interest if they might not be able to render an unbiased evaluation due to:

- Involvement in the patient's care
- Relationship to patient or patient family
- Relationship with the involved practitioners as a partner or direct

competitor It is the responsibility of the reviewer to disclose potential conflicts.

It is the responsibility of the Credentials Committee to determine whether a conflict would prevent the individual from participating and the extent of that participation if allowed.

Individuals determined to have a conflict may be present during group discussion (if approved by Credentials Committee) but are required to recuse themselves prior to final deliberation and vote.

III. PROCEDURE

The OPPE will be updated with the latest available data every 12 months focusing on collection of metrics between July 1 and June 30 each year. Departmental OPPE data is coordinated between each clinical service and the ZSFG Medical Staff Services Team as detailed within the timeline table in the section below. Internal (ZSFG defined) benchmark data will be provided by the clinical services for specified metrics with each clinical service. Each clinical service will be responsible to review and validate the OPPE data for providers within their service.

Submission of OPPE data related to the clinical practice of each service Chief shall be reviewed/validated by someone other than the service Chief such as a senior faculty member in the department with the same clinical privileges.

A. TIMING & RECURRING SCHEDULE

The calendar below outlines the timeframes that the various parts of OPPE are carried out each cycle:

MONTH	DESCRIPTION	RESPONSIBLE PARTIES
July	1. On July 1st, run retrospective master roster of credentialed providers from the credentialing database which lists provider holding an appointment/privileges through the ZSFG Medical Staff during the previous July 1 thru June 30 OPPE cycle. 2. Run the Board Certification Issues Report & the Suspensions Report from MD-STAFF for the previous July 1 thru June 30 OPPE cycle. 3. Obtain copy of the Hydra ZSFG Compliance Report from Dean's Office 4. Sort/edit the roster to create department-specific list of providers. 5. Sort/edit the roster again to identify providers with privileges in the department but whose home department is elsewhere. These are referred to as the "add-on" providers for the department for purposes of OPPE. They are listed at the end of each department's OPPE spreadsheet. 6. Reconcile the provider count against the original master roster to assure quality with no names overlooked throughout the data sorting process. 7. Copy the finalized department-specific OPPE spreadsheets as templates from the previous OPPE cycle. This involves deleting the provider names/metric data/comments, add/delete/revise metrics as directed by notes from Chiefs/approved by Chair, Credentials Committee to create the OPPE spreadsheets for the current OPPE cycle. 8. Copy/paste the provider names, including the "add-on" providers, from the department sections of the final edited master roster to the department-specific spreadsheet templates. (**Note:** *Totaled 47 spreadsheets for 30 OPPE departments last OPPE cycle.)* 9. Update/revise the instructions for completing the OPPE spreadsheet. 10. Update the Chief/Credentials Committee annual OPPE email language directed to Chiefs & designees. Save a copy to Outlook drafts folder. 11. Obtain note closure report data from IT/OPPE workgroup. Add board certification, license, & note closure data to the OPPE spreadsheet templates	OPPE Coordinator/ MSSO Chief, Creds Committee with OPPE IT workgroup UCSF Deans Office

August	1. Complete any remaining steps from July list. 2. Aim towards a mid-August target for issuing OPPE lists to Chiefs & designees. 3. Use the department-specific annual OPPE email language indicating the due-date deadline within 60 days. Attach a copy of the department-specific OPPE spreadsheets along with a copy of the instructions for completion. 4. Repeat step #3 for each department or clinical service specialty. 5. Create a Tracking Log of Spreadsheets Returned by Due Date & Finalized which lists the departments or clinical service specialties who have received the OPPE email outreach requests. Use this log to track the response and versions returned.	OPPE Coordinator/ MSSO
September	1. Complete outreach to any remaining departments regarding remaining steps from August. 2. Send out reminders as 6 weeks, 4 weeks, and 2 weeks to services that have not responded. 3. Review/return spreadsheets back to Chiefs/designees with replies/requests for clarification/comments /finalization with cc to Chair/Creds Committee & Manager/MSSO Update Tracking Log of M&U OPPE Evals as indicated by reviews	OPPE Coordinator /MSSO Chair/Creds Committee Manager/ MSSO
October - November	1. Update & issue the Tracking Log of Spreadsheets Returned by Due Date & Finalized biweekly to Chair/Credentials Committee for his updates to Creds Committee, MEC, etc. 2. Continue spreadsheet reviews/replies/requests for clarification/comments/ working towards finalization for all clinical services remaining. Continue updating Tracking Log of M&U OPPE Evals as indicated by reviews.	OPPE Coordinator /MSSO Chair/Creds Committee
December	1. Finalize any remailing reviews of departments or clinical service specialties OPPEs spreadsheets. 2. Finalize the Tracking Log of M&U OPPE Evals Finalize the Tracking Log of Spreadsheets Returned by Due Date & Finalized	OPPE Coordinator / MSSO
January	1. When all spreadsheet reviews are finalized, meet with Credentials Committee Chair to review all marginal & unacceptable OPPE ratings identified. 2. Ensure that each marginal & unacceptable has commentary and has been appropriately addressed.	OPPE Coordinator /MSSO
May - June	Prepare Prep file folders and structure on T Drive for the next cycle of OPPE	OPPE Coordinator/ MSSO

B. Marginal and Unacceptable OPPE Evals:

1. During the review of the annual department OPPE spreadsheets, the Medical Staff Services Coordinator updates the Tracking Log of Marginal & Unacceptable OPPE Evals by department/provider and advises the respective Service Chief regarding providers whose OPPE evals may trigger a Focused Professional Practice Evaluation (FPPE) based on the following frequency thresholds:
   a. Two (2) consecutive Unacceptable (U) evals for the same OPPE metric, OR
   b. Three (3) consecutive Marginal (M) evals for the same OPPE metric, OR
   c. One (1) Unacceptable and two (2) Marginal evals consecutively for the same OPPE metric
2. Marginal and Unacceptable OPPE ratings require the Chief to enter a comment in the COMMENTS column of the department's OPPE spreadsheet for providers whose data for any OPPE metric falls within the Marginal or Unacceptable threshold range for the metric. The Service Chief will consult with the Chair/Credentials Committee regarding the need for a for-

cause FPPE plan.

3. The Chief or designee will discuss any Marginal or Unacceptable OPPE evals with the provider. The Medical Staff Services Coordinator will confirm and document through use of a DocuSign form signed by both the service chief and subject provider.
4. Following completion of the annual OPPE spreadsheet reviews and finalization, the OPPE Coordinator and the Chair of the Credentials Committee meet to review the Tracking Log of M&U OPPE Evals to ensure that all have been reported to/addressed by the Chief.

C. RESPONSIBILITIES

1. Service Chief's Responsibilities:
   a. Review, validate each practitioner's OPPE data within 60 days of posting by the ZSFG Medical Staff Services Department.
   b. Comment on performance metrics that have not met the established thresholds or address identified clinical practice irregularities.
   c. Sign-off on the data provided for each practitioner within the department, per OPPE review period.
   d. Forward identified concerns or clinical practice irregularities to the ZSFG Medical Staff Services Department immediately, for further review by the ZSFG Credentials Committee.
   e. May opt to assign a designee with the primary responsibility to review practitioners within the department. The Chair must keep the Medical Staff Services Department advised of any changes or updates.
   f. Arrange for appropriate coverage to review OPPE data performance metrics reports during periods of planned absences.

2. Practitioner
   a. May request to review their OPPE data.
   b. May add supplemental information/comments for the Service Chief or designee to review as part of periodic validation and sign-off of the OPPE metrics.
   c. May communicate with Service Chief or designee regarding any concerns regarding the content of the OPPE data.

D. OVERSIGHT & DATA RETENTION

1. The Medical Staff Services Department will be notified by the Chief or designee upon completion of the annual review/sign-off of OPPE clinical practice metrics. The Medical Staff Services Department will retain electronic copies of the individual practitioner's data for inclusion in the credentials file to be reviewed by the Credentials Committee as part of each provider's credentialing reappointment.

E. PROCEDURE REVIEW AND REVISION

The Ongoing Practitioner Practice Evaluation Procedure will be reviewed on an annual basis. Compliance with The Joint Commission and functionality will be evaluated as well as the continued relevance of the indicators chosen.

Appropriate revisions will be recommended by the Medical Executive Committee and/or the Credentials Committee.

APPENDIX F – Credentialing of HIV/AIDS Specialists Procedure

I. PURPOSE

Zuckerberg San Francisco General Hospital (ZSFG) provides members with access to qualified specialists for HIV care. This procedure defines the additional qualifications for designating practitioners with an HIV/AIDS specialty at ZSFG. All practitioners are credentialed, recredentialed, and enrolled according to the National Committee for Quality Assurance (NCQA) policy and procedure CR-06.

II. PROCEDURE

REQUIRED QUALIFICATIONS: Practitioners can be designated as an HIV specialist if both of the following requirements are met.

1. Valid unrevoked and unsuspended California state medical license
2. Meets one of the 3 qualifications below:
    a. Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM)
    b. Board certified in the field of Infectious Diseases by a member board of the American Board of Medical Specialties (ABMS)
    c. Long-standing HIV provider (5 years or greater) with at least 25 ongoing patients with HIV under their care
3. For qualifications in (2) above, the following requirements should also be met:
    a. In the immediately preceding 12 months has clinically managed care to a minimum of 25 HIV patients; and
    b. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV patients, including a minimum of five (5) hours related to antiretroviral therapy per year.

III. AFFILIATED PROFESSIONALS (NP, PA)

Nurse practitioners and physician assistants may be designated with HIV/AIDS specialty if they are under the supervision of an HIV/ AIDS physician specialist, are credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM) or have provided ongoing care to at least 25 patients with HIV infection with the additional requirements in #3 above.

IV. CREDENTIALING PROCEDURE

1. Any practitioner who wants to serve as an HIV/AIDS specialist must request to be credentialed as one using the HIV/AIDS Specialist Designation form in the credentialing packet.
2. HIV/AIDS Specialist applicants will be subjected to the credentialing requirements and process described in policy and procedure CR-06 Initial Credentialing, Recredentialing, Screening, and Enrollment of Practitioners. (NCQA)
3. HIV/AIDS Specialist applicants attest that they meet licensure, board certification, and work experience requirements established in Section IIS of this policy.
4. Physician Advisory/Peer Review/Credentialing Committee (PAC) reviews and approves all HIV/AIDS Specialist credentialing applications as described in policy and procedure CR-06.
5. A list of HIV/AIDS Specialists is kept current in the provider directory according to policy PR-21 and is searchable based on the HIV specialist designation.

V. MONITORING

Monitoring: ZSFG Medical Staff Services ensures HIV/AIDS Specialists' board certification or specialty

certification are monitored for their qualifications as part of the recredentialing process every 24 months, at minimum. The ZSFG/UCSF Division of HIV, Infectious Diseases & Global Medicine is responsible for monitoring the minimum amount of hours is met, if applicable

Committee Review: The Credentials Committee review all cases for approval or denial and provide feedback or request additional information or corrections as needed at regularly scheduled Credentials Committee meetings.

VI. DEFINITIONS

Continuing Medical Education:

1) For physicians, continuing medical education courses recognized as qualifying for Category 1 credit by the Medical Board of California;
2) For nurse practitioners, continuing education contact hours recognized by the California Board of Registered Nursing;
3) For physician assistants, continuing education units approved by the American Association of Physician Assistants or those described in either subsection (1) or (2), above.

Credentialing: a process of reviewing and evaluating licenses, permits, training, and other qualifications of licensed practitioners and organizational providers.

Initial Credentialing: initial review of a practitioner or organizational provider credentials

Credentials Committee: (a) Review the credentials of Applicants and make recommendations for membership and delineation of Clinical Privileges in compliance with these Bylaws; (b) Make a report to the MEC on each Applicant for Medical Staff membership and privileges, which shall include recommendations from the appropriate Clinical Service Chief; (c) Review all information available regarding the competence of Medical Staff Members and as a result of such review makes recommendations for the granting of Privileges, reappointments, and the assignment of Applicants to the various Clinical Services as provided in theses Bylaws.

Practitioner: a licensed or certified professional who provides medical or behavioral healthcare services (source NCQA).

Recredentialing: process of reevaluating Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical Staff and the continuation of Clinical Privileges.

APPENDIX G – Credentialing of HIV/AIDS Specialists Procedure

I. PURPOSE

Zuckerberg San Francisco General Hospital (ZSFG) provides members with ~~HIV~~ access to qualified specialists for HIV care. This procedure defines the additional qualifications for designating practitioners with an HIV/AIDS specialty at ZSFG. All practitioners are credentialed, recredentialed, and enrolled according to the National Committee for Quality Assurance (NCQA) policy and procedure CR-06.

II. PROCEDURE

REQUIRED QUALIFICATIONS: Practitioners can be designated as an HIV specialist if both of the following requirements are met.

1. Valid unrevoked and unsuspended California state medical license
2. Meets one of the ~~3~~4 qualifications below:
    a. Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM)
    ~~b. Board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties (ABMS)~~
    b. Board certified in the field of ~~i~~infectious D~~d~~iseases by a member board of the American Board of Medical Specialties (ABMS)~~, and meets the following requirements:~~
    c. Long-standing HIV provider (5 years or greater) with at least 25 ongoing patients with HIV under their care

~~3. For qualifications in (2) above, the following requirements should also be met:~~

3.

~~a.~~ In the immediately preceding 12 months has clinically managed care to a minimum of 25 HIV patients; and

a.

~~I.~~b. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV patients, including a minimum of five (5) hours related to antiretroviral therapy per year.

~~b. In the immediately preceding 24 months has clinically managed care to a minimum of 20 HIV patients and has completed one of the following:~~

~~I. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the ABMS; or~~

~~II. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV patients; or~~

~~III. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the AAHM.~~

III. AFFILIATED PROFESSIONALS (NP, PA)

Nurse practitioners and physician assistants may be designated with HIV/AIDS specialty if they are under the supervision of an HIV/ AIDS physician specialist, are credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM)~~meet all the qualifications set forth in Section II of this~~

Commented [MG1]: There is no HIV certification in the ABMS so removed b

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Commented [MG2]: Part c was very complicated and we shouldn't really have anyone credentialed who is not seeing at least 25 patients with HIV over the past year

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APPENDIX G – Credentialing of HIV/AIDS Specialists Procedure

~~procedure~~ or have provided ongoing care to at least 25 patients with HIV infection with the additional requirements in #3 above.~~, and have the capacity to see an additional patient.~~

IV. CREDENTIALING PROCEDURE

1. Any practitioner who wants to serve as an HIV/AIDS specialist must request to be credentialed as one using the HIV/AIDS Specialist Designation form in the credentialing packet.
2. HIV/AIDS Specialist applicants will be subjected to the credentialing requirements and process described in policy and procedure CR-06 Initial Credentialing, Recredentialing, Screening, and Enrollment of Practitioners. (NCQA)
3. HIV/AIDS Specialist applicants attest that they meet licensure, board certification, and work experience requirements established in Section IIS of this policy.
4. Physician Advisory/Peer Review/Credentialing Committee (PAC) reviews and approves all HIV/AIDS Specialist credentialing applications as described in policy and procedure CR-06.
5. A list of HIV/AIDS Specialists is kept current in the provider directory according to policy PR-21 and is searchable based on the HIV specialist designation~~. HIV cannot be a provider's primary specialty; it is indicated as a secondary specialty only.~~

Commented [MG3]: Removed this line as HIV can be the primary specialty for NPs (for instance, UCSF has an HIV track in the MEPN program) or for MDs who are certified by AAHIVM

V. MONITORING

Monitoring: ZSFG Medical Staff Services ensures HIV/AIDS Specialists' board certification or specialty certification are monitored for their qualifications as part of the recredentialing process every 24 months, at minimum. The ZSFG/UCSF Division of HIV, Infectious Diseases & Global Medicine is responsible for monitoring the minimum amount of hours is met, if applicable

Committee Review: The Credentials Committee review all cases for approval or denial and provide feedback or request additional information or corrections as needed at regularly scheduled Credentials Committee meetings.

VI. DEFINITIONS

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recommendations for the granting of Privileges, reappointments, and the assignment of Applicants to the various Clinical Services as provided in theses Bylaws.

Practitioner: a licensed or certified professional who provides medical or behavioral healthcare services (source NCQA).

Recredentialing: process of reevaluating Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical Staff and the continuation of Clinical Privileges.

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

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.aspericueta@sfdph.org).*

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form: Elisha Perez	
Standardized Procedure Title:	Discharge of Adult and Pediatric Ambulatory Surgery Patients
Department:	Periop
Dept Chief:	Nandini Palaniappa
SP Author(s):	Edits to previous version made by Elisha Perez and Gerard Padilla
Update #1:	Updated year, gendered language, Surgicenter to Pre-Op
Update #2:	Grammatical corrections
Update #3:	Addition of italicized text under B. 2. Objective Data: "Supplemental oxygen has been discontinued for a minimum of 30 minutes prior to discharge *unless patient is on oxygen at home. For patients on home oxygen, the patient has returned to baseline level of administered oxygen for 30 minutes prior to discharge."*
Update #4:	B. 2. Objective Data: removal of "Urologic, gynecologic, hernia procedures and/or spinal and epidural anesthesia patients must void, unless a physician orders differently." Replaced with "Unless there is an order for the patient to void prior to discharge, if patients have not voided post-op they may be

	discharged with instructions informing them to seek help if they have not voided six to eight hours after discharge."
Update #5:	Removal of "The following registered nurses are authorized to discharge adult and pediatric ambulatory surgery patients under this standardized procedure:" from last (signatory) page.

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below. See also CA BRN Standardized Procedure Guidelines

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	Specify any experience, training, and/or education requirements for performance of standardized procedure functions. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions. Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
Record Keeping	Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition. State the limitations on settings, if any, in which standardized procedure functions may be performed.

	Specify patient record keeping requirements. Provide for a method of periodic review of the standardized procedures, with signatures and dates of approval of Authors, Nursing Director, and Department Chief of Services/Medical Director.

20252

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

STANDARDIZED PROCEDURE

Title: Discharge of Adult and Pediatric Ambulatory Surgery Patients

1. Policy Statement
   A. *It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, Registered Nurses, Physicians, Pharmacists, ~~Psychologists,~~ Administrators and other affiliated staff and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474,* the Nurse Practice Act, Business and Professions Code Section 2725.
   B. A copy of the signed procedures will be kept in an operational manual in the Post Anesthesia Care Unit (PACU) and on file in the Medical Staff Office.

2. Functions to Be ~~b~~e Pp~~p~~erformed
   When an RN provides health care that involves areas of overlapping practice between nursing and medicine, a standardized procedure is required. This standardized procedure includes guidelines stating specific conditions requiring the RN to seek physician consultation.

3. Circumstances Uu~~n~~der Ww~~w~~hich RN mm~~m~~ay Pp~~p~~erform Ff~~f~~unction
   A. Setting
      The Registered Nurse may perform the following standardized procedure function in the Post Anesthesia Care Unit (PACU) and Pre-Op consistent with their experience and training.

   B. Scope of Ss~~s~~upervision Rr~~r~~equired
      1. The RN is responsible and accountable to the PACU and Pre-Op~~Surgicenter~~ Nurse Manager and Perioperative Medical Director or physician designee.
      2. Overlapping functions are to be performed in areas that allow for a consulting physician to be always available to the RN by phone or in person, including, but not limited to, the clinical area.
      3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
         a. If~~When~~ the ambulatory surgery patient fails to meet discharge criteria
         b. If the patient e~~E~~xperiences emergency conditions such as unstable vital signs that require prompt medical intervention.

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Commented [EK1]: Do we need to change this to the updated preamble verbiage: *and must conform to "all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474."?*

Commented [ZJ2R1]: Yes. I agreed

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Commented [ZJ3]: When listed as title, #1, #2, and #3 may need to get capitalized the words in order to keep consistency.

4. List of Protocols:
   Protocol #1 Discharge of Adult and Pediatric Ambulatory Surgery Patients

5. Requirements for the Registered Nurse
   A. Experience and Education
      1. Active California Registered Nurse license
      2. Graduate of an approved RN program
      3. Current BLS certification from an approved American Heart Association Providers

   B. Special Training
      1. The RN has successfully completed their~~his/her~~ orientation to the PACU and/or Pre-Op~~Surgicenter~~ with a completed orientation checklist on file.
      2. The RN has learned the criteria contained in the Standardized Protocol defined in Protocol #1 Discharge of Adult and Pediatric Ambulatory Surgery Patients.

   C. Evaluation of the RN's Competence in Performance of the Standardized Procedure.
      1. Initial:
         After completion of the standardized procedure training, the PACU/Pre-Op Nurse Manager or designee will assess the RN's ability to perform the procedure:
         a. Clinical Practice
            - Successful completion of the PACU/Pre-Op RN orientation program.
            - Successful completion of the PACU/Pre-Op Standardized Procedure training. The RN is assessed, and documentation reviewed on three (3) discharge patients in accordance with the standardized procedure.
      2. Annual:
         The PACU/Pre-Op Nurse Manager or designee will evaluate the RN's competence via the annual performance appraisal and skills competency review along with feedback from colleagues and/or physicians. Direct observation and/or chart review may be used.
      3. Follow-up:
         RNs with elements requiring increased proficiency, as determined by the initial or annual review will be re-evaluated by the PACU/Pre-Op Nurse Manager or designee at appropriate intervals until acceptable skill level is achieved. Feedback from colleagues, physicians, direct observation and/or chart review may be used to determine competency.

6. Development and Approval of Standardized Procedure
   A. Method of development

Commented [TM4]: When a distinction is made between requirements for experienced and new providers, inclusion of the following language to qualify the designation of experienced: "documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years." The text in quotations seems to apply to #2 "annual" here.

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Commented [TM5]: I'm new to reviews here, so just curious if it is sufficient to state "at appropriate levels or until acceptable skill level is achieved." Just asking since the CIDP guideline states it should be "specified" and the current language seems generalized.

Commented [KA6R5]: Agree that usually we see more specific intervals, and # charts for review as well

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

B. Approval

All standardized procedures must be approved by the CIDP, Credentials Committee, Medical Executive Committee and Joint Conference Committee prior to use.

C. Review schedule

The standardized procedure will be reviewed every three years (and as practice changes) by the PACU/Pre-Op Nurse Manager, Perioperative Medical Director and staff.

D. Revisions

All changes to the standardized procedures are to be approved by the CIDP.

Protocol #1
Title: Discharge of Adult and Pediatric Ambulatory Surgery Patients

A. Definition
1. Patients may be discharged from the Pre-Op or PACU when the physician performing the procedure writes a discharge order indicating the patient may be discharged by the Registered Nurse when all discharge criteria have been met.
2. Additionally, patients cared for by an anesthesiologist must have a postoperative note written within 48 hours from the end of the anesthetic administration ~~by an anesthesiologist prior to discharge~~.

B. Database
~~a. Subjective Data~~
1. Subjective Data
~~b.~~a. Patient is awake, alert and oriented or~~and~~ has returned to their baseline pre-operative level of consciousness
2. Objective Data Meets Discharge Criteria when:
~~b. Meets Discharge Criteria when:~~:

~~c.~~a. The m~~M~~inimum time required for monitoring~~passed~~ the patient has passed, starting from the end of the procedure based on~~y~~ sedation/anesthesia type the patient received

Minimum ~~T~~time period required for monitoring ~~has passed since~~ from the end of procedure	**Type of sSedation/aA~~A~~nesthesia the patient received**
30 minutes	Moderate Sedation or Monitored Anesthesia Care (MAC)
60 minutes	General, spinal, regional or epidural anesthesia

~~d.~~b. A minimum of t~~T~~wo hours from time of administration ~~is the minimum time~~ has passed~~elapsed~~ for monitoring any patient who received~~ing~~ a reversal agent (Naloxone or Flumazenil) to detect potential re-sedation (Hosp Policy 19.08 – Moderate and Deep Sedation).
~~e.~~c. The patient has, at most, mild nausea and/or dizziness.
~~f.~~d. The patient is alert and oriented to person, place and time and can verbalize appropriately or has returned to their ~~his/her~~ pre-operative/baseline level of consciousness.
~~g.~~e. Vital signs are within 20% of pre-operative/baseline levels (blood pressure, heart rate, respiratory rate).
~~h.~~f. Supplemental oxygen has been discontinued for a minimum of 30 minutes prior to discharge unless patient is on oxygen at home. For patients on home oxygen, the patient has returned to baseline level of administered oxygen for 30 minutes prior to discharge.

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~~i.~~g. The patient is a~~Mobility: A~~ble to ambulate with minimal assistance or has returned to pre-operative mobility status.

~~j.~~h. Pain is no greater than mild to moderate (~~*NRS* <~~/= 5) with or without PO medication or 30 minutes after IV/IM opioids~~narcotics~~.

~~k.~~i. Wound site is dry or appropriate for type of surgery.

~~l.~~j. Neurovascular status of operative extremity is appropriate for postoperative state (if applicable).

~~m.~~k. Unless there is an order for the patient to void prior to discharge, if patients have not voided post-op they may be discharged with instructions informing them to seek help if they have not voided six to eight hours after discharge~~Urologic, gynecologic, hernia procedures and/or spinal and epidural anesthesia. Patients must void, unless a physician orders differently~~.

~~n.~~l. Blocks:

- All block patients will receive written block instructions and must understand how to protect their extremity.
- Upper extremity blocks - patients ~~may be discharged with partial motor and sensory return. They~~ must ~~understand how to protect their extremity and~~ have a sling in place.
- Lower extremity blocks - p~~P~~atients will be given crutches or assistive devices to ambulate safely. Crutch teaching is done by the RN and a return demonstration by the patient should be performed with the assistance of two staff members for safety needs.
- ~~All block patients will receive written block instructions in their discharge teaching.~~

~~o.~~m. P~~Escort: P~~atients should have a responsible adult escort to accompany them from the hospital or they may be discharged using an approved transportation service.

~~p.~~n. ~~Housing –~~In cases where the patient is homeless, they should have shelter and transportation arranged via Social Services.

C. Diagnosis

Physician consultation is required for the following:

1. Failure to meet discharge criteria
2. Vital signs unstable or ~~(~~not within 20% of pre-operative level for blood pressure, heart rate, and respiratory rate~~)~~.
3. In situations where a responsible adult escort is not present and/or the patient refuses to wait for transportation/escort. T~~,t~~he service physician may evaluate the patient in consultation with the Anesthesia attending and, if appropriate, write an order for the patient to be discharged independently.

D. Plan

Education of patient and family and post-operative follow-up:

1. If discharge medications/prescriptions are~~have been~~ ordered, the patient is~~has been~~ educated regarding the~~se~~ medications/~~ or~~ prescriptions~~ given.~~
2. Post-operative discharge instructions ~~along with medication reconciliation~~ (including~~and~~ instructions on nerve blocks if applicable) ~~have been~~are

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Commented [KA8]: Confirming intention is "physician" not including advanced practitioners for RN SP?

reviewed with the patient (and escort if appropriate), using an interpreter as neededappropriate.

3. The patient ishas received scheduled for a post-operative follow-up appointment with the appropriate pProvider and clinic when applicable.

E. Record Keeping
Nursing documentation in the medicalclinical record is complete, reflecting that all discharge criteria are met.

San Francisco General Hospital and Trauma Center
Post Anesthesia Care Unit (PACU) and ~~Surgicenter~~Pre-Op

STANDARDIZED PROCEDURES

Discharge of Adult and Pediatric Ambulatory Surgery Patients
Based upon Discharge Criteria

~~The following registered nurses are authorized to discharge adult and pediatric ambulatory surgery patients under this standardized procedure:~~

Approved by:

_____	_____
Gerard F. Padilla, RN MS Nurse Manager, PACU/Pre-Op~~SC~~	Date
_____	_____
Patty Coggan, RN MSN Nursing Director, Perioperative Services	Date
_____	_____
Romain Pirracchio, MD Chief of Anesthesia	Date
_____	_____
Nandini Palaniappa, MD Medical Director, Perioperative Services	Date

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CIDP: 8/6/2025

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

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SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

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Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:	
Standardized Procedure Title:	Interventional Radiology
Department:	Radiology
Dept Chief:	Mark Wilson MD
SP Author(s):	Ryan Sincic NP
Update #1:	Added Protocol #27 Fluoroscopy
Reason/Explanation for Revision:	Reflects current procedures and continuing competency requirements for PAs
Update #2:	
Reason/Explanation for Revision:	

*Include additional rows to table, if needed

Section II: Standardized Revisions

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)
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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. *Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure*. (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)

San Francisco General Hospital and Trauma Center
STANDARDIZED PROCEDURES INITIAL AND REAPPPOINTMENT CRITERIA

PROVIDER NAME: _____

CLINICAL SERVICE: RADIOLOGY

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/ UNMET*	COMMENTS
CORE				
#1 Health Care Management: Interventional Radiology Services	3 months in length. Direct observation of 10 cases. 30 chart reviews (15 neuro IR and 15 body IR)			
# 2 Furnishing Medications and Drug Orders	Review as part of noted case review.			
#3 Discharge of Inpatient	Review as part of noted case review			
SPECIAL				
# 4 eConsult	Concurrent review of 15 consultations.	Review 4 consultations every 2 years.		
# 5 Surface Trauma and Wound Care	New practitioners will do 3 procedures. Experienced practitioners will do 2 procedures. 3 chart reviews.	3 procedures and 3 chart reviews every 2 years.		
# 6 Lumbar Puncture/Lumbar Drain Insertion	New practitioner will do 5 procedures. Experienced practitioner will do 3 procedures.	3 procedure and 3 chart reviews every 2 years.		
# 7 Chest Tube and Drainage Catheter Removal	New practitioners 5 procedures, experienced practitioners 3 procedures.	3 procedure and 3 chart reviews every 2 years.		
#8 Abdominal Paracentesis	New practitioner 5 procedures, experienced practitioner 3 procedures.	3 procedure and 3 chart reviews every 2 years.		
# 9 Interventional Radiology Procedural Assistant	3 months in length. Direct observation from an attending in Interventional or Neuro-interventional Radiology & Review of all cases at end of procedure.	10 procedures and 10 chart reviews every 2 years		
#10 Central Venous Catheter Placement #	Perform 10 placements under direct observation.	Placement of 5 CVCs every 2 years. 1 direct observation		

Commented [KE1]: Not mentioned in the SP

		and 3 chart reviews every 2 years.		
#11 Tunneled Central Venous Catheter Placement	Perform 10 catheter placements under direct observation.	Perform 10 catheter placements, 1 direct observation and 3 chart reviews every 2 years.		
#12 Tunneled Central Venous Catheter Removal	Perform 5 catheter removals under direct observation.	Perform 2 catheter removals and 2 chart reviews every 2 years.		
# 13 Chest Port Central Venous Catheter Placement	Perform 10 chest port placements under direct observation without need for procedural ~~sedation.~~ intervention by training provider	5 procedures every 2 years and 1 direct observation every 2 years. 3 chart reviews every 2 years.		
# 14 Chest Port Central Venous Catheter Removal	Perform 5 removals under direct observation.	Perform 2 procedures and 2 chart reviews every 2 years.		
# 15 Gastrostomy Catheter Exchange	Complete 3 gastrostomy and 3 gastrojejunostomy exchanges under direct observation without need of procedural intervention by training provider.	Perform 1 gastrostomy and 1 gastrojejunostomy exchange annually. Direct observation of 1 ~~gastrosomy and 1~~ gastrojejunostomy and chart reviews of 1 gastrosomy and 1 gastrojejunostomy every 2 years		
# 16 Pleural Catheter Placement	Perform 10 procedures under direct observation.	3 procedures, 2 direct observations and 3 chart reviews every 2 years.		
# 17 Tunneled Pleural Catheter Placement	Perform 10 procedures under direct observation.	Complete 3 procedures, 2 direct observations and 3 chart reviews every 2 years.		
# 18 Thoracentesis	Perform 5 procedures under direct observation. Experienced providers will perform a minimum of 3 observed demonstrations.	3 procedures and 2 chart reviews every 2 years.		
#19 Procedural Sedation/Moderate Sedation (ACLS Required)	30 procedures under direct observation and 10 procedures for experienced practitioner. Review 30 procedure notes. Completion of education module with test score of at least 90%.	Perform 15 procedures, Direct observation of 1 patient clinic encounter~~rocedure~~ every 2 years, ~~maintenance of ACLS and BLS~~. Completion of ~~education module~~Procedural Sedation Test with passing score of at least 90%.		
#20 Lower Extremity Venous Sclerotherapy	Perform 10 procedures under direct observation. Experienced providers complete 4 observed procedures.	4 procedures and 4 chart reviews every 2 years.		

Commented [KE2]: SP says 5 removals

Commented [KE3]: This matches SP. Affiliated Staff document changes tracked.

Commented [KE4]: SP says 2 direct obs.

Commented [KE5]: SP says "Direct observation of one observed moderate sedation case" and also includes ACLS and BLS Cert. maintenance.

Hip Aspiration and Injection #21	Perform 5 procedures under direct observation. Experienced providers will perform a minimum of 3 observed demonstrations.	Perform 2 procedures and 2 chart reviews every 2 years.		
Shoulder Aspiration and/or Injection #22	Perform 5 procedures under direct observation. Experienced providers will perform a minimum of 3 observed demonstrations.	Perform 2 procedures and 2 chart reviews every 2 years.		
Nephrostomy Catheter Exchange #23	Perform 4 nephrostomy exchanges and 4 nephroureterostomy exchanges under direct observation	Perform 1 nephrostomy tube and 1 nephorurterostomy tube annually. Direct observation of 1 nephroureterostomy tube exchange procedure every 2 years. 2 chart reviews every 2 years of 1 nephrostomy and 1 nephroureterostomy.		
Cholecystostomy Catheter Exchange #24	Perform 5 procedures under direct observation.	2 procedures performed annually. 1 procedure observed every 2 years with 2 chart reviews.		
Abscess Drainage Catheter Exchange #25	Perform 5 procedures under direct observation.	2 procedures performed annually. 1 procedure observed every 2 years with 2 chart reviews.		
CT Guided Spinal Steroid Injections #26	Direct supervision of 10 procedures, ~~and~~ 10 chart reviews and review of referrals for 10 cases (Any qualified provider can proctor)	5 procedures completed ~~in 2 years~~ & 10 ~~or 5 procedures annually with 5~~ chart reviews every 2 years.. No direct observation of procedure is needed		
#27 Fluoroscopy	New provider, minimum 5 supervised fluoroscopy cases and any additional procedures necessary to verify clinical competence. Experienced provider to procedure, a minimum of 5 successful observed demonstrations	3 procedures and 2 chart reviews every 2 years		

Commented [KE6]: SP is confusing - states:
"Reappointment Competency Documentation:
a. Minimum number of procedures that must be completed in two years or state number of procedures annually: 5
b. Minimum number of chart reviews needed in a two years or state number of chart reviews annually: 10"
Are these numbers for every 2 years or annually?

Chief of Surgery _____ Date _____

*Clinical data relevant to privileges, or performance evaluation of standardized procedures, is available for review on 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: Interventional Radiology

I. Policy Statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Radiology Program Office (Room 1x55) and on file in the Medical Staff Office.

II. Functions To Be Performed

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

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

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

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

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

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). Inpatient settings to include ICU and inpatient units. Outpatient settings to include the Radiology Department and Emergency Department.

B. Supervision

   1. Overall Accountability:
      The NP/PA is responsible and accountable to: Chief of Interventional Radiology.
   2. A consulting physician, which may include attendings, and credentialed fellows, 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. Unexplained historical, physical, or laboratory findings.
      c. Upon request of patient, affiliated staff, or physician.
      d. Problem requiring hospital admission or potential hospital admission.
      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: Interventional Radiology Service
Protocol #2	Furnishing Medications/Drug Orders
Protocol #3	Discharge of Patients
Protocol #4	eConsult
Protocol #5	Surface Trauma and Wound Care
Protocol #6	Lumbar Puncture/Lumbar Drain Insertion
Protocol #7	Chest Tube and Drainage Catheter Removal
Protocol #8	Abdominal Paracentesis
Protocol #9	Interventional Radiology Procedural Assistant
Protocol #10	Central Venous Catheter Placement
Protocol #11	Tunneled Central Venous Catheter Placement
Protocol #12	Tunneled Central Venous Catheter Removal
Protocol #13	Chest Port Central Venous Catheter Placement
Protocol #14	Chest Port Central Venous Catheter Removal
Protocol #15	Gastrostomy Catheter Exchange
Protocol #16	Pleural Catheter Placement
Protocol #17	Tunneled Pleural Catheter Placement
Protocol #18	Thoracentesis
Protocol #19	Procedural Sedation
Protocol #20	Lower Extremity Venous Sclerotherapy
Protocol #21	Hip Aspiration and Injection
Protocol #22	Shoulder Aspiration and Injection
Protocol #23	Nephrostomy Catheter Exchange
Protocol #24	Cholecystostomy Catheter Exchange
Protocol #25	Abscess Drainage Catheter Exchange
Protocol #26	CT Guided Spinal Steroid Injections
Protocol #27	Fluoroscopy

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
1. Active California Registered Nurse/Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider. Must have certification of Advanced Cardiac Life Support (ACLS) training if requesting Procedural Sedation Protocol.

5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the ZSFG Physician 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 ANP, FNP, ACNP.
      b. Current ACLS certification if requesting Procedural Sedation protocol.
      c. Pass National Certification as a Physician Assistant.
      d. Specialty training will be provided by the Radiology/Interventional Radiology attendings as part of the orientation process.
      e. For Minor Procedure Protocol training please refer to each Procedure Protocol.

   2. Amount of previous experience in specialty area expected for this position.
      a. Two years experience as a Registered Nurse or Nurse Practitioner in an emergency department, acute care or intensive care unit in an acute care hospital within 6 months of hire.
      b. Two years experience as a PA in an emergency department, acute care or intensive care unit in an acute care hospital within 6 months of hire.

C. Evaluation of NP/PA Competence in performance of standardized procedures. For procedures please refer to specific Procedure Protocol.
   1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and/or other supervisors, as applicable will assess the NP/PA's ability to practice.

      a. Clinical Practice
      - Length of proctoring period will be three months. The term may be shortened or lengthened at the discretion of the supervising physician. This proctoring will also include 30 chart reviews (15 neuro IR and 15 body IR)., which will include direct observation of NP/PA clinic encounters of 5 body IR and 5 neuro IR cases. The evaluator will be the Chief of

Interventional Radiology or Clinical Supervising Physician Designee.

- The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
    a. Ten (10) directly observed clinical encounters are presented to the evaluator
    b. For directly observed clinical encounters evaluator reviews co-signs orders and progress notes
    c. For directly observed clinical encounters, co-signatures by a licensed physician must be concurrent to patient care
    d. For directly observed clinical encounters, medical record review is conducted for in-patient medication ordering and out-patient discharge medication
    e. Medical Record review may be conducted retrospectively by the Clinical Supervising Physician

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

3. Ongoing Professional Performance Evaluation (OPPE): Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff office.

4. Biennial Reappointment: Medical Director, designated physician or designated same discipline peer must evaluate the NP/PA Clinical competence. Case numbers will be found in each procedure.

VI. Development and Approval of Standardized Procedure

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

B. Approval
    1. The CIDP, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to 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. All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.

Protocol #1: Health Care Management – Interventional Radiology Services

A. DEFINITION

This protocol covers the procedure for health care management in specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses. Settings to include; Emergency Department, Radiology Department, Outpatient Clinics, ICU and Inpatient Units.

B. DATA BASE

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

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

C. DIAGNOSIS

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

D. PLAN

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

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

d. Initiation or change of medication other than those in the formularies.
e. Acute, severe respiratory distress
f. An adverse response to respiratory treatment, or a lack of therapeutic response.

3. Education
   a. Patient education appropriate to diagnosis and should include treatment modalities and lifestyle counseling (e.g. diet and exercise).
   b. Discharge information and instructions.

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

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

Protocol #2: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners (NPs) and certified nurse midwives (CNMs) is defined as the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license.

All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively:

- PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the California Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistant's Physician Assistant Practice Agreement.

- NPs and CNMs 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.
- PAs, NPs and CNMs with an x-waiver may prescribe medications containing buprenorphine for the purpose of treating patients with opiod use disorder.

The practice site (clinic or inpatient), 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 that will 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 ZSFG Administrative policy on Furnishing Medications (policy no. 13.02) and the writing of Drug Orders. (Policy no. 13.05).

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. If applicable, physical findings that support use for CSII-III medications.

c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment

a. Initiate, adjust, discontinue, and/or renew drugs and devices.

b. NPs may order Schedule II - III controlled substances for patients with the following patient specific protocols. Insert the following:

1. location of practice
2. diagnoses, illnesses, or conditions for which medication is ordered
3. parameters for acute conditions including maximum daily morphine equivalents and duration of treatment
4. parameters for treatment with chronic opioids including checking CURES, toxicology screening, treatment plan and clinic specific policies
5. names of medications, daily maximums, refill limitations and time period for follow-up.

c. To facilitate patient receiving medications from a pharmacist provide the following:

1. name of medication
2. strength
3. directions for use
4. name of patient
5. name of prescriber and title
6. date of issue
7. quantity to be dispensed
8. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation
    a. Initiation or change of medication other than those in the formulary.
    b. Unexplained historical, physical or laboratory findings.
    c. Upon request of patient, NP, PA, or physician.
    d. Failure to improve pain and symptom management.

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

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

E. RECORD KEEPING

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

Protocol #3: Discharge of Patients

A. DEFINITION
This protocol covers the discharge of patients from ZSFG. The direction to discharge a patient will come from the attending physician. This protocol covers patients who are admitted by the Radiology/Interventional Radiology Service to the inpatient Wards, patients in the Radiology Department and those sent to PACU, 4C, Acute Dialysis (H47) and Chronic Dialysis (Ward 17) to recover from interventional procedures and treatment.

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

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

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

D. PLAN
1. Treatment
   a. Review treatment plan with patient and/or family.
   b. Initiation or adjustment of medications per Furnishing/Drug Orders protocol.
   c. Assure that appropriate follow-up arrangements (appointments/studies) have been made.
   d. Referral to specialty clinics and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings.
   c. Upon request of patient, NP, PA or physician.
   d. Initiation or change of medication other than those in the formulary.
   e. Referral to specialty services not provided by DPH.

3. Education
    a. Review patient course and what will need follow-up.
    b. Provide instructions on:
        - follow-up clinic appointments
        - outpatient laboratory/diagnostic tests
        - discharge medications
        - signs and symptoms of possible complications
        - whom to call if have symptoms of complications

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

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

PROTOCOL #4: eConsult Review

A. DEFINITION

eConsult review is defined as the review of outpatient imaging consultation requests via the online eConsult system. An imaging request is defined as a request for advanced imaging study, such as MRI, CT or Ultrasound, submitted by a health care provider to the radiology department. A review of imaging request is defined as determination of appropriateness and urgency (priority) of a requested imaging study, based on the provided subjective and objective data.

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

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

3. Proctoring: 15 reviews of the eConsult consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.

B. DATA BASE

1. Subjective Data
   a. eConsult imaging request review will include the review of medical and surgical history, which is relevant to determination of appropriateness and priority of the imaging study. The scope of the review will be limited to the data provided by the referring provider on the electronic referral. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.
   b. The review will include the review of allergy history to anticipate contrast reactions.
   c. The review will include the review of special patient data that may affect the imaging study. This data may include, but is not limited to patient's language requirements, mobility issues, anxiety and need

for sedation. Review of these special patient data will help anticipate problems during performance of the study, and thereby improve efficiency of the department.

2. Objective Data
   a. The review will include the review of physical exam findings, which are relevant to the determination of appropriateness and priority of the imaging study. The review will be limited in scope to the data provided by the referring provider.
   b. The record of prior radiological exams will be reviewed, to exclude (duplicate entries of the same study), and to help assess appropriateness of imaging. The record of prior radiological exams will be retrieved by the eConsult system automatically, however in some cases the reviewer may need to consult the electronic medical record.
   c. The record of laboratory findings, which are relevant to imaging, such as Creatinine and eGFR, will be automatically retrieved by the eConsult system. However, in some cases the reviewer may need to consult the electronic medical record to retrieve further information.

C. DIAGNOSIS
Establishing the correct diagnosis is the goal of radiological imaging, therefore the eConsult review is not aimed at establishing the final diagnosis. However, it is essential to know the preliminary or provisional diagnosis in order to assess the appropriateness and priority of the imaging study. A correct ICD10 code of the preliminary diagnosis is also crucial to successful billing of the radiological procedures. eConsult review will include the preliminary diagnosis as provided by the referring provider through the eConsult system.

D. PLAN
1. Review of eConsult
   a. All data provided via the eConsult consultation request will be reviewed and assessed for appropriateness of the imaging request and priority (urgency) of the study. The review will be based on the published appropriateness guidelines of the American College of Radiology. The reviewer will also consider factors, which are local to ZSFG, such as availability constraints and wait times in assigning priority to the imaging requests.
   b. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient conditions requiring Attending Radiologist Review
   a. Upon request of the referring NP, PA or physician

b. Complex imagining questions, not clearly addressed by the American College of Radiology guidelines.
c. Problems requiring emergent imaging studies.
d. Problems requiring relatively counter-indicated imaging studies, when the benefits outweigh the risks.
e. Problems requiring emergent/urgent surgical intervention.

3. Education
Provider education appropriate to the referring problem including usefulness, indications, counter-indications of imaging studies. The reviewer will also advise the referring clinicians regarding the limitations of availability of certain studies at ZSFG.

4. Scheduling of Appointments
Dependent upon the urgency of the referral, the eConsult will be forwarded to the scheduler for the next available imaging appointment.

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

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

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

Protocol #5: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment and management of wounds.

1. Location to be performed: For purposes of this procedure, the protocol will be completed in the inpatient and outpatient unit(s) at ZSFG

2. Performance of procedure:
   a. Indications
      Patient's presenting for assessment and treatment of lacerations, abrasions and avulsions.
   b. Precautions (require attending physician consultation):
      - Coagulopathy
      - Potential for Foreign Bodies within wound
      - Malnutrition
      - Diabetes
      - Immunocompromized State
      - Peripheral Vascular Disease
      - Unexplained historical, physical or laboratory findings.

3. Contraindications requiring attending physician consultation
   a. Vascular compromise or cases where direct pressure does not stop bleeding
   b. Wounds requiring large area of debridement or excision prior to closure
   c. Wounds with bone fragments or fracture
   d. Wounds with tendon, ligament, vessel or nerve involvement
   e. Head laceration with galea disruption
   f. Facial lacerations with cosmetic consideration (e.g. eyelids and vermillion borders)
   g. Lacerations penetrating into joints
   h. Children under the age of 10
   i. Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
   j. Wounds requiring repair of cartilage
   k. Through and through lip lacerations
   l. Unexplained historical, physical or laboratory findings that could compromise safety of the procedure.

B. DATA BASE

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

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed. Physical exam of the wound including a description of its location, extent, depth and appearance of discharge, erythema, swelling or ecchymosis
   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 consistent with hospital policy before procedure is performed.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, clinic, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Inability to approximate wound edges
   e. Persistent or uncontrolled bleeding
   f. Scalp wounds involving the galea
   g. Upon request of patient, NP, PA, or physician
   h. Initiation or adjustment of medication other than those in the formularies.
   i. 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 initiation of proctoring and provision of direct patient care: a. Specialty training will be provided by the Interventional Radiology attendings as part of the orientation process. b. Observe 2 wound care and surface trauma care procedures with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 3 successful observed demonstrations. b. Experience practitioner to procedure, a minimum of 2 successful observed demonstrations. c. Three medical record reviews/audits by the Chief of Interventional Radiology or Clinical Supervising Physician designee. d. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Evaluation of Reappointment Competency a. Evaluation will be performed by Supervising Physician and/or his or her designee. b. Demonstration of 3 procedures completed every 2 years. c. Three chart reviews needed every 2 years

Protocol #6: Lumbar Puncture/Lumbar Drain Insertion

A. DEFINITION

Lumbar catheter insertion is defined as placement of a lumbar Cerebral Spinal Fluid (CSF) drainage catheter located within the subarachnoid space as decided upon by the Interventional Radiology team and in accordance with the Neuro-Interventional Radiology Attending Physician.

1. Locations to be performed: For purposes of this procedure, the protocol will be completed in the Radiology Department or inpatient units at ZSFG.

2. Performance of procedure:
   a. Indications
      1. Lumbar puncture should be performed primarily on patients with severe headache with or without fever of unknown origin, especially if an alteration of consciousness is present. Aspiration of the spinal fluid with subsequent analysis may be necessary to the diagnosis of CSF infection, bleeding or embolus (e.g. meningitis, syphilis, subarachnoid hemorrhage, MS).
      2. A lumbar drain should be placed primarily for the purposes of CSF diversion. This procedure should be considered in the presence of a persistent CSF leak, operative cases requiring temporary decompression/diversion during the postoperative period, in cases of documented mental status improvement following serial high volume LP taps, in lieu of or until a definitive mode of diversion is achieved i.e. EVD or VP shunt.

   b. Precautions (Requiring a physician consultation)
      1. Mass effect, subarachnoid hemorrhage or obstructive hydrocephalus: will typically obtain a head CT to rule out these conditions.
      2. Platelets should be greater than or equal to 100,000
      3. Patients on anticoagulants or who have bleeding tendencies (ex.Atrial fibrillation. Von Willebrand's, Hemophilia, Liver disease)
      4. ASA/NSAIDS/Cox II Inhibitors taken within past 5 days.

   c. Contraindications (Requiring a physician consultation)
      1. Infection in the tissues near the puncture site.
      2. Increased intracranial pressure, if suspected rule out with head CT
      3. Coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
      1. Presence of motor or sensory deficits
      2. Presence of headache or meningitic symptoms
      3. Presence of continued or new CSF leak.
   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 consistent with hospital policy before procedure is performed.
   b. Time out performed per hospital policy.
   c. Referral to specialty clinic, supportive services for provider as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Resistance met on drain insertion
   c. Patient complaint of nerve root pain
   d. Failure to obtain CSF drainage or flow
   e. Upon request of patient, NP, PA, or physician
   f. Initiation or adjustment of medication other than those in the formularies.

3. Education

   Discharge information and instructions.

4. Follow-up

   As appropriate for procedure performed.
   a. Assess for signs and symptoms of insertion site infection
   b. Assess for signs of CSF leak

c. Assess for complaints of headache in the upright position

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Specialty training will be provided by the Interventional Radiology attendings as part of the orientation process. c. Observe 2 lumbar punctures/drain insertions with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee. d. Successful completion of these requirements as determined by the Chief of Interventional Radiology or Clinical Supervising Physician designee is needed prior to independent practice.
Evaluation of Reappointment Competency: a. Evaluation will be performed by Supervising Physician and/or his or her designee. b. Demonstration of 3 procedures every 2 years. c. Three chart reviews every 2 years.

Protocol #7: Chest Tube and Drainage Catheter Removal

A. DEFINITION

For the purposes of this protocol, a drainage catheter is defined as an indwelling catheter placed for therapeutic removal of fluid. A chest tube is defined as an indwelling catheter placed in the thoracic cavity for therapeutic removal of fluid or air.

1. Location to be performed: The removal of a chest tubes and drainage catheters will be performed on the inpatient units, Emergency Department, or Radiology Department.
2. Indications
   a. Patient symptoms related to intrapleural air/fluid have diminished
   b. Patients current chest radiograph/ laboratory studies support procedure
3. Precautions/Contraindications requiring attending consultation
   a. Relevant diagnostic modalities indicate continued presence of air/fluid.

B. DATA BASE

1. Subjective Data
   a. Comfort, c/o shortness of breath, exercise tolerance.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications
   c. Relevant history and review of symptoms including but not limited to: results respiratory, allergies.

2. Objective Data
   a. Appropriate physical exam including but not limited to: results of previous chest imaging, quantity and quality of output from the Chest Tube, evaluation for air leak, oxygen saturation, and breath sounds, to confirm appropriateness of procedure.
   b. Evaluation of the chest tube insertion site for signs of infection including but not limited to purulence, erythema, induration, fluctuance, foul odor.
   c. Review of current medication regiment including recent analgesia administration.
   d. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   e. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Resolution of pneumothorax, hemothorax, effusion, suspected malfunction of the chest tube to function adequately (e.g. suspected clotted tube, proximal hole external to chest wall cavity). Prior to chest tube removal,

the Interventional Radiology Service will complete an assessment of the subjective and objective data- see above.

D. PLAN

1. Therapeutic Treatment Plan
   a. Explain procedure to the patient, if possible. If patient unable to understand, advise bedside nurse of procedure and plan.
   b. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   c. Time out performed per hospital policy.
   d. Diagnostic tests to confirm appropriateness of procedure.
   e. This procedure is performed following standard medical technique according to the departmental guidelines/ standards.
   f. Observe patient for signs of respiratory compromise immediately following procedure including (as indicated) respiratory rate, pattern, oxygen saturation. For ventilated patients, observe the measured airway pressures post removal.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation including but not limited to acute shortness of breath, persistent desaturation post removal.
   b. Evidence of, or suspicion of air intra-thoracic air entrapment at the time of or immediately after removal (e.g. audible leaking from the chest wound site at the time of removal, increased intrathoracic pressures on ventilated patients).
   c. Inability to remove the chest tube fractured or retained catheter.
   d. Given evidence of increasing or unstable pneumothorax on post-pull imaging.
   e. Upon request of patient, NP, PA, or physician

3. Education
   Provide patient education related to the procedure. If patient is unable to comprehend instructions due to decreased mental status, provide nursing instruction prior to performance. If patient is on a ventilator or positive pressure ventilation advise respiratory therapist prior to performance.

4. Follow-up
   a. Reassess the patient frequently following the procedure.
   b. As appropriate, obtain a follow up chest radiograph 4-6 hours after the completion of the procedure.
   c. Advise the patient and the nurse not to disrupt the occlusive dressing for at least 72 hours post removal.

E. RECORD KEEPING

1. A comprehensive procedural note and post procedure assessments will be documented in the medical record. Any sutures not removed at the time of the chest tube removal shall be described in this note.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care : a. Specialty training will be provided by Interventional Radiology attendings as part of the orientation process. b. Observe 2 chest tube removals with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee. d. Successful completion of these requirements as determined by the Chief of Interventional Radiology or Clinical Supervising Physician designee is needed prior to independent practice.
Evaluation of Reappointment Competency: a. Evaluation will be performed by Supervising Physician and/or his or her designee. b. Demonstration of 3 procedures every 2 years. c. 3 chart reviews every 2 years.

Protocol #8: Abdominal Paracentesis

A. Definition - Abdominal paracentesis entails inserting a needle through the abdominal wall into the peritoneal cavity under local anesthetic for aspiration of peritoneal fluid (ascites).
   1. Locations to be performed: Emergency Department, inpatient units, Radiology Department.

   2. Performance of Procedure: (When possible paracentesis should be performed bedside with ultrasound guidance; an alternative is to have fluid localized and transport patient on same bed used for marking, i.e. patient is not moved).
      i. Indications:
         a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhotic).
         b. Pt with ascites, fever, abdominal pain, i.e. to evaluate for spontaneous bacterial peritonitis.
         c. Symptomatic treatment of tense ascites.
      ii. Precautions (the following conditions necessitate attending physician consultation and ultrasound guided paracentesis):
         a. Abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
         b. Intra-abdominal adhesions or suspicion for loculated fluid.
         c. Pregnancy
      iii. Contraindications:
         a. Fibrinolysis or DIC.
         b. Cellulitis at puncture site.

B. Data Base

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

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

D. Plan

   1. Therapeutic Treatment Plan.

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

2. Patient conditions requiring attending consultation
   a. All patients with conditions listed in precaution section.
   b. Acute decompensation of patient.
   c. Upon the request of the patient, PA, NP or physician.

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

E. Record Keeping

Patient visit, consent forms, and other transfusion-specific documents (completed transfusion report and “blood sticker”) will be included in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Specialty training will be provided by Interventional Radiology attendings as part of the orientation process. b. Observe 3 Abdominal Paracentesis procedures with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Evaluation of Reappointment Competency:

a. Evaluation will be performed by Supervising Physician and/or his or her designee.
b. Demonstration of 3 procedures every 2 years.
c. Three chart reviews every 2 years.

Protocol #9 Interventional Radiology Procedural Assistant

A. DEFINITION

This protocol covers the participation of the Nurse Practitioner who provides assistance to Interventional Radiology Attendings during interventional radiology procedures, where an Interventional Radiology Attending or Neuro-Interventional Radiology Attending is the primary operator and is present in the interventional radiology suite or at the patient bedside during procedures performed outside the IR suite. The assisted procedures are: angiography, venography, angioplasty, venoplasty, vascular embolization procedures, image guided biopsies, drainage procedures, drainage catheter placements, transjugular intrahepatic portosystemic shunts, inferior vena cava filter placements, gastrostomy tube placements, liver biopsies, chest tube placement, thoracentesis, chest port placements, chest port removals, tunneled central venous catheter removal, central venous catheter removal procedures and venous access procedures. Assistance refers to the process where under an attending's direct supervision and direction, the Nurse Practitioner assists the attending operator in the technical steps of the procedure but does not independently perform them. Technical steps of the procedure are the administration of medications, obtaining vascular access, suturing, preparation of instruments, tissue dilation, tissue dissection, tissue cutting, manipulation of intra-corporeal instruments, manipulation of intra-corporeal needles, manipulation of intra-corporeal catheters and drain insertions.

1. Location to be performed: Radiology Department, inpatient units, and Emergency Department.

2. Performance of procedure:
   a. Indications
      This protocol addresses patients presenting to the Radiology Department, or patients undergoing interventional radiology procedures on the inpatient units, or in the Emergency Department.
   b. Precautions
      None
   c. Contraindications
      None.

B. DATA BASE
   1. Subjective Data

a. History of chief complaint and review of symptoms relevant to the suggested procedure, possible organ systems affected by the procedure, mechanism of injury and type of injury
b. Pertinent past medical history including current medications, allergies, clotting disorders, previous wound history, previous vascular disease history, previous history of infection.

2. Objective Data
   a. Physical exam of the system prescribed for procedure, i.e. for neurovascular procedures performing neurologic exam, for vascular procedures providing an examination of associated tissues perfused.
   b. When a drain is implemented, data will include quantity and quality of drainage, level of set negative pressure, and assessment of the site.
   c. Appropriate motor, sensory and vascular exam of the involved area.
   d. The procedure is performed following standard procedural technique according to departmental guidelines.
   e. Laboratory and imaging evaluation, as indicated, relevant to history and exam. Appropriate laboratory values to be considered include (but are not limited to): complete blood count and coagulation studies, nutritional status and electrolytes.
   f. All Point of Care Testing (POCT) will be performed according to ZSFG POCT Policy and Procedure 16.2.

C. DIAGNOSIS
Assessment of subjective and objective data to identify disease process requiring intervention.

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Explain procedure to the patient (if patient unable to receive information due to mental status, explain to surrogate and/or bedside RN) Explain the procedure to the family.
   c. Diagnostic tests for purposes of disease identification.
   d. Time out per hospital policy.
   e. Biopsy tissue is sent to pathology if specimen collected.
   f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   g Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending

a. All assisted interventional radiology procedures shall be performed in direct consultation with an Interventional Radiology Attending or Neuro-Interventional Radiology Attending, who will be in the IR suite during assisted procedures.

3. Education:
   Discharge information and instructions.

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

E. RECORD KEEPING

1. Documentation of a detailed procedure note will be recorded in the medical record. Required follow up of the wound (e.g. suggested suture removal dates, ongoing care to be delivered by nursing/wound care orders, or future drain change) will be indicated in the procedure note and in daily progress notes.
2. All procedural dictations are reviewed and cosigned by an Attending Physician for quality assurance purposes.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of 10 observed cases. b. Specialty Training Provided by Interventional Radiology Attendings.
Proctoring Period: a. All procedures will have direct supervision from a consulting Attending Interventional Radiologist or Neuro-Interventional Radiologist. Review will be done after each case. b. Proctoring period will be three months in length.
Reappointment Competency Documentation: a. Minimum number of 10 procedures must be completed every two years. b. 10 chart reviews needed every two years.

Protocol #10: Central Venous Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of central venous catheters. A central venous catheter refers to a device used for central venous infusion or dialysis.

1. Location to be performed: Radiology Department, inpatient units, PACU, Emergency Department.

2. Performance of procedure:
   a. Indications: Central venous access for delivery of medications, nutrition blood products, and frequent blood sampling. Dialysis for renal failure.
   b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
   c. Contraindications requiring attending physician consultation: Patients who have exhibited prior intolerance to the materials of construction.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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

3. Education
   Instructions for clinical staff.

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 initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Observe two CVC placements with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 10 CVC placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency: a. Successful placement of 5 CVCs every two years. b. Direct observation of one CVC placement procedure will be

performed every two years by a qualified provider.

c. 3 chart reviews will be performed every two years.
d. The Chief of the Interventional Radiology Department or qualified provider designee will be the proctor/evaluator.

Protocol #11: Tunneled Central Venous Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of central venous catheters which are placed for the purposes of central venous infusion or hemodialysis. For the purposes of the protocol/procedure a central venous catheter refers to a venous access device, which is tunneled under the skin to the catheter exit site.

1. Location to be performed: Placement of tunneled central venous catheters will be conducted in the Radiology Department.

2. Performance of procedure:
   a. Indications: Central venous access for delivery of medications, nutrition, blood products, and frequent blood sampling. Hemodialysis as indicated by presence of acute and/or chronic renal failure/insufficiency.
   b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting.
   c. Contraindications requiring attending consultation: Absolute contraindications to tunneled central venous catheter placement include bacteremia or sepsis, infection at the insertion site, and disseminated intravascular coagulopathy. Relative contraindications include neutropenia, recent but resolved sepsis, and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.
   f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Observe two tunneled hemodialysis catheter placements with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 10 tunneled hemodialysis catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA)

and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency: a. Successful placement of 10 tunneled hemodialysis catheter placements every 2 years. b. Direct observation of one hemodialysis access catheter placement procedure will be performed every 2 years by a qualified provider. c. 3 chart reviews will be performed every 2 years.

Protocol #12: Tunneled Central Venous Catheter Removal

A. DEFINITION

This procedure/protocol covers removal of tunneled central venous catheters (CVC). For the purposes of the protocol/procedure a tunneled central venous catheter refers to venous access devices used for central venous infusion and/or hemodialysis, which is tunneled under the skin to the catheter exit site.

1) Location to be performed: Removal of tunneled central venous catheters may occur in the Radiology Department, inpatient units, Emergency Department, PACU, and 4C.

2) Performance of procedure:
   i. Indications: Discontinuation of catheters in patients with suspected CVC infections or for CVCs that are no longer medically needed.
   ii. Precautions requiring attending physician consultation: patients with central venous obstruction or abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department...
   iii. Contraindications: No absolute contraindications.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Requirements, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Observe one tunneled CVC removal with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 5 tunneled hemodialysis catheter removals without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency Documentation: a. Continued proficiency will be documented on annual evaluation or re-credentialing through the successful removal of 2 tunneled CVC

annually and no unexpected complications. b. 2 chart reviews will be performed annually. c. The Chief of the Interventional Radiology Department or qualified provider designee will be the proctor/evaluator.
Any additional comments:

Protocol #13: Chest Port Central Venous Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of chest port central venous catheters. A chest port central venous catheter refers to a device used for central venous access with an infusion port which lies underneath the skin, typically at the upper anterior chest, and a catheter tip which lies in a central vein.

1. Location to be performed: Radiology Department.

2. Performance of procedure:
   a. Indications: Central venous access for delivery of medications, nutrition, blood products, and frequent blood sampling.
   b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department...
   c. Contraindications requiring attending physician consultation: presence of known or suspected infections, septicemia, or peritonitis. Patients who have exhibited prior intolerance to the materials of construction, or patients whose body size or tissue is insufficient to accommodate the size of the port or catheter.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Observe two chest port placements with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 10 chest port placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency: a. Successful placement of 5 chest port central venous infusion

catheter placements every two years.

b. Direct observation of one chest port placement procedure will be performed every two years by a qualified provider.
c. 3 chart reviews will be performed every two years.
d. The Chief of the Interventional Radiology Department or qualified provider designee will be the proctor/evaluator.

Protocol #14: Chest Port Central Venous Catheter Removal

A. DEFINITION

This procedure/protocol covers removal of chest port central venous catheters (CVC). For the purposes of the protocol/procedure a chest port central venous catheter refers to venous access devices used for central venous infusion which is tunneled under the skin to a subcutaneous port.

1) Location to be performed: Chest port CVCs will be removed in the Radiology Department.

2) Performance of procedure:
   i. Indications: Discontinuation of catheters in patients with suspected CVC infections or for CVCs that are no longer medically needed.
   ii. Precautions requiring attending physician consultation: patients with central venous obstruction, abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
   iii. Contraindications: No absolute contraindications.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Observe removal of one chest port CVC with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 5 chest port removals without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency Documentation: a. Continued proficiency will be documented on annual evaluation or re-credentialing through the successful removal of 2 chest ports every two years and no unexpected complications.

b. 2 chart reviews will be performed every two years. c. The Chief of the Interventional Radiology Department or qualified provider designee will be the proctor/evaluator.
Any additional comments:

Procedure: Protocol #15: Gastrostomy Catheter Exchange

A. DEFINITION
This protocol/procedure covers the exchange or removal of percutaneous gastrostomy and gastrojejunostomy catheters/tubes. For the purposes of this procedure a gastrostomy tube would be defined as catheter inserted percutaneously into the stomach, and with catheter end located in the stomach, duodenum or proximal jejunum.

1. Location to be performed: Gastrostomy catheter exchange will take place in Radiology Department, Emergency Department or inpatient units at San Francisco General Hospital. Gastrojejunostomy exchange will take place in the Radiology department at San Francisco General Hospital.

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: Gastrostomy tubes which have been in place less than 6 weeks and replacement of gastrostomy catheters that have completely fallen out of the body.
   c. Contraindications requiring attending physician consultation: immature gastrostomy tracts that may require fluoroscopic replacement.

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

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

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 Requirements, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Observe one gastrostomy exchange with qualified provider. c. Observe one gastrojejunostomy exchange with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 3 gastrostomy exchanges and 3 gastrojejunostomy exchanges with qualified provider without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.

Reappointment Competency:

a. Successful exchange of one gastrostomy tube and one gastrojejunostomy tube annually.
b. Direct observation of one gastrojejunostomy tube exchange every 2 years will be performed with qualified provider.
c. 2 chart reviews will be performed every 2 years, of one gastrostomy and one gastrojejunostomy.
d. The Chief of the Interventional Radiology Department or qualified provider designee will be the evaluator.

Protocol #16: Pleural Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of a percutaneous pleural catheter. For the purposes of this protocol a pleural catheter or chest tube refers to a catheter placed using thoracentesis followed by dilation and catheter exchange over a wire method for obtaining access to the intra-pleural space for drainage of pleural fluid, in which the catheter may or may not have a locking cope loop.

1. Location to be performed: Radiology Department, inpatient units, PACU and emergency department.

2. Performance of procedure:
   a. Indications: pleural effusions and pneumothorax.
   b. Precautions requiring attending physician consultation, pulmonary bullae. Pleural adhesions and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines, which are posted in the Radiology Department.
   c. Contraindications: need for emergent thoracotomy, skin infection over insertion site.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Qualification to perform thoracentesis. c. Observe two pleural catheter placements with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 10 pleural catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.

Reappointment Competency: a. Successful placement of 3 pleural catheters every 2 years. b. Direct observation of two pleural catheter placement procedures will be performed every 2 years. c. 3 chart reviews will be performed every 2 years. d. The Chief of the Interventional Radiology Department or qualified provider designee will be the proctor/evaluator.

Procedure: Protocol #17: Tunneled Pleural Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of a tunneled percutaneous pleural catheter. For the purposes of this protocol a tunneled pleural catheter and tunneled chest tube are used interchangeably and refer to a pleural catheter placed using thoracentesis followed by dilation and subcutaneous tunneling to an adjacent exit site for drainage of pleural fluid.

1. Location to be performed: Radiology Department, inpatient units, PACU and emergency department.

2. Performance of procedure:
   a. Indications: chronic pleural effusions.
   b. Precautions requiring attending physician consultation, pulmonary bullae. Pleural adhesions and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines, which are posted in the Radiology Department.
   c. Contraindications: active infection, parapneumonic effusions, skin infection over insertion site.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Qualification to perform thoracentesis. c. Observe two pleural catheter placements with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 10 tunneled pleural catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency: a. Successful placement of 3 tunneled pleural catheters every 2

years.
b. Direct observation of two pleural catheter placement procedures will be performed every 2 years.
c. 3 chart reviews will be performed every 2 years.
d. The Chief of the Interventional Radiology Department or qualified provider designee will be the proctor/evaluator.

Protocol #18: Thoracentesis

A. DEFINITION: Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid.

1. Location to be performed: Radiology Department, inpatient units, and emergency department.

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

Contraindications
   a. Infection in the tissues near the puncture site.
   b. Acute respiratory compromise
   c. Abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
   d. Significant pulmonary parenchymal disease

B. DATA BASE

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

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

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

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 initiation of proctoring and provision of direct patient care a. Onsite training by a qualified provider.
Proctoring Period a. Under direct observation of a qualified provider, trainee will perform 5 thoracentesis procedures without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Experienced provider to procedure, a minimum of 3 successful observed demonstrations c. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider
Reappointment Competency

a. The evaluator will be the Chief of Interventional Radiology or designated qualified provider.
b. Ongoing competency evaluation.
    1. Perform a minimum of 3 procedures every 2 years.
    2. Two chart reviews every 2 years.

Protocol #19: Procedural Sedation/Moderate Sedation (ACLS required)

A. DEFINITION

Procedural Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation ZSFG policy number 19.8 titled, “Procedural Sedation: Moderate and Deep”) by the Nurse Practitioner/Physician Assistant during procedures in adults within a monitored setting.

For the purpose of this protocol, the setting is specifically in the Radiology Department. The Nurse Practitioner/Physician Assistant practices under the supervision of the Chief of Interventional Radiology or designee. Practitioners inducing a level of moderate sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes, and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedure may only be done in the designated areas for procedural sedation within the Radiology Department, which are equipped and staffed, according to departmental and hospital policy.

Materials necessary for procedural sedation and rescue include:

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

Indications:

a. Procedural sedation may be indicated for procedures in which a need for moderate sedation is anticipated to manage procedural discomfort, including but not limited to chest tubes, and tunneled central venous catheters.

Precautions/Contraindications requiring attending physician consultation:

a. Inability to obtain informed patient consent.
b. Anticipated difficult intubation.

c. The patient's American Society of Anesthesiologists (ASA) physical status; consultation with Anesthesia Service should be considered for patients who have an ASA class of 3 or above. A procedure requiring sedation would not be done on a patient with an ASA class above a three (3) without anesthesia assistance.
d. When the patient's cardiovascular status will not permit positioning in a recumbent position.

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

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

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

D. PLAN
1. Therapeutic Treatment Plan shall follow SFGH policy number 19.8 titled "Procedural Sedation: Moderate and Deep"
a. Informed consent for the procedure and sedation must be obtained and documented by the nurse practitioner/physician assistant prior to the

delivery of sedation. The consent form must list the procedure to be performed as well as the sedation planned.

b. Pre-Procedure patient education shall be given and documented, to include, but not be limited to:
    1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
    2. Risks, benefits, and alternatives.
    3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
    4. Date/time of procedure.
    5. Necessity of an escort for discharge to home and/or an appropriate mode of transportation home.
c. Re-assessment immediately prior to the procedure to include:
    1. Indication for procedure.
    2. Two patient identifiers.
    3. A “time out” documented.
    4. Vital signs (blood pressure, cardiac rhythm, heart rate, oxygen saturation, and end-tidal carbon dioxide).
    5. An assessment of level of movement and consciousness, and responsiveness.
d. The Procedure:
    1. Verify pre-procedure assessment and monitoring guidelines.
    2. Administer appropriate medications as indicated.
    3. Continuously assess the patient’s response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, ETCO2, rhythm, and pain level). Vital signs will be documented no less frequently than every 5 minutes beginning with the first administration of sedation.
    4 Cardiac monitoring if patient has any cardiac history.
    5. Reversal agents, if indicated.
e. Post-procedure
    1. Monitor level of consciousness, respiratory and cardiovascular parameters, and pain level.
f. Termination of Treatment
    1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.

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

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

4. Follow-up
   A. If the patient is transferred to the recovering unit:
      1. The patient must be accompanied by trained and/or licensed personnel.
      2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:

         a. Pertinent medical history.
         b. The procedure performed.
         c. The condition of the patient; including pain score.
         d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
         e. Any significant clinical events occurring during and post-procedure.
         f. Any additional orders relating to the post-procedural/moderate sedation care.

   B. Any patient receiving a reversal agent (naloxone or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re- sedation. In addition an Unusual Occurrence Report must be completed. See Hospital Policy 19.08 for other criteria requiring the submission of an unusual occurrence report.

   C. The outpatient is discharged “to home”:
      1. By a specific discharge order from a physician or nurse practitioner/physician assistant; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.
      2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
      3. Outpatients who are discharged to home must be accompanied by a responsible adult and have an appropriate mode of transportation.

E. RECORD KEEPING
   Patient visit, consent forms, and other procedure specific documents will be recorded in the Medical record as appropriate. The patient status and

compliance with discharge criteria must be documented in the patient's medical record by the physician, nurse practitioner, physician assistant, or registered nurse discharging the patient. Document all findings in the computerized procedure database, usually the PACS system.

F. Summary of prerequisites, proctoring & reappointment of competency

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

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

B. Training Program
1. Read and sign ZSFG Hospital Policy 19.08 "Procedural Sedation – Moderate and Deep"
2. Completion of the ZSFG Procedural Sedation module and Test with a passing score of 90%.
3. Completion of Advanced Cardiac Life Support (ACLS) training.
4. Completion of the Registered Nursing Moderate Sedation Education Module.
5. Furnishing License and/or DEA number.

Proctoring

A. Direct observation by IR attending staff credentialed in moderate sedation for a minimum of 30 procedures with moderate sedation, while an experienced practitioner to moderate sedation requires a minimum of 10 successful observed demonstrations.

B. Review of 30 procedure notes by interventional radiology attendings.

Reappointment Competency:

A. Ongoing competency will include the successful completion of 15 procedures every 2 years.

B. Direct observation of one observed moderate sedation case will be conducted by the Medical Director or other designated attending physicians every 2 years.

C. Maintenance of ACLS and BLS Certification.

D. Passing of Procedural Sedation test with a passing score of 90%

Protocol #20: Lower Extremity Venous Sclerotherapy

A. DEFINITION

For purposes of this protocol sclerotherapy refers to lower extremity venous sclerotherapy. Sclerotherapy is a medical procedure to eliminate varicose veins and spider veins. Sclerotherapy involves an injection of solution directly into the vein. The sclerosing agent irritates the lining of the blood vessel, causing to collapse and the blood to clot.

1) Location to be performed: Interventional Radiology- Building 5 and Building 25

2) Performance of procedure:
   i. Indications Symptomatic superficial venous insufficiency with symptoms including edema, pain, restless legs, and/or ulceration.
   ii. Precautions the following list of conditions necessitate attending physician consultation:
      a. Current phlebitis
      b. History of, or current DVT.
   iii. Contraindications
      a. Pregnancy
      b. Any allergy to the sclerosing agent

B. DATA BASE

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

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 is obtained before the procedure is performed and filed according to hospital policy.
b. Time out is performed before the procedure per hospital policy.
c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
d. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

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 Specialty training will by provided by Interventional Radiology attendings as part of the orientation process. a. Observe 1 Sclerotherapy procedure with MD. b. US-guided PICC line or IV placement, with documentation of training completed by either Radiology/IR SP protocol, or ZSFG RN training in US-guided IV or PICC placement. c. Observation of 5 patient pre-evaluations in the Vein Clinic or Vascular Surgery Clinic.
Proctoring Period: a. New practitioner to procedure, a minimum of 10 successful observed demonstrations. b. Experienced practitioner to procedure, a minimum of 4 successful observed demonstrations. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency Documentation: a. Demonstration of 4 procedures every 2 years. b. Minimum 4 chart reviews every 2 years. c. Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.
Any additional comments:

Protocol #21: Hip Aspiration and Injection

A. DEFINITION

Hip aspiration and injection is a medical procedure which involves placing a needle percutaneously into hip joint, followed by aspiration and/or injection of liquid agents.

1) Location to be performed: Interventional Radiology- Building 5 and Building 25

2) Performance of procedure:
   i. Indications: Analysis of hip fluid in evaluation of infectious and non-infectious arthritis. Treatment of hip pain or inflammation.
   ii. Precautions the following list of conditions necessitate attending physician consultation:
      a. Patients with abnormal blood clotting reflected by anticoagulant usage or laboratory values outside of interventional radiology standard consensus guidelines.
   iii. Contraindications
      a. Pregnancy
      b. Any allergy to procedural medications.
      c. Injections are contraindicated for severe dermatitis, soft tissue swelling suspicious for infection.

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

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 is obtained before the procedure and filed according to hospital policy.
   b. Time out is performed before procedure per hospital policy.
   c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician.
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.
   g. Severe dermatitis, soft tissue swelling suspicious for infection (see also contraindications).

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 paper or 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. Specialty training will by provided by Interventional Radiology attendings as part of the orientation process. b. Observe 1 hip aspiration and/or injection procedure with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experienced practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee. Chart review of all observed cases.
Reappointment Competency Documentation: a. Demonstration of 2 procedures every 2 years. b. Minimum 2 chart review needed to monitor ongoing competency every 2 years. c. Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.
Any additional comments:

Procedure: Protocol #22: Shoulder Aspiration and/or Injection

A. DEFINITION

Shoulder aspiration and injection is a medical procedure which involves placing a needle percutaneously into shoulder joint, followed by aspiration and/or injection of liquid agents.

1) Location to be performed: Interventional Radiology- Building 5 and Building 25

2) Performance of procedure:
   i. Indications: Analysis of shoulder fluid in evaluation of infectious and non-infectious arthritis. Treatment of shoulder pain or inflammation.
   ii. Precautions the following list of conditions necessitate attending physician consultation:
      a. Patients with abnormal blood clotting reflected by anticoagulant usage or laboratory values outside of interventional radiology standard consensus guidelines.
   iii. Contraindications
      a. Pregnancy
      b. Any allergy to procedural medications.
      c. Injections are contraindicated for severe dermatitis or soft tissue swelling suspicious for infection.

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

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 is obtained before the procedure and filed according to hospital policy.
   b. Time out is performed before the procedure per hospital policy.
   c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.
   g. Severe dermatitis, soft tissue swelling suspicious for infection (see also contraindications).

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 paper or 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. Specialty training will by provided by Interventional Radiology attendings as part of the orientation process if NP/PA does not have previous experience, defined as active privileges for this procedure at another institution within the past six months. b. Observe 1 shoulder aspiration and/or injection procedure with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experienced practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee. d. Chart review of all observed cases
Reappointment Competency Documentation: a. Demonstration of 2 procedures every 2 years. b. Minimum 2 chart reviews every 2 years. c. Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.
Any additional comments:

Protocol #23: Nephrostomy Catheter Exchange

A. DEFINITION
This protocol/procedure covers the exchange or removal of percutaneous nephrostomy and nephroureterostomy catheters. For the purposes of this procedure a nephrostomy tube would be defined as catheter inserted percutaneously into the renal pelvis, and with catheter end located in the renal pelvis, or bladder. A nephroureterostomy catheter would be defined as a special subtype of nephrostomy catheter, that is inserted percutaneously into the renal pelvis, and with catheter end located in the bladder.

1. Location to be performed: Nephrostomy catheter exchange will take place in Radiology Department and Interventional Radiology procedural rooms at San Francisco General Hospital.

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: IR Attending will be consulted prior to any planned nephrostomy catheter exchange.
   c. Contraindications requiring attending physician consultation: immature nephrostomy tracts and nephrostomy tubes which have been in place less than 6 weeks.

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

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

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

D. PLAN
1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
b. Time out performed per hospital policy.
c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug -
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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.

G. Summary of Prerequisites, Proctoring and Reappointment

Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
a. Completion of training on site. b. Completion of training on gastrostomy and gastrojejeunostomy exchange as outlined in separate hospital approved standardized procedure. c. Completion of training on Interventional Radiology Procedural Assistant d. Observe two nephrostomy exchange with qualified provider. e. Observe two nephroureterostomy exchange with qualified provider.

Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 4 nephrostomy exchanges and 4 nephroureterostomy exchanges with qualified provider without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by qualifying experienced MD/NP/PA and signed off by the Chief of the Interventional Radiology Department or qualified provider designee.
Reappointment Competency: a. Successful exchange of one nephrostomy tube and one nephroureterostomy tube annually. b. Direct observation of one nephroureterostomy tube exchange every 2 years will be performed with qualified provider. c. 2 chart reviews will be performed every 2 years of one nephrostomy and one nephroureterostomy. d. The Chief of the Interventional Radiology Department or qualified provider designee will be the evaluator.

Protocol #24: Cholecystostomy Catheter Exchange

A. DEFINITION
This protocol/procedure covers the exchange or removal of percutaneous cholecystostomy catheters/tubes. For the purposes of this procedure a cholecystostomy tube would be defined as catheter inserted percutaneously into the gallbladder, and with catheter end located in the gallbladder.

1. Location to be performed: cholecystostomy catheter exchange will take place in Radiology Department and Interventional Radiology procedural rooms at San Francisco General Hospital.

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: IR Attending will be consulted prior to any planned cholecystostomy catheter exchange.
   c. Contraindications requiring attending physician consultation: immature cholecystostomy tracts, cholecystostomy tubes which have been in place less than 6 weeks.

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

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

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

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

d. Initiation or adjustment of medication per Furnishing/Drug -
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Completion of training on gastrostomy and gastrojejeunostomy exchange as outlined in separate hospital approved standardized procedure. c. Completion of training on Interventional Radiology Procedural Assistant d. Observe two cholecystostomy drain exchange with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 5 cholecystostomy catheter exchanges with qualified provider without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified

(MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency: a. Successful exchange of two cholecystostomy tubes annually. b. Direct observation of one cholecystostomy tube exchange every 2 years will be performed with qualified provider. c. 2 chart reviews will be performed every 2 years. d. The Chief of the Interventional Radiology Department or qualified provider designee will be the evaluator.

Protocol #25: Abscess Drainage Catheter Exchange

A. DEFINITION
This protocol/procedure covers the exchange or removal of percutaneous abscess catheters/tubes. For the purposes of this procedure an abscess drain would be defined as catheter inserted percutaneously with end draining intracorporal free fluid or contained collections. Fluid drained by these catheters may be infected or sterile and may contain fluid leaked or secreted from other organ systems.

1. Location to be performed: Abscess drain exchange will take place in Radiology Department, and Interventional Radiology procedure rooms at San Francisco General Hospital.

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, optimization of drainage therapy, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: Unexplained physical or laboratory findings

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

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

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug -

e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   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 initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Completion of training on gastrostomy and gastrojejeunostomy exchange as outlined in separate hospital approved standardized procedures. c. Completion of training on Interventional Radiology Procedural Assistant d. Observe two abscess drain exchange with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 5 abscess drain exchanges with qualified provider without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified provider MD/NP/PAand signed by the Chief of the Department of Interventional Radiology or qualified provider designee.

Reappointment Competency:

a. Successful exchange of two abscess drain exchanges annually.
b. Direct observation of one abscess drain exchange every 2 years will be performed with qualified provider.
c. 2 chart reviews will be performed every 2 years, of one nephrostomy and one nephroureterostomy.
d. The Chief of the Interventional Radiology Department or qualified provider designee will be the evaluator.

Protocol #26

A. DEFINITION

Using CT guidance to inject steroid medication near where the nerve root exits the spinal column, the intrathecal sac, or into the facets.

1) Location to be performed: *Outpatient and In Patient*

2) Performance of procedure:
   i. Indications Back pain with corresponding imaging findings of transforaminal stenosis, facet arthropathy, or canal stenosis.
   ii. Precautions Hypertension < 160/100, hyperglycemia
   iii. Contraindications Active infection, Hypertension > 160/100, lack of correspondent imaging findings for target. Anticoagulants contraindicated for intra-laminar (epidural) injections.

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. Biopsy tissue is sent to pathology.*(ONLY IF TISSUE IS SENT)*
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and direct patient care: A. Completion of training on site B. Observe 10 procedures by qualified provider C. Completion of a Pain Management Training and Injection Certification through a credentialed program a. Example: Empire Medical Pain Management Training Certification Program, eligible for board certification through the American Academy of Procedural Medicine (AAOPM) D. Prior credentialing for Lumbar Puncture
Proctoring Period: A. Perform 10 procedures with direct supervision B. Chart review and review of referrals for 10 cases c. Any qualified provider (MD, NP, PA) can proctor
Reappointment Competency Documentation: a. Minimum number of procedures that must be completed in two years or state number of procedures annually: 5 b. Minimum number of chart reviews needed in a two years or state number of chart reviews annually: 10 c. No direct observation of procedure is needed for reappointment
Any additional comments: These are comparable to the standard training protocol for the nurse practitioners performing this procedure at the Connecticut Back Center, which is credentialed by the North American Spine Society.

Protocol #27: Fluoroscopy Operation

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A. DEFINITION: Operation of fluoroscopy by the Physician Assistant (PA) for interventional radiology (IR) procedures, in accordance with California law (California Code of Regulations, Title 17, Section 30450 et seq.) and institutional policy.

1. Location to be performed: Radiology Department, Operating Room and Interventional Radiology Suites.

2. Performance of procedure
Indications
a. Operating fluoroscopy for IR procedures within the scope of the PA's privileges.

3. Contraindications
a. Pregnancy
b. Exceeding table weight limit

B. DATA BASE

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

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

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

D. PLAN

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

d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- Confirm patient identity and consent.
- Verify fluoroscopy settings and minimize radiation exposure in accordance with ALARA principles.
- Use appropriate personal protective equipment (lead apron, thyroid shield, etc.).
During Procedure:
- Operate the fluoroscope to obtain necessary images for the intended procedure.
- Limit fluoroscopy time to the minimum required.
- Record total fluoroscopy time and dose in the EMR.
Post-procedure:
- Document findings and technical details in the procedure note.
- Report any radiation incidents to the Radiation Safety Officer (RSO) and supervising physician immediately.

2. Patient conditions requiring Attending Consultation
a. Acute decompensation of patient situation.
b. Unexplained physical or laboratory findings
c. Upon request of patient, PA, or physician
d. Initiation or adjustment of medication other than those in the formularies.
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 initiation of proctoring and provision of direct patient care
a. Didactic & Practical Training: Completion of a California Department

of Public Health–Radiologic Health Branch (CDPH-RHB) approved PA fluoroscopy course, including radiation safety, equipment operation, image optimization, and regulatory compliance. b. Examination: Successful completion of the Fluoroscopy Permit examination administered by CDPH-RHB. c. Permit: Maintenance of a valid California Fluoroscopy Permit. d. Institutional Orientation: Completion of UCSF/ZSFG Radiation Safety training and annual refreshers.
Proctoring Period a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform a minimum of 5 supervised fluoroscopy cases without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Experienced provider to procedure, a minimum of 5 successful observed demonstrations c. Proctoring may be performed by experienced qualified (MD) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency a. The evaluator will be the Chief of Interventional Radiology or designated qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. b. Ongoing competency evaluation. 1. Perform a minimum of 3 procedures every 2 years. 2. Two chart reviews every 2 years.

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