PREAMBLE

Title: Nurse Practitioner/Physician Assistant in the Emergency Department and Clinical Decision Unit

I. Policy Statement

A. It is the policy of the Community Health Network and 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, Certified Nurse Midwives, 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 Emergency Department of San Francisco General Hospital and Trauma Center 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 setting or emergent care in an inpatient 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 PA’s in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every six years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PA’s 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/issues drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Emergency Department
   2. The functions of the NP/PA in the ED & CDU are to provide management for acute self-limiting injury/illness or acute stages of chronic diseases and prescription refills.

B. Supervision
   1. The NP/PA is responsible and accountable to:
      Chief of Emergency Services
   2. A consulting physician to be available to the NP/PA, by phone, in person, or by other electronic means, this may include but not limited to the attendings, chief residents and fellows.
   3. Attending 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. Problem requiring hospital admission or potential hospital admission.
      f. Acute, severe respiratory distress.
      g. An adverse response to respiratory treatment, or a lack of therapeutic response.
      h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions.
      i. At time of discharge for a CDU patient.

IV. Scope of Practice - Protocols

1. Health Care Management - Primary Care/Specialty Care
2. Health Care Management - Urgent/Acute Care
3. Health Care Management - Emergent Care
4. Furnishing Medications/Drug Orders
5. Procedures and Minor Surgery #1: Surface Trauma and Wound Care
6. Procedures and Minor Surgery #2: Musculo-skeletal Strains or Sprains
7. Procedures and Minor Surgery #3: Slit Lamp Exam
8. Procedures and Minor Surgery #4: Arthrocentesis
9. Procedures and Minor Surgery #5: Lumbar Puncture
10. Procedures and Minor Surgery #6: Paracentesis
11. Procedures and Minor Surgery #7: Ordering Transfusions
12. Procedure #8: Waived testing
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 Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
4. Possession of a furnishing and dispensing license and DEA Number within 6 months at time of hire.
5. Maintenance of certification of Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS).
6. Possession of a Medicare/Medical National Billable Provider Identifier or must have submitted an application.
7. Copies of licensure and certificates must be on file at the Medical Staff Office.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA).

B. Specialty Training
1. Master's Degree in Nursing and NP specialization in Acute Care/Trauma, Adult Medicine or Family Medicine
2. Two (2) years experience as a registered nurse/physician assistant in an adult medical clinic or an inpatient acute Med/Surg, Critical Care, or Emergency Department setting within the last three (3) years.

1. Initial: At the conclusion of the standardized procedure training, the Medical Director physician designee will assess the NP/PA's ability to practice.

Clinical Practice
- Length of proctoring period will be 3 months, during which time all 20 cases will be proctored by or presented to an ED Attending physician. An initial written evaluation of NP/PA performance will be conducted at the conclusion of this period.
- The evaluations will be conducted by nursing and physician clinical supervisors and approved by the Chief of Emergency Services.
- Additional, procedurally specific requirements are listed in individual protocols. The method of evaluation in clinical practice will be direct observation and medical record review of twenty or more patient interactions.

- b. Competency in performance of wound care/suturing, musculo-skeletal care, slit lamp use, arthrocentesis, lumbar puncture, paracentesis, and ordering blood transfusions:
  - Initial evaluation for competency of wound care/suturing, musculo-skeletal care, slit lamp use, arthrocentesis, lumbar puncture, paracentesis, and ordering blood transfusions in the ED will be made by the Chief of Emergency Services and ED Attending physicians during the proctoring period, with direct observation of 3 cases. All paracentesis shall be done with the attending physician or qualified EM resident present for ultrasound guidance. The NP/PA will complete a signed skills checklist upon completion of the proctoring period.
  - The proctoring period may be extended or shortened depending on the skill level of the NP/PA and the quality/number of experience(s) obtained during the proctoring period.

2. Annual: Medical Director or physician designee will evaluate the NP/PA’s competence through an annual performance appraisal and appropriate competency validation for the setting which will include...
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 at appropriate intervals until acceptable skill level is achieved.

4. Ongoing Professional Performance Evaluation (OPPE)

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

5. Biennial Reappointment: Medical Director, designated physician, or designated same discipline peer must evaluate the NP/PA’s clinical competence with chart audit or direct observation.

   a. Health care Management: 5 chart reviews and/or direct observations every 2 years
   b. Furnishing Medications and Drug Orders: 5 chart reviews and/or direct observations every 2 years
   c. Additional, procedurally specific requirements as listed in individual protocols
   d. Lumbar Puncture: Performance of 5 procedures and 2 chart reviews every 2 years
   e. Musculo-skeletal Strains and Sprains: Performance of 5 procedures every 2 years
   f. Abdominal Paracentesis: Performance of 4 procedures and 4 chart reviews every 2 years
   g. Slit Lamp: Performance of 5 procedures every 2 years
   h. Surface Trauma and Wound Care: Performance of 5 procedures every 2 years
   i. Ordering Blood Transfusions: Completion of Transfusion Education Module with a passing score of at least 80%. Review of any Transfusion Committee Reports. Performance of 2 transfusions and 2 chart reviews every 2 years.
   j. Waived Testing: Successful completion of Halogen/PPMP quizzes for each waived test and achievement of a score of 80% or more.

6. 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

   a. Examination of the patient by Supervising Physician the same day as care is given by the PA.
   b. Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter.
   c. 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 physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases by which diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

   b. Minor procedures

Comment [GS2]: For the purposes of an SP, chart review criteria are not specified for the annual review.

Comment [GS3]: Requirements for reappointment of specific procedures do not need to be specified here as they are described elsewhere in the SP.
VI. Development and Approval of Standardized Procedure

A. Method of Development
   1. Standardized procedures are developed collaboratively by the Nurse Practitioners/Physician Assistants, 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 affiliated staff 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 – Primary Care/Specialty Care

A. DEFINITION
This protocol covers the procedure for age-appropriate health care management in primary care in the Emergency Department and Clinical Decision Unit. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses.

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

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

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

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical, or laboratory findings.
   d. Upon request of patient, affiliated staff, or physician.
   e. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress.
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.
   h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions.
      i. At time of discharge for a CDU patient.
         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 appropriate to diagnosis including treatment modalities and lifestyle counseling.
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.

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

E. RECORD KEEPING
   All information from patient visits will be recorded in the ED medical record. For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases by which diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.
PROTOCOL #2: Health Care Management – Urgent/Acute 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 ED/CDU.

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

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

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, PA, or physician
   e. Problem requiring hospital admission or potential hospital admission Upon request of patient, NP, PA, or physician
   f. Acute, severe respiratory distress, initiation or change of medication other than those in the formularies.
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.
   h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
   i. At time of discharge for a CDU patient Problem requiring hospital admission or potential hospital admission.

3. Education
   Patient education including treatment modalities. Discharge information and instructions.

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

E. RECORD KEEPING
All information from patient visits will be recorded in the Emergency Department medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty(30) days. The
physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.
PROTOCOL #3: Health Care Management – Emergent Care

A. DEFINITION
This protocol covers the procedure for health care management of emergency situations in the ED/CDU, which are acute and life threatening.

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Signs of illness or injury from family, friends or observers.
   c. 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 evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of disease (e.g. stable, unstable, critical, life-threatening).

D. PLAN
1. Therapeutic Treatment Plan
   a. Initial treatment and stabilization of patient that may include all modalities of BLS and ACLS for which the NP/PA holds current certification.
   b. Concomitant notification of physician and immediate management by a physician.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician or specialty areas (e.g. operating room, intensive care, labor and delivery) and supportive services, as appropriate.

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. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress.
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.
   h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
   i. At time of discharge for a CDU patient.

   a. Acute decompensation of patient situation.
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Uncommon, unfamiliar, unstable, and complex patient conditions.
   e. Upon request of patient, NP, PA, or physician
   f. Initiation or change of medication other than those in the formularies.
g. Problems requiring hospital admission or potential hospital admission.

3. Education
   Patient and/or family education as appropriate.

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

E. RECORD KEEPING
   All information from patient encounter will be recorded in the ED medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases by which diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.
PROTOCOL.#4 Furnishing Medications/Drug Orders

A. DEFINITION
“Furnishing” of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A “drug order” is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II - V with possession of a DEA number. 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. Nurse practitioners may order Schedule II - V controlled substances when in possession of a DEA number. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. 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 following formularies may be used by the NP/PA's in the Emergency Department: San Francisco General Hospital and Trauma center, Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (policy no. 13.5).

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 of 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 SFGHMC POCT policy and procedure 16.20.

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

D. PLAN
1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
   c. Nurse Practitioners may order Schedule II and III controlled substances for patients with the following patient specific protocols. These protocols may be listed on the patient chart, in the medications section 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.

d. To facilitate patient receiving medications from a pharmacist provide the following:
   i. name of medication
   ii. strength
   iii. directions for use
   iv. name of patient
   v. name of prescriber and title
   vi. date of issue
   vii. quantity to be dispensed
   viii. license no., furnishing no., DEA no., if applicable

2. Patient conditions requiring consultation:
   a. Problem which does not resolve 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.
   f. Acute, severe respiratory distress
   g. An adverse response to respiratory treatment or a lack of therapeutic response.

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

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

E. RECORD KEEPING
All medications furnished by NPs and all drug orders written by PAs will be recorded in the ED medical record/LCR. When a physician assistant writes a drug order for a schedule II medication, the supervising physician must sign and date the medical record containing such a drug order within seven (7) days.
PROTOCOL #5: Procedures and Minor Surgery: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the ED/CDU by the NP/PA.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:
   a. Indications
      • This protocol covers patients presenting to the Emergency Department for assessment and treatment of lacerations, abrasions, avulsions, bites and stings, burns and abscesses
   b. Precautions
      • 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 laceration 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 the age of 10
      • Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
      • Wounds requiring repair of cartilage
   c. Contraindications
      • None

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure/surgery to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, 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.
   e. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.
D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed.
   b. Time out performed per hospital policy.
   c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   d. Diagnostic tests for purposes of disease identification.
   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. 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. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress.
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.
   h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
   i. At time of discharge for a CDU patient.
      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 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 diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
F. Summary of Training Prerequisites, Proctoring and Evaluation of Competency Reappointment

Training Prerequisites
1. New practitioner Practitioner will attend a wound care/suturing course or lab (at outside facility or through SFGH ED).
2. Documentation of Completion of Training: orientation checklist, wound care lab letter, or certificate
   1.3. Documentation of completion of training must be sent to the Medical Staff Office
2. The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times, no fewer than two times for experienced practitioners.

Proctoring
New practitioner to procedure, a A minimum of 2 successful observed demonstrations, observed by an experienced provider (MD, NP, or PA)
Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations
3. Explanation needed for any exceptions to minimum requirements

Evaluation of Competency Reappointment
1. Documentation of Completion of Training: orientation checklist, wound care lab letter, certificate or chart reviews
2. Documentation of completion of training must be sent to the Medical Staff Office
3. Who will be the evaluator: ED Attending physicians
4. Ongoing competency evaluation.
   a. Perform wound care/suturing a minimum of 1 time every 2 years to maintain proficiency
   b. One chart review needed to monitor ongoing competency for annual review every 2 years

Any additional comments:
PROTOCOL #6: Procedures and Minor Surgery: Assessment and Management of Musculoskeletal Sprains or Strains

A. DEFINITION
This protocol covers the initial assessment of patients with musculoskeletal injuries.

1. Location to be performed: Emergency Department/CDU

2. Performance of procedure/minor surgery:
   i. Indications
      This protocol covers patients presenting to the Emergency department for assessment and treatment of strains and sprains.
   ii. Precautions
      None
   iii. Exclusion (or referral to Attending Physician, Emergency Medicine Resident or Surgical Resident, PGY II or above) under the following circumstances:
      a. Vascular compromise
      b. Unstable joint

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting chief complaint including mechanism of injury.
   b. Pertinent past medical history, surgical history, current medications and allergies.

2. Objective Data
   a. Physical exam of the involved and adjacent area including documentation of any swelling, ecchymosis, pain, range of motion, instability, crepitance or effusion and appropriate neuro-vascular exam.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

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

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed.
   b. Time out performed per hospital policy
   a. Ice pack for first 24-48 hours followed by ice or heat
   b. Diagnostic tests for purposes of disease identification.
   c. Rest and elevation of affected part
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Provide necessary written and verbal instructions including sprain care, crutch walking as appropriate
   f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
d. Upon request of patient, NP, PA, or physician

e. Problem requiring hospital admission or potential hospital admission.

f. Acute, severe respiratory distress.

g. An adverse response to respiratory treatment, or a lack of therapeutic response.

h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions

i. At time of discharge for a CDU patient

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 ED 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 Training Prerequisites, Proctoring and Evaluation of Competency Reappointment

### Training Prerequisites

1. The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times, no fewer than 2 times for experienced practitioners.
   - a. On site training by a qualified provider.

### Proctoring Period

- a. New practitioner to Performance of 2 procedures, a minimum of 3 successful observed demonstrations
- b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstration

### Evaluation of Competency Reappointment

- a. Documentation of Completion of Training (e.g., orientation checklist, letter, certificate, guides list or chart reviews)
- b. Documentation of completion of training must be sent to the Medical Staff Office
- c. Who will be the evaluator: ED Attending physicians
- d. Ongoing competency evaluation.
  1. Perform a minimum of 153 procedure exams per every 2 years to maintain proficiency
  2. One or more chart review(s) needed every 2 years to monitor ongoing competency for annual review

Any additional comments:
PROTOCOL #7: Procedures and Minor Surgery: Slit Lamp Exam

A. DEFINITION
This protocol describes the use of the slit lamp for patients presenting with external eye complaints.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:
   a. Indications
      • The slit lamp examination is indicated in any eye complaint requiring illumination or magnification of the external eye area (i.e. lid/lashes, cornea, iris, anterior chamber) for complaints such as eye redness or foreign body sensation.
   b. Precautions and Contraindications
      • None

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

2. Objective Data
   a. Physical exam including visual acuity appropriate to the eye complaint.
   b. The slit lamp exam is performed following standard medical technique according to the departmental resources (per manufacturer's instructions) with or without fluorescein as indicated.
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Screening tests performed as part of age-appropriate health maintenance.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to Ophthalmologist or Primary Care 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. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress.
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.
h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
  i. At time of discharge for a CDU patient

2. Patient conditions requiring Attending/Ophthalmologist Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Complex opthalmologic conditions (i.e. iritis, acute glaucoma, hyphema, ulcers)
   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 and diagnosis.

E. RECORD KEEPING
   Patient visit, consent forms, and other procedure specific documents will be recorded in the ED 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 diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
F. Summary of Training Prerequisites, Proctoring and Evaluation of Competency Reappointment

Prerequisite Training

1. The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) - 5 times, no fewer than 3 times for an experienced practitioner.
   a. Training on site by a qualified provider.

Proctoring Period

a. Performance of 5 New practitioner to procedures, a minimum of 5 successful observed demonstrations
b. Experienced practitioner to procedure, a minimum of 3 successful observed demonstrations
c. Explanation needed for any exceptions to minimum requirements

Evaluation of Competency Reappointment

a. Documentation of Completion of Training (e.g. letter, certificate, orientation check off, guides list or chart reviews)
b. Documentation of completion of training must be sent to the Medical Staff Office
c. Who will be the evaluator: ED Attending physicians

ad. Ongoing competency evaluation.
   1. Perform a minimum of 3-5 exams per every 2 years
   2. One chart review every 2 years needed to monitor ongoing competency for annual review

Any additional comments:
PROTOCOL #8: Procedures and Minor Surgery: Arthrocentesis

A. DEFINITION
This protocol covers arthrocentesis of the knee and elbow.

1. Location to be performed: Emergency Department

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

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, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed.
   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. All patients requiring this procedure.

3. Education
Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the 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 diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
F. Summary of Training Prerequisites, Proctoring and Evaluation of Competency Reappointment

**Prerequisite Training**
- The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times, no fewer than 2 times for an experienced practitioner. Training on site by a qualified provider.

**Proctoring Period**
- Performance of 2 New practitioners to procedures, a minimum of 3 successful observed demonstrations.
- Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations.
- Explanation needed for any exceptions to minimum requirements.

**Training**
- Direct observation of procedure no fewer than 3 times, direct supervision of procedure no fewer than 2 times.

**Evaluation of Competency Reappointment**
- Documentation of Completion of Training: orientation checklist, skills lab, letter, certificate, guide list or chart reviews.
- Documentation of completion of training must be sent to the Medical Staff Office.
- Who will be the evaluator: ED Attending Physicians.
- Ongoing competency evaluation.
  1. Perform a minimum of 32 procedures every 2 years.
  2. One chart review needed to monitor ongoing competency for annual review.

Any additional comments:
PROTOCOL #9: Procedures and Minor Surgery: Lumbar Puncture

A. DEFINITION
This protocol covers lumbar puncture. Training, guidelines and evaluation for satisfactory performance is described in the preamble Section V. subsections C and D.

1. Location to be performed: Emergency Department.

2. Performance of procedure/minor surgery:
   a. Indications
   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 of this may be necessary in the diagnosis of CSF infection, bleeding or embolus (e.g. meningitis, syphilis, subarachnoid hemorrhage, MS).
   
   b. Precautions
   - Indication for brain CT scan prior to LP include the following:
     - Age >60 yrs.
     - Immunocompromised patients
     - Known CNS lesions
     - Recent seizure activity
     - Abnormal level of consciousness
     - Focal findings on neurological exam
   
   c. Contraindications
   - Infection in the tissues near the puncture site.
   - Increased intracranial pressure, if suspected rule out with head CT.
   - Coagulopathy.

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 (head CT), as indicated, relevant to history and exam.
   c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

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

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

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

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the 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 Training Prerequisites, Proctoring and Evaluation of Competency Reappointment

**Training Prerequisites**

The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times, no fewer than 2 times by an experienced practitioner.

a. Training on site by a qualified provider.

**Proctoring Period Proctoring**

a. Performance of 3 New practitioner to procedures, a minimum of 3 successful observed demonstrations.

b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations.

c. Explanation needed for any exceptions to minimum requirements.

**Evaluation of Competency Reappointment**

a. Documentation of Completion of Training: orientation checklist, completion of skills lab, letter, certificate, guides list or chart reviews.

b. Documentation of completion of training must be sent to the Medical Staff Office.

c. Who will be the evaluator: ED Attending Physician.

d. Ongoing competency evaluation.

1. Perform a minimum of 2-35 procedures *every 2 years*, needed to maintain proficiency.

2. *Three One* chart reviews *every 2 years*, needed to monitor ongoing competency for annual review.

Any additional comments:
PROTOCOL #10: Procedures and Minor Surgery: Abdominal Paracentesis

A. DEFINITION
Paracentesis is the insertion of a needle into the peritoneal cavity to aspirate peritoneal fluid for analysis and/or relieve pressure caused by ascites. Ultrasound guidance by an experienced ultrasound physician (ED Attending, resident) is used to guide needle placement.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:
   a. Indications
      For the purposes of this protocol, paracentesis may be used to evaluate the etiology of ascites (infectious, malignant, or cirrhosis)
      • To relieve the symptoms of ascites
   b. Precautions
      • Use caution in coagulopathy
   d. Contraindications
      • Infection in the overlying soft tissues near the puncture site.
      • Intestinal obstruction

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 SFGHMC POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed.
   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. All patients requiring this procedure.

3. Education
   Discharge information and instructions.
4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the 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 diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
F. Summary of Prerequisites, Proctoring and Reappointment

Prerequisites
Training will be conducted by a qualified provider. The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 5 times, no fewer than 2 times for by an experienced practitioner.

All paracentesis procedures will be ultrasound guided by an experienced ultrasound provider (ED Attending or Resident).

a. 

Proctoring
a. Performance of 4 New practitioner to procedures, a minimum of 5 successful observed demonstrations
b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations
c. Explanation needed for any exceptions to minimum requirements

Reappointment
a. Documentation of Completion of Training: orientation checklist, completion of skills lab, letter, certificate, guides list or chart reviews
b. Documentation of completion of training must be sent to the Medical Staff Office
c. Who will be the evaluator: ED Attending Physicians
d. Ongoing competency evaluation.
1. Perform a minimum of 4 procedures every 2 years needed to maintain proficiency
2. Maintain list of procedures completed
23. Four chart reviews every 2 years needed to monitor ongoing competency for annual review

* Any additional comments:

Direct observation of procedure
Proctoring Period
a. New practitioner to procedure, a minimum of 3 successful observed demonstrations
b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations
c. Explanation needed for any exceptions to minimum requirements

Evaluation of Competency
a. Documentation of Completion of Training (e.g., letter, certificate, guides list or chart reviews)
b. Who will be the evaluator: ED attending physicians
c. Ongoing competency evaluation.
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<td>Maintain list of procedures completed</td>
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<td>One chart review needed to monitor ongoing competency for annual review</td>
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*Any additional comments:*
PROTOCOL #12: Procedures and Minor Surgery: Femoral Vein Cannulation

A. DEFINITION

Femoral venous access provides a rapid and reliable route for administration of medications and fluid.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:

   a. Indications
   - Femoral vein cannulation should be performed with ultrasound guidance primarily when peripheral venous access is not possible in a patient who requires urgent administration of IV fluids or medications.

   b. Precautions
   - Markedly obese patient with poorly defined anatomical landmarks
   - An uncooperative patient
   - The presence of an overlying skin infection
   - Coagulopathies
   - Previous radiation therapy

   c. Contraindications
   - Uncorrectable coagulopathy
   - Known or suspected thrombus of the femoral vein on the proposed side of cannulation
   - Abdominal trauma or trauma at the level of the femoral veins

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   - All patients requiring this procedure.
3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
   Patient visit, consent forms, and other procedure specific documents will be
   recorded in the 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 in which diagnosis, problem, treatment or
   procedure represent in his/her judgment the most significant risk to patients.
### Summary of Training Proctoring and Evaluation of Competency

#### Training
- **a. Observation of procedure performed by an experienced provider (MD, NP, or PA)**
  - Direct observation of procedure no fewer than 3 times, direct supervision of procedure no fewer than 2 times.

#### Proctoring Period
- **a. New practitioner to procedure, a minimum of 3 successful observed demonstrations**
- **b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations**
- **c. Explanation needed for any exceptions to minimum requirements**

#### Evaluation of Competency
- **a. Documentation of Completion of Training orientation checklist, completion of skills lab, letter, certificate, guides list or chart reviews**
- **b. Documentation of completion of training must be sent to the Medical Staff Office**
- **c. Who will be the evaluator: ED Attending physicians**
- **d. Ongoing competency evaluation.**
  - **1. State number of procedures needed to maintain proficiency**
  - **2. Maintain list of procedures completed**
  - **3. One chart review needed to monitor ongoing competency for annual review**

### Any additional comments:
PROTOCOL #11: Procedures and Minor Surgery: Ordering Transfusions

A. DEFINITION
Ordering the administration of whole blood or blood components, i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate.

1. Location to be performed: Emergency Department or Clinical Decision Unit

2. Performance of procedure/minor surgery:
   a. Indications
      • Anemia
      • Thrombocytopenia or platelet dysfunction
      • Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means
   
   b. Precautions
      • Blood and blood components must be given according to SFGH guidelines.
      • Emergency exchange transfusion orders are not covered by this standardized protocol - these must be countersigned by the responsible physician.
      • If (relative) contraindications to transfusion exist (see below), the decision whether to transfuse or not must be discussed with the responsible physician
   
   c. Contraindications
      • Absolute: none
      • Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.

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

2. Objective Data
   a) Physical exam relevant to the decision to transfuse
   b) Laboratory evaluation
   c) POCT will be performed according to SFGH POCT P&P 16.20

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

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

2. Patient conditions requiring Attending Consultation
   a) Acute decompensation of patient situation
   b) Unexplained historical, physical or laboratory findings
   c) Uncommon, unfamiliar, unstable, and complex patient conditions
   d) Upon request of patient, NP, PA, or physician
      e) Problem requiring hospital admission or potential hospital admission.
f) Acute, severe respiratory distress.
g) An adverse response to respiratory treatment, or a lack of therapeutic response.
h) Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
i) At time of discharge for a CDU patient.
j) Initiation or adjustment of medication other than those in the formularies

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

4. Follow-up
   As appropriate for the patients condition and reason transfusion were ordered

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

F. Prerequisites, Proctoring and CompetencyReappointment
Location to be performed: Emergency Department and Clinical Decision Unit

1. Prior experience, training or expertisePrerequisites required for this minor procedure
   a. Successful completion of San Francisco General Hospital Transfusion Training course
   b. Successful completion of Transfusion Training course test on blood ordering & informed consent

2. Training program for this protocol includes:
   a. Read and sign assignments:
      1. SFGH Admin P&P 2.3: Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options.
      2. San Francisco General Hospital Transfusion Training Course Education module.
      3. SFGH Transfusion Guidelines

3. ProctoringPeriod:
   a. Until documentation of 5 countersigned transfusion orders

4. Competency in performance of this standardized procedure:
   a. Completion of training, required Transfusion course modules and 5 countersigned transfusion orders.
   b. No inappropriate transfusions during the proctoring period
   c. The evaluator will be the responsible medical director or other designated physician.

5. Ongoing competency:
   a. Method to evaluate continued competency will be successful completion of review of course modules / tests every 2 years at time of reappointment.
   b. Review of any Transfusion Committee Reports
   c. Performance of 2 transfusions and 2 chart reviews every 2 years.
PROTOCOL #12: Procedure: Waived Testing

A. DEFINITION

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

1) Location where waived testing is to be performed: Emergency Department and Clinical Decision Unit.

2) The following non-instrument based waived tests are currently performed at SFGH in the ED and CDU:
   a. Fecal Occult Blood Testing (Hemocult ®)
      Indication: Assist with detection or verification of occult blood in stool.
   b. Vaginal pH Testing (pH Paper)
      Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.

B. DATA BASE

1) Subjective Data

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

2) Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Testing

   a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
b. Use gloves and other personal protective equipment, as appropriate.

c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.

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

d. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are not outdated? Have necessary controls been done and come out as expected?

2. Test Results requiring Attending Consultation

a. Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

3. Education

a. Inform patient of test results and need of additional tests, as necessary

4. Follow-up

a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

| Prerequisites: |
| Certification as NP or PA practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics. |

| Proctoring: |
| Successful completion of Halogen or PPMP quizzes for each of the waived tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module. |

| Reappointment Competency Documentation: |
| Renewal required every two years with documentation of successful completion of the required Halogen or PPMP quizzes. Provider must have passed each required module with a score of 80%. |