San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Dermatology Clinic

I. Policy Statement

A. It is the policy of San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse –Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Dermatology Clinic Building 90 Room 224 and on file in the Medical Staff Office.

II. Functions To Be Performed

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

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.
Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every six years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of San Francisco General Hospital and Trauma Center, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Delegation of Services Agreement (documents supervising agreement between supervising physician and PA).

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

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is the outpatient Dermatology clinic.

B. Supervision
   1. Overall Accountability:
      The NP/PA is responsible and accountable to: the Medical Director, Chief of Service, and supervising physician.
   2. A consulting physician, who may include: attending's, chief residents, and fellows will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
      a. Acute decompensation of patient situation
      b. Problem that is not resolved after reasonable trial of therapies.
      c. Unexplained historical, physical, or laboratory findings.
      d. Upon request of patient, affiliated staff, or physician.
      e. Initiation or change of medication other than those in the formulary (ies).
f. Problem requiring hospital admission or potential hospital admission.

IV. Scope of Practice

1. Health Care Management: Acute/Urgent Care
2. Furnishing Medications and Drug Orders
3. Procedure: Surface Trauma and Wound Care
4. Procedure: Skin Biopsy (Shave, Punch and Excisional)

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.
   4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
   5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
   6. Copies of licensure and certificates must be on file in the Medical Staff Office.
   7. Furnishing Number and DEA Number if applicable.
   8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each practice site for each PA.

B. Specialty Training
   1. Specialty requirements ANP or FNP.
   2. Evidence of dermatology training in course study or clinical experience.

   1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician, as applicable will assess the NP/PA’s ability to practice.
      a. Clinical Practice
         - Length of proctoring period will be 6 months, 50
observed patients and 25 chart reviews and 25 reviews of biopsies
- The evaluator will be the Medical Director, Chief of Service, and designated physicians on the faculty of UCSF Department of Dermatology.

2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician 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, and/or designated physician must evaluate the NP/PA’s competence by a review of 10 charts, feedback from colleagues, physicians and 25 direct observations.

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

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

D. Revisions
   1. All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.
Protocol #1: Health Care Management – Acute/Urgent Care

A. DEFINITION
This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable or complex conditions in the outpatient Dermatology clinic.

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, psychological and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
   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 SFGH POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Diagnostic tests for purpose of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   c. Referral to specialty clinics and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, PA, or physician
e. Initiation or change of medication other than those in the formulary/ies.

f. Problem requiring hospital admission or potential hospital admission.

3. Education
   a. Patient education should include treatment modalities.
   b. Discharge information and instructions.

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

E. RECORD KEEPING
   All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.
Protocol #2: Furnishing Medications/Drug Orders

A. DEFINITION

“Furnishing” of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A “drug order” is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II - V with possession of an appropriate DEA license. All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistants Delegation of Service document. Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies to be used are the San Francisco General Hospital and Trauma Center, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program). This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

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

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Describe physical findings that support use for CSII-III medications.
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
C. DIAGNOSIS
Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.

D. PLAN
1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   c. To facilitate patient receiving medications from a pharmacist provide the following:
      i. name of medication
      ii. strength
      iii. directions for use
      iv. name of patient
      v. name of prescriber and title
      vi. date of issue
      vii. quantity to be dispensed
      viii. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation:
   a. Problem which is not resolved after reasonable trial of therapies.
   b. Initiation or change of medication other than those in the formulary.
   c. Unexplained historical, physical or laboratory findings.
   d. Upon request of patient, NP, PA, or physician.
   e. Failure to improve pain and symptom management.

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

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

E. RECORD KEEPING
All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record\LCR\MAR as appropriate. The medical record of any patient cared for by a PA for whom the supervising physician and surgeon’s schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.
PROTOCOL # 3: Procedure: Surface Trauma and Wound Care

A. DEFINITION
This protocol covers the initial assessment of wounds seen in the Outpatient Dermatology Clinic by the NP/PA.

1. Location to be performed: Dermatology Clinic.

2. Performance of procedure/minor surgery:
   a. Indications
      • This protocol covers patients presenting to the Dermatology Clinic for assessment and treatment of lacerations, abrasions, avulsions, bites and stings, burns and abscesses
   b. Precautions The following require consultation with the attending physician
      • Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
      • Uncooperative patients with high risk wound repairs to the patient and the provider
   c. Contraindications
      • Vascular compromise or cases where direct pressure does not stop bleeding
      • Wounds requiring large area of debridement or excision prior to closure
      • Wounds with bone fragments involved
      • Wounds with tendon, ligament, vessel or nerve involvement
      • Head lacerations where galea disruption is greater than 2 cm.
      • Facial lacerations with cosmetic consideration (i.e. Eyelids and vermillion borders)
      • Lacerations penetrating into joints
      • Patients requiring conscious sedation
      • Children under age of 10
      • Wounds requiring repair of cartilage

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, tetanus prophylaxis history, current medications, allergies, vocation/avocation.

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. Appropriate motor, sensory and vascular exam of the
involved area according to the departmental resources (i.e.
specialty guidelines).
d. Laboratory and imaging evaluation, as indicated, relevant
to history and exam.

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, specialty clinics, and supportive
   services, as needed.

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

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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<thead>
<tr>
<th>Prerequisites:</th>
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<tbody>
<tr>
<td>1. Practitioner will attend a wound care/suturing course or at a lab at an outside facility or through on-site SFGH training.</td>
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<th>Proctoring:</th>
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<td>a. Proctoring Period will be 6 months.</td>
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<td>b. Practitioner must have a minimum of 50 successful observed demonstrations.</td>
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<td>c. Will require a minimum of 25 chart reviews.</td>
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<td>d. Explanation will be needed for any exceptions to minimum requirements.</td>
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<th>Reappointment Competency Documentation:</th>
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<td>a. Competency evaluation.</td>
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<td>1. Will require 25 direct observations to monitor for competency every 2 years.</td>
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<td>3. Ten chart reviews needed to monitor competency every 2 years.</td>
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Protocol # 4: Procedure: Skin Biopsy (Shave, Punch and Excisional)

A. DEFINITION
Removal of a small portion of abnormal skin to be treated in a laboratory. There are three types of skin biopsy:
1. Shave biopsy: the outer part of the suspect area is removed.
2. Punch biopsy: a small cylinder of skin is removed using a punch tool.
3. Excision biopsy: the entire area of abnormal growth is removed.

1. Location to be performed: is in the outpatient Dermatology Clinic.

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

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

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

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

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

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

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

4. Follow-up
   As appropriate for procedure performed.

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

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<tr>
<th>Prerequisites:</th>
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<tr>
<td>a. Practitioner will attend a training class or have on-site training at SFGH.</td>
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<th>Proctoring:</th>
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<tr>
<td>a. Proctoring Period will be 6 months in length.</td>
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<td>b. Practitioner must have a minimum of 50 successful observed demonstrations including all 3 types of biopsies.</td>
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<td>c. Will require a minimum of 25 chart reviews.</td>
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<td>d. Will require a minimum of 25 biopsy reviews.</td>
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<td>e. Explanation needed for any exceptions to minimum requirements.</td>
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<th>Reappointment Competency:</th>
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<tr>
<td>a. Evaluator will be the Medical Director or other qualified physician.</td>
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<td>b. Competency evaluation.</td>
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<td>1. 25 direct observations needed to monitor competency every 2 years.</td>
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<td>2. 10 chart reviews needed to monitor competency every 2 years.</td>
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