Standardized Protocol for Assessment and Management of Acute and Chronic Patients: Anesthesia Pre-Op Clinic
Protocol for the Management of Acute and Chronic Illness and Injuries prior to the administration of anesthesia

Policy Statement
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.

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 Pre-Op Clinic Medical Director's Office and on file in the Medical Staff Office.

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.

The NP conduct physical exams, diagnoses and treats illness, order and interpret tests, counsel on preventative health care, assists in surgery, performs invasive procedures and furnish medications/issue drug orders as established by state law.

Circumstances Under Which NP May Perform Function
Setting
Location of practice is the Anesthesia Pre-Op Clinic including visits to any other part of the hospital where preoperative patient evaluations are required.

Supervision
• Overall Accountability: The NP is responsible and accountable to the Medical Director and the anesthesia attending assigned to supervise the Pre-Op Clinic.
• A consulting physician (Anesthesia attending) will be available to the NP, by phone, in person, or by other electronic means at all times.
• Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
  a. Acute decompensation of patient situation
  b. Problem that is not resolved after reasonable trial of therapies.
  c. Unexplained historical, physical, or laboratory findings.
  d. Upon request of patient, affiliated staff, or physician.
  e. Initiation or change of medication other than those in the formulary (ies).
  f. Problem requiring hospital admission or potential hospital admission.
  g. Acute, severe respiratory distress.
  h. An adverse response to respiratory treatment, or a lack of therapeutic response.

**Scope of Practice – Protocols**
- Pre-Op Screening of Adults
- Pre-Op Screening of Children

**Requirements for the Nurse Practitioner**

**Basic Training and Education**
- Active California Registered Nurse/ Certified Nurse-Midwife/Physician Assistant license.
- 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.
- Degree needed: ANP, FNP for adults and FNP or PNP for children.
- Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
- Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
- Possession of a National Provider Identifier or must have submitted an application.
- Copies of licensure and certificates must be on file in the Medical Staff Office.
- Furnishing Number and DEA Number if applicable.
Evaluation

Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and other supervisors, as applicable will assess the NP’s ability to practice.

Clinical Practice
- Length of proctoring period will be one month. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic. The method of evaluation in clinical practice will be presentation of all cases to either the Medical Director or designated physician during the proctoring period.
- 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.
- 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.
- Biennial Reappointment: Medical Director, and/or designated physician must evaluate the NP’s clinical competence. Evaluation will be the review of 5 medical records and one direct observation of an adult and child assessment.

Development and Approval of Standardized Procedure

Method of Development
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.

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

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

Revisions
All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.
Protocol #1: Pre-Op Screening of Adults

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

Data Base

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

Objective Data:
• Physical examination appropriate to the disease process;
• Review of appropriate laboratory / diagnostic studies
• All Point of Care Testing (POCT) will be performed according to the SFGHMC PCOT policy and procedure 16.20.

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).

Management

Diagnostic
• Appropriate screening tests, and/or diagnostic tests for purposes of disease identification
• Referral to specialty clinics and supportive services, as needed

Treatment
• Physical and/or occupational therapy and/or speech therapy, if appropriate;
• Diet and exercise prescription as indicated by the disease process and the patient condition;
• Management of medication as appropriate and clinical expertise.

Patient conditions requiring Attending Consultation
• With emergent conditions requiring prompt medication attention;
• With acute decompensation of the patient situation;
• When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings;
• Upon request of the patient, Nurse Practitioner, or Physician;
• When ordering expensive and/or unusual diagnostic studies;
• When prescribing medications not within the clinical expertise of the Nurse Practitioner
• Patient conditions that may require physician consultation in addition to the ones mentioned in the General Policy including:
  • Significant abnormal lab values
  • New carotid bruits
  • New cardiac murmurs or other cardiac symptoms
  • Current uncompensated heart failure
  • New ECG changes
  • Other acute conditions which will benefit from treatment and stabilization prior to surgery.
• Patients evaluated for surgery who have unusual and/or unanticipated findings.

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

Follow-up and referral
• Performed in accordance with the standard of practice and/or with the consulting physician’s recommendation.

Record Keeping
• Patient contacts and visits are to be documented in accordance with standard practice and institutional policy.
• All information relevant to patient care will be recorded in the medical record.
Protocol #2: Pre-Op Screening of Children

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

Data Base

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

Objective Data:
- Physical examination appropriate to the disease process;
- Review of appropriate laboratory / diagnostic studies
- All Point of Care Testing (POCT) will be performed according to the SFGHMC PCOT policy and procedure 16.20.

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).

Management

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

Treatment
- Physical and/or occupational therapy and/or speech therapy, if appropriate;
- Diet and exercise prescription as indicated by the disease process and the patient condition;
- Management of medication as appropriate and clinical expertise.

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

Patient / Family Education
• In verbal and/or written format, the Nurse Practitioner explains to the pertinent party or parties involved the diseased process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up.
• The Nurse Practitioner will provide age appropriate verbal and/or written information to prepare a child and/or their family for the operative experience.

Follow-up and referral
• Performed in accordance with the standard of practice and/or with the consulting physician’s recommendation.

Record Keeping
• Patient contacts and visits are to be documented in accordance with standard practice and institutional policy.
• All information relevant to patient care will be recorded in the medical record.
CERTIFICATION OF COMPETENCE: PROTOCOLS

____________________NP, has successfully demonstrated competence in patient management utilizing the following protocol for the assessment and management of acute and chronic patients: Pre-Op Clinic.

Initial competency was assessed by ____________________________MD, continued proficiency will be documented below upon annual evaluation or re-credentialing and as circumstances require. After two years, this protocol must be reviewed by the Committee on Interdisciplinary Practices.

Initial Protocol Competency

_________________________________________________  ____________________________
Signature – Supervising Physician                                                      Date