San Francisco General Hospital and Trauma Center  
Committee on Interdisciplinary Practice  
STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT  
PREAMBLE

Title: Department of Medicine

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 1M Clinic room 1M 13, Cardiology 5G1, Cardiac Catheterization Lab, Unit 5B Nurse Lounge, GI Fellows Conference Room, Hematology/Oncology Administration Office, GI Conference Room 3D22, Occupational Health Clinic, HERO Medical record system 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 and in performance of procedures.

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 the Community Health Network, 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 conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel patients on preventative health care, perform invasive procedures and furnish 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: Inpatient Units, 5B Research Unit, Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Infusion Center, 3 D Gastroenterology Clinic, Occupational Health Service, Positive Health Clinic, Hematology/Oncology Clinic, 1M and 5F Cardiology Clinics, Ward 17 Renal Dialysis Service and the Emergency Department.
   2. Role may include primary care, urgent care, furnishing medications, performing procedures and coordinating admissions and discharges. Role may also include admissions, transfers and discharges. Role may also include clinical research studies.
B. Supervision

1. Overall Accountability:
   The NP/PA is responsible and accountable to: site Medical Director, Chief of Service, designated physician and other supervisors as applicable.

2. A consulting physician, who may include attendings, 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.
   g. Acute, severe respiratory distress.
   h. An adverse response to respiratory treatment, or a lack of therapeutic response.
   i. Problem requiring invasive or surgical procedure.
   j. Need for transfusion.
   k. Review of electrocardiograms, if no prior interpretation of change from previous recording.
   l. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.
   m. Upon seeing a newly diagnosed oncology patient in outpatient clinic.
   n. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
   o. Conditions severe enough to warrant partial or total disability work status prescription.
   p. Any problem requiring transfer of care to the Emergency Department.

4. NP/PA management of medical emergencies, including cardio-pulmonary arrest, shock and life-threatening bleeding shall include initial evaluation and stabilization of the patient through the utilization of Advanced Cardiac Life Support (ACLS), alerting the supervising physician and activation of the Code Blue Team by dialing X61122.
IV. Scope of Practice

Protocol #1: Health Care Management: Acute/Urgent
Protocol #2: Health Care Management: Primary Care
Protocol #3: Discharge of Inpatient
Protocol #4: eReferral Review
Protocol #5: Furnishing Medications/Drug Orders
Protocol #6: Routine Occupational Health Screening
Protocol #7: Evaluation and treatment of Occupational Illness/Injury and Exposure to Physical Chemical and Biological Hazards
Protocol #8: Procedure: Abdominal Paracentesis
Protocol #9: Procedure: Arthrocentesis and Intraarticular Injections
Protocol #10: Procedure: Bone Marrow Aspiration and Biopsy
Protocol #11: Procedure: Buprenorphine Induction and Maintenance
Protocol #12: Procedure: Colonoscopy
Protocol #13: Procedure: Esophagastroduodenoscopy (EGD)
Protocol #14: Procedure: Esophageal Manometry and Prolonged Ambulatory pH Monitoring
Protocol #15: Procedure: Exercise Tread Mill Test
Protocol #16: Procedure: High Resolution Anoscopy
Protocol #17: Procedure: Incision and Drainage Skin Abscesses with Administration of Local Anesthesia
Protocol #18: Procedure: Intraperitoneal Chemotherapy
Protocol #19: Procedure: Intraventricular Chemotherapy Administration via Ommaya Reservoir
Protocol #20: Procedure: Lumbar Puncture
Protocol #21: Procedure: Lumbar Puncture with the Administration of Intrathecal Chemotherapy
Protocol #22: Procedure: Procedural Sedation
Protocol #23: Procedure: Ordering Blood Transfusions
Protocol #24: Procedure: Ordering Chemotherapy
Protocol #25: Procedure: Skin Biopsies
Protocol #26: Procedure: Surface Trauma and Wound Care
Protocol #27: Procedure: Thoracentesis
Protocol #28: Procedure: Waived Testing
Protocol #29: Procedure: Tattoo Removal

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
   1. Active California Registered Nurse/Physician Assistant
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.

3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification. Nurse Practitioners hired prior to the current Board requirement will be “grandfathered” in when up for reappointment.

4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider. Please note ACLS or other certification may be required for specific procedures.

5. Possession of a National Provider Identifier or must have submitted an application.

6. Copies of licensure and certificates must be on file in the Medical Staff Office.

7. Furnishing Number and DEA Number if applicable.

8. Physician Assistants are required to sign and adhere to the 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: NP Specialization in Acute Medicine, Family Medicine, Adult Medicine, Geriatric Medicine or Physician Assistant.

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 or previous experience in Oncology within the last three (3) years preferred.

3. All Affiliated Staff who will participate in the Buprenorphine protocol must have on the job training by a certified physician.

4. Clinical research and human subjects training (Research Unit only).

5. All staff working in Occupational Health will receive training from an OHS Physician in:
   a. California and CCSF Workers Compensation procedures.
   b. Management of body fluid exposures.
VI. Evaluation

   1. 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/PA’s ability to practice.
      a. Clinical Practice
         - Length of proctoring period will be 3 months; review of cases and medical record reviews will be as listed in each protocol or procedure.
         - The evaluator will be Medical Director, Chief of Service and/or designated physician or privileged provider as applicable.
         - The method of evaluation in clinical practice will be those needed to demonstrate clinical competence as noted in each procedure.

   2. Bi-Annual Reappointment: Medical Director, and/or designated physician must evaluate the NP/PA’s clinical competence as described in each procedure.

   3. Follow-up: areas requiring increased proficiency as determined by the initial or biennial evaluation will be re-evaluated by the Medical Director, and/or designated physician, at appropriate intervals. If staff have not achieved competency within two years of initial appointment, provider may no longer operate under these standardized procedures.

   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. 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.

VII. Development and Approval of Standardized Procedure

A. Method of Development
   1. Standardized procedures are developed collaboratively by the Nurse Practitioners, Physician Assistants, Nurse Midwives, Registered Nurses, 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 within the Medicine Service, and in the Emergency Department.

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.
   c. Present status of current symptoms (present, stable or absent)
   d. Pain history to include onset, location and intensity.

2. Objective Data
   a. Physical examination of systems relevant to the problem 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 SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of data from the subjective and objective findings to identify disease processes. Assessment will include statement of current status of disease. To refine the diagnosis and adjust treatment in an effort to maintain wellness.

D. PLAN
1. Therapeutic Treatment Plan
   a. Diagnostic tests for purposes of disease identification.
   b. Review of medical record, laboratory and other test results and specialty consultations.
   c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   d. Referral to physician, specialty clinics, and supportive services, as needed.
   e. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Uncommon, unfamiliar, unstable, and complex patient conditions
   e. Upon request of patient, NP, PA, or physician
   f. Initiation or change of medication other than those in the formularies.
   g. Any Problem requiring hospital admission or potential hospital admission.

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g.: diet, exercise).
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.
   c. Discharge information and instructions.

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

E. RECORD KEEPING
   All information from patient visits will be recorded in the medical record or Lifetime Clinical Record (LCR) e.g.: admission notes, progress notes, procedure notes. 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 #2: Health Care Management – Primary Care/Inpatient Units

A. DEFINITION
   This protocol covers the procedure for appropriate health care management in primary care, specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses within the Medicine Service.

B. DATA BASE
   1. Subjective Data
      a. Screening: appropriate history that includes but is not limited to: age, ethnic and national origin, appropriate review of symptoms, 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, and uncontrolled).

D. PLAN
   1. Treatment
      a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
      b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol. Initiation or adjustment of medications as covered in Research Protocols.
      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, 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.
   g. Patients on Chemotherapy, referrals for radiation therapy,
   h. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.
   c. Discharge information and instructions.

4. Follow-up
   As indicated and appropriate to 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). The Lifetime Clinical Record (LCR) will be used to obtain and record patient information as required and 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 the patient.
Protocol #3: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from San Francisco General Hospital and Trauma Center. Direction to discharge patient will come from the attending physician.

B. DATA BASE
1. Subjective Data
   a. Review: heath history and current health status

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Review medical record: in-hospital progress notes, consultations to assure follow-through.
   c. Review recent laboratory and imaging studies and other diagnostic tests noting any abnormalities requiring follow-up.
   d. Review current medication regimen, as noted in the MAR (Medication Administration Record).

C. DIAGNOSIS
Review of subjective and objective data and medical diagnoses, ensure that appropriate treatments have been completed, identify clinical problems that still require follow-up and that appropriate follow-up appointments and studies have been arranged.

D. PLAN
1. Treatment
   a. Review treatment plan with patient and/or family.
   b. Initiation or adjustment of medications per Furnishing/Drug Orders protocol.
   c. Assure that appropriate follow-up arrangements (appointments/studies) have been made.
   d. Referral to specialty clinics and support services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA or physician.
   c. Initiation or change of medication other than those in the formulary.

3. Education
   a. Review inpatient course and what will need follow-up.
   b. Provide instructions on:
- follow-up clinic appointments  
- outpatient laboratory/diagnostic tests  
- discharge medications  
- signs and symptoms of possible complications  

4. Follow-up  
   a. Follow-up appointments  
   b. Copies of relevant paperwork will be provided to patient.  

E. RECORD KEEPING  
All information from patient hospital stay will be recorded in the medical record. 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.
Protocol #4: eReferral Review

A. DEFINITION

eReferral review is defined as the review of new outpatient consultation requests via the online eReferral system. A new outpatient is defined as a patient that has neither been consulted upon by the specialty service, admitted to the specialty service nor seen in the specialty clinic within the previous two years.

1. Prerequisites:
   a. Providers reviewing eReferrals will have six months experience with patients in the specific specialty area provided at San Francisco General Hospital and Trauma Center or elsewhere before allowed to review eReferrals independently.
   b. Providers reviewing eReferrals will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
   c. Providers reviewing eReferrals will consistently provide care to patients in the specialty clinic for which they are reviewing.
   d. Providers reviewing eReferrals will have expertise in the specialty practice for which they are reviewing.

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Medical/Surgical Director, which will be used to facilitate screening, triaging and prioritizing of patients in the eReferral system.

3. Proctoring: A review of the eReferral consultation decisions will be performed by the consulting physician or supervising Nurse Practitioner concurrently for the first 20 eRefferals (minimum). More eRefferal reviews may be required depending on performance.

4. Location to be performed: Avon Comprehensive Breast Center, 3D GI Clinic and sites as they institute e-Referral capability.

B. DATA BASE

1. Subjective Data
   a. History: 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 relevant to the presenting disease process as provided by the referring provider on the electronic referral.
eReferral review will be confined to data found in the submitted eReferral form. Data contained in the paper or electronic medical record, but not in the eReferral, is specifically excluded from the eReferral review. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

2. Objective Data
a. Physical exam consistent with history and clinical assessment of the patient as provided by the referring provider.
b. Laboratory and imaging evaluation as obtained by the referring provider relevant to history, physical exam and current disease process will be reviewed. Further evaluation will be requested from the referring provider if indicated.

C. DIAGNOSIS
A diagnosis will not be determined at the time of eReferral review. Differential diagnosis will be provided at the time the patient is seen in clinic by the consulting provider. Assessment of the subjective and objective data as performed by the consulting provider in conjunction with identified risk factors will be evaluated in obtaining a diagnosis.

D. PLAN
1. Review of eReferral
a. Algorithms or referral guidelines developed and approved by the Medical/Surgical Director will be used to facilitate screening, triaging and prioritizing of patients in the eReferral system.
b. All data provided via the eReferral consultation request will be reviewed and assessed for thoroughness of history, adequacy of work up and urgency of condition.
c. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient conditions requiring Attending Review
a. Unexplained historical, physical or laboratory findings
b. Upon request of the referring NP, PA, or physician
c. Problem requiring hospital admission or potential hospital admission
d. When recommending complex imaging studies or procedures for the referring provider to order
e. Problem requiring emergent/urgent surgical intervention
f. As indicated per the algorithms developed by the Medical Director

3. Education
   a. Provider education appropriate to the referring problem including disease process, additional diagnostic evaluation and data gathering, interim treatment modalities and lifestyle counseling (e.g. diet, exercise).

4. Scheduling of Appointments
   a. Dependant upon the urgency of the referral, the eReferral will be forwarded to the scheduler for either next available clinic appointment scheduling or overbook appointment scheduling.

5. Patient Notification
   a. Notification of the patient will be done by the referring provider if the appointment is scheduled as next available. If the appointment is scheduled as an over book within two weeks of the eReferral, the consulting scheduler is responsible for notifying the patient.

E. RECORD KEEPING
   All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the lifetime clinic record (LCR) upon scheduling and after consultation visit and follow up visits.

   During the proctoring period, the eReferral consultation request will be printed and the provider recommendations will be written on the print out. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into the LCR and forwarded to the scheduler.
Protocol #5: 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: Medicine service, 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 use are: 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. Medications authorized by the CCSF Worker's Compensation Division and by affiliated third part administrators and utilization review agencies. 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.
d. 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 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 - 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.
   d. Any client requiring controlled substances on a chronic basis will have a patient/provider agreement form included in the medical record. The contract will state the type and amount of medication allowed, along with the effective date of the contract. The consulting physician may approve refills outside of these guidelines.
   e. 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.
   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 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 #6: Routine Occupational Health Screening

A. DEFINITION

This protocol covers the procedures for screening history, physical examination, diagnostic evaluation of and appropriate preventive interventions for adult employees of the City and County of San Francisco (CCSF) and other affiliated clients within the Occupational Health Service. Relevant activities include:

1. Employment pre-placement, promotion and fitness-for-duty evaluations
   a. Includes specific medical certifications such as California DMV Class A/B License, medical clearance for respirator use

2. Specific medical surveillance programs for occupational hazards (physical, chemical and biological)
   a. Includes pertinent preventive interventions such as immunizations and N95 respirator fit-testing, including UCSF campus employees.

B. DATA BASE

1. Subjective Data
   a. Screening: age- and examination/job-appropriate history that can include but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
   b. Ongoing/Continuity: review of symptoms and history relevant to the patient's age, health history, examination type and job class
   c. Pain history obtained to include onset, location, and intensity

2. Objective Data
   a. Job description and other relevant qualification requirements/guidelines
   b. Physical examination consistent with health history and examination type
   c. Laboratory and imaging evaluation, as indicated, relevant to history and examination type
   d. Previous medical records and clinical consultation reports, as needed
e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

1. Assessment of data from the subjective and objective findings identifying risk factors, disease/injury/disability and medical qualification for work duties

D. PLAN

1. Action/Intervention
   a. Age- and examination- appropriate screening/diagnostic testing or referral to primary health care system for consultation (as needed to complete occupational assessment)
   b. Age- and examination/job-appropriate preventive interventions, including but not limited to:
      1) Education as described below
      2) Immunizations

2. Patient conditions requiring Physician consultation
   a. Acute decompensation of patient situation, including hostile or threatening patient behavior
   b. Any problem requiring transfer of care to an Emergency Department or specialist Physician
   c. Unexplained historical, physical, or laboratory findings
   d. Upon request of patient, NP, PA or Physician.
   e. Conditions severe enough to warrant partial or total disability work status prescription

3. Education
   a. Regarding occupational hazards and personal protection/safety measures
   b. Regarding relevant health issues
   c. Regarding relevant administrative/regulatory procedures

4. Follow-up
   a. As indicated to complete assessment and disposition

E. RECORD KEEPING

1. All information relevant to patient evaluation/care will be recorded in the patient’s OHS medical record, which is maintained in the OHS clinic.
A. DEFINITION

This protocol covers the procedures for screening history, physical examination, diagnostic evaluation and treatment of adult employees of the City and County of San Francisco (CCSF) and other affiliated clients who present to the Occupational Health Service with specific occupational health complaints or concerns. Relevant activities include:

1. Diagnosis and treatment of occupational injury or illness

2. Assessment and appropriate intervention following potentially significant occupational exposure to hazards (e.g. tuberculosis, human body fluids, chemical agents etc.).

B. DATA BASE

1. Subjective Data
   a. Initial visit: Age- and incident-appropriate history that can include but is not limited to: history of current problem and detailed mechanism of injury or exposure, current symptoms, past medical history including relevant hospitalizations/injuries/immunizations, past surgical history, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
   b. Subsequent visits: Interval history to include current symptoms, response to treatment, impact of injury/illness on function
   c. Pain history obtained to include onset, location, and intensity

2. Objective Data
   a. Focused physical examination
   b. Focused diagnostic testing
   c. Review of relevant past medical records, exposure data
   d. Job description or other knowledge of essential job duties
   e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.
C. DIAGNOSIS  
1. Assessment of data from the subjective and objective findings identifying diagnosis of illness/injury or exposure risk factors.
2. Assessment of need for prescribed work restrictions or total disability

D. PLAN  
1. Treatment  
a. Pharmaceutical agents (see Furnishing Medications/Drug Orders Protocol)  
   1. As needed to cure or relieve injury/illness symptoms or conditions  
   2. As needed prophylaxis following exposure to hazards  
c. Referrals as clinically indicated  
   1. To primary care clinician (for non-occupational conditions)  
   2. To Emergency Department  
   3. To Physician specialist  
   4. To mental health clinician  
   5. To nurse case manager or claims adjuster (for issues of disability benefit management)  
d. Prescription of appropriate work and other activity restrictions  
e. Education as described below  
2. Patient conditions requiring Physician consultation  
a. Acute decompensation of patient situation, including hostile or threatening patient behavior  
b. Any problem requiring transfer of care to an Emergency Department or specialist clinician  
c. Unexplained historical, physical, or laboratory findings  
d. Problem that is not resolved after reasonable trial of therapies  
e. Unexplained historical, physical, or laboratory findings  
f. Upon request of patient, NP, PA or Physician.  
g. Initiation or change of medication other than those in the formulary (ies).  
h. Conditions severe enough to warrant partial or total disability work status prescription  
3. Education  
a. Regarding injury/illness diagnosis, treatment options, prognosis, activity restrictions/disability, follow-up plan
b. Regarding risk of exposure to specific hazard, prevention/prophylaxis options, follow-up plan

c. Regarding workers' compensation and other disability benefit programs

4. Follow-up
   a. As indicated to complete assessment and disposition

E. RECORD KEEPING

1. All information relevant to patient evaluation/care will be recorded in the patient's OHS medical record, which is maintained in the OHS clinic.
Protocol #8: Procedure: Abdominal Paracentesis

A. Definition - Abdominal paracentesis is a procedure that entails inserting a trocar and cannula through the abdominal wall under local anesthetic for aspiration of peritoneal fluid (ascites). The term ascites denotes the accumulation of fluid in the peritoneal cavity.

1. Locations to be performed: Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Outpatient Infusion Center, 3D GI Clinic, Hematology/Oncology Clinic and Inpatient units.

2. Performance of Procedure: (When possible any paracentesis should be performed bedside with ultrasound guidance; an alternative is to have fluid localized and transport patient on same bed used for marking, i.e. patient is not moved).
   i. Indications:
      a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhotic).
      b. Pt with ascites, fever, abdominal pain, i.e. to evaluate for spontaneous bacterial peritonitis.
      c. Symptomatic treatment of tense ascites.
   ii. Precautions:
      a. INR greater than 4.0, Platelets less than 30K.
      b. Intra-abdominal adhesions or suspicion for loculated fluid.
      c. Pregnancy
      d. Necessity for ultrasound guided paracentesis if any conditions listed above are present.
   iii. Contraindications:
      a. Fibrinolysis or DIC.
      b. Cellulitis at puncture site.

B. Data Base

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis
   Assessment of data from the subjective and objective findings to identify disease processes.
D. Plan

1. Therapeutic Treatment Plan.
   a. Informed consent obtained prior to procedure and according to hospital policy.
   b. Time out performed according to hospital policy.
   c. Diagnostic tests for purpose of identifying disease etiology. Sent for cytology as relevant.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders Protocol.
   e. Referral to specialty clinic, supportive services for provider as needed.

2. Patient conditions requiring attending consultation
   a. All patients with any condition listed in precaution section.
   b. Acute decompensation of patient.
   c. Upon the request of the patient, PA, NP or physician.

3. Education
   a. Appropriate and relevant patient and family education in written and/or verbal format.
   b. Contact information for follow up should needle puncture site result in leaking ascitic fluid.

4. Follow-up
   a. As indicated and appropriate for procedure performed.

E. Record Keeping

Patient visit, consent forms, and other transfusion-specific documents (completed transfusion report and "blood sticker") will be included in the medical record, 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. Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisite:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Training by a privileged provider or documentation of previous training.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proctoring:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providers new to procedure must complete a minimum of 4 successful procedures prior to completion of proctoring period.</td>
</tr>
<tr>
<td>2. Experienced providers must complete a minimum of 2 successful procedures prior to completion of proctoring period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency Evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To maintain ongoing competency a minimum of 4 procedures every 2 years must be met. If not met, provider will be proctored through 1 successful procedure.</td>
</tr>
<tr>
<td>2. Two chart reviews every two years.</td>
</tr>
<tr>
<td>3. Evaluation must be done by Medical Director or designated physician.</td>
</tr>
</tbody>
</table>
Protocol #9: Procedure: Arthrocentesis & Intraarticular Injections

A. DEFINITION

This protocol covers arthrocentesis of the knee and elbow and injection of corticosteroids and/or xylocaine preparations for pain relief. The procedure is insertion of a needle into the joint space (the tendon sheath, bursa, or carpal canal) to aspirate fluid for analysis and/or inject medicine.

1. Location to be performed: Inpatient Units, Adult Medical Clinic and Medical Specialty Clinics on Ward 92 and the Emergency Department.

2. Performance of procedure:
   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 or acute trauma.

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique.
   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 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, consistent with hospital policy, prior to start of procedure.
   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 orthopedic physician, specialty clinic, 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 Prerequisites, Proctoring and Reappointment Competency

Prerequisite:
   a. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
   b. The NP/PA will be directly observed performing the procedure by an experienced provider (MD, NP, or PA) 2 times, no less than 1
time for an experienced practitioner.

<table>
<thead>
<tr>
<th>Proctoring Period</th>
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</thead>
<tbody>
<tr>
<td>a. New practitioner to procedure, a minimum of 3 successful observed demonstrations</td>
<td></td>
</tr>
<tr>
<td>b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstration</td>
<td></td>
</tr>
<tr>
<td>c. Chart review of observed cases.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reappointment Competency:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. An Attending Physicians or Chief Resident or qualified provider will be the evaluator.</td>
<td></td>
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<tr>
<td>b. Provider must:</td>
<td></td>
</tr>
<tr>
<td>1. Perform a minimum of 4 procedures every 2 years</td>
<td></td>
</tr>
<tr>
<td>2. 2 chart reviews needed every 2 years.</td>
<td></td>
</tr>
</tbody>
</table>
Protocol #10: Procedure: Bone Marrow Aspiration and Biopsy

A. Definition – Bone marrow may be removed by aspiration or needle biopsy under local anesthesia and are often used concurrently to obtain the best possible marrow specimens.

1. Procedure may be performed in the 4C Infusion center, Hematology/Oncology Clinic and Inpatient Units.

2. Performance of procedure:
   a. Indications:
      • To diagnose thrombocytopenia, leukemias, granulomas, and aplastic, hypoplastic, and pernicious anemias.
      • To diagnose primary and metastatic tumors.
      • To determine the cause of infection.
      • To aid staging of disease, such as Hodgkin’s disease.
      • To evaluate the effectiveness of chemotherapy and help monitor myelosuppression.
   b. Relative contraindications include infection at the site of biopsy, thrombocytopenia less than 30K or uncorrected coagulopathy.

B. Data Base

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

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, and uncontrolled).

D. Plan
   1. Therapeutic Treatment Plan.
      a. Obtain informed consent prior to procedure and according to hospital policy.
      b. Time out performed per hospital policy.
2. Patient conditions requiring attending consultation, inability to obtain adequate sample, upon request of NP, PA or physician.

3. Education
   Appropriate and relevant patient and family education/counseling in written and/or verbal format.

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

E. Documentation
   Post-procedure note recorded in the medical record and will include all necessary documentation including consent form. For PAs 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 that 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

<table>
<thead>
<tr>
<th>Prerequisites</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.  Will be trained on site by a privileged provider (MD, NP or PA)</td>
</tr>
<tr>
<td>b.  Documentation of previous training.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Proctoring Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proctoring period: new practitioners to procedure will complete a minimum of 3 successful observed demonstrations and experienced practitioners will complete a minimum of 2 successful observed demonstrations. Chart reviews of all observed cases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reappointment Competency Documention</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.  Evaluation of competency will include a letter from clinical director with input from attending hematologist regarding practitioners’ proficiency as well as annual observation of 1 successful completion of procedure by attending hematologist and 2 chart reviews.</td>
</tr>
<tr>
<td>b.  Evaluation will be done by the Medical Director or Physician/NP designee.</td>
</tr>
</tbody>
</table>
Protocol #11: Procedure: Buprenorphine Induction and Maintenance

A. DEFINITION

This protocol covers the procedure for initiating and continuing sublingual buprenorphine treatment for opioid replacement for the adult outpatient population. Prior to treatment initiation, confirm patient eligibility for DPH buprenorphine treatment, including diagnosis of opioid dependence and a review of the inclusion/exclusion criteria. Treatment initiation can occur at the Office-based Buprenorphine Induction Clinic (OBIC) designed specifically for this purpose. Treatment can also be initiated by a registered (has a DEA “X” number) physician’s choice at DPH outpatient clinics. Treatment will follow DPH/OBIC Policy and Procedures. Protocol will be done in the Positive Health Clinic and Adult Medical Clinic.

Inclusion Criteria

- Patient is at least 18 years old
- Patient meets current DSM criteria for Opioid Dependence
- Female patients who are pregnant, trying to become pregnant or nursing should notify the buprenorphine-prescribing physician. It is recommended that patients receiving buprenorphine(suboxone) use adequate birth control methods pill, IUD, condom with spermicide, abstinence etc. as its safety in pregnancy has not been fully established. Methadone is the medication of choice for this population.
- Patient is eligible for care at a SFDPH site and has completed registration process.

Exclusion Criteria

- Patient has serious uncontrolled/unrelated psychiatric problems (suicidality, active psychosis, etc.)
- Patient has serious/uncontrolled/untreated medical problems (hypertension, hepatic failure, asthma, diabetes, etc.)
- Patient currently uses more than 30 mg/day of methadone
- Patient has a chronic pain disorder for which opiate analgesic medication is required(evaluated on case by case basis)
- Patient is dependent on alcohol
- Patient uses high doses of non-prescribed or misuses prescribed benzodiazepines, sedatives or hypnotics
- Patient requires the structure of a higher level of care (i.e. methadone maintenance)
- Patient has a known allergy/hypersensitivity to buprenorphine or naloxone
B. DATA BASE

1. Subjective Data
   a. Chief Complaint. Review patient opioid withdrawal symptoms including cravings, anxiety, discomfort, pain, nausea, hot or cold flushes. Include patient subjective rating of these symptoms (mild, moderate, or severe).
   b. Health History. A review and confirmation of the following are recommended for all patients:
      1. Substance use history. Review current opioid habit, i.e. type of opiate, frequency and method of use, last use. Review alcohol, sedative, stimulant, and other substance use/abuse.
      2. Previous opioid and other drug treatments (e.g. methadone replacement, residential treatment, etc.), including patient response to treatment and perceived effectiveness. **Note: For patients on Methadone, a taper down to dose of 30 mg/day or less is recommended prior to buprenorphine induction.
      3. Sequellae of substance abuse (e.g. hepatitis C, HIV disease, violence, psycho-social and functional problems).
      4. Past and current medical problems, including psychiatric problems, medications, allergies, and health care providers.
      5. For female clients of childbearing age, assessment and documentation of effective use of birth control.

2. Objective Data
   a. Physical exam, including Mental Status Examination (MSE) and also include the following:
      • Documentation of opioid withdrawal symptoms if present, including elevated BP, increased HR, mydriasis, tremors, and agitation/restlessness. Also note the presence or absence of yawning, rhinorrhea, piloerection, diaphoresis, lacrimation, vomiting and muscle fasciculations. To assess opioid withdrawal severity, use the Clinical Opioid Withdrawal Scale (COWS).
      • Assessment of possible needle use sequellae, including presence of track marks, abscesses, cellulitis.
      • Assessment of possible substance intoxication, including but not limited to etoh odor, nystagmus,
positive Romberg test, client disinhibition, or other altered mental status.

b. Laboratory results, including the following
   • Drug toxicology screening test
   • Liver panel (AST, ALT, total bilirubin and alkaline phosphatase—results over 5 times the normal upper limit are a buprenorphine contraindication)
   • HCG screening for female clients of child-bearing potential

C. DIAGNOSIS
1. Opioid Dependence per current DSM criteria.
2. If in opioid withdrawal include severity (mild, moderate, severe), based on COWS score.

D. PLAN
1. Treatment
   a. Ensure that the following consent, agreement, and authorization forms are signed and completed prior to patient induction:
      • Consent to Treatment
      • HIPAA privacy practices notice (if not already in CHN/DPH medical record)
      • IBIS Patient Handbook
   b. Medication—buprenorphine induction and upward titration
      • DAY #1. For mild withdrawal give buprenorphine 2 to 4mg SL. For patients exhibiting moderate to severe withdrawal, give buprenorphine 4mg SL. Observe client for 30 minutes to 1 hour after which time an additional dose of buprenorphine 2 to 4mg SL may be given at the physician’s discretion. The physician may prescribe or dispense take-home buprenorphine 2 to 6mg for patient self-administration later in the day/evening if continued opioid withdrawal is expected. Total buprenorphine dose for 1st 24 hours typically ranges between 6mgs and 14mgs with an average of 12mgs.

   Adjunctive Medications
   In addition to the use of buprenorphine as described above, additional medications can be prescribed/provided for symptom management. These may include the following: Clonidine 0.1 to 0.3mg PO q4 to 6 hours PRN lacrimation, diaphoresis, rhinorrhea, piloerection; phenergan 25mg PO q4 to 6 hours PRN
nausea/vomiting; imodium 4mg PO x I PRN diarrhea, then 2mg PO PRN each loose stool or diarrhea thereafter, NTE 16mg/24h; ibuprofen 400 to 800 mg PO 4 to 6 hours with food PRN myalgias/arthralgias, NTE 2400mg/24hours.

- **DAY 2** Repeat day 1 buprenorphine dose PLUS an additional 2 to 4mg as needed based on presenting withdrawal severity. Consider take-home doses of 2-4mgs if appropriate. Doses of 8-16 mgs are typical for Day 2.

- **DAY 3/Additional Days/Titration Up** Repeat plan as per day 2, increasing buprenorphine dose each day by 2 to 4mg until the patient no longer exhibits signs of opioid withdrawal. Doses of 12-16 mgs are typical for Day 3. Most patients experience good control of withdrawal and cravings by the end of their first 3-5 days on Suboxone.

  Target Dose: The dose that results in the optimal relief of objective and subjective opioid withdrawal symptoms. This is expected to be in the range of 12 to 20mg daily, though doses from 4 to 32 mg/day may be required to suppress opioid withdrawal effects. Maximum daily dose is 32mg.

2. **Patient conditions requiring Attending Consultation**
   a. All buprenorphine orders, initial as well as subsequent, come from a registered physician. The NP administers and dispenses buprenorphine only as dictated by this standardized procedure/protocol.
   b. Acute decompensation of patient situation
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, or physician
   e. Problem requiring hospital admission or potential hospital admission.

3. **Education**
   a. Patient education appropriate to diagnosis including harm reduction and substance abuse counseling.
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.

4. **Counseling** can be available on site or by referral as indicated. While not mandatory, counseling is recommended at onset of treatment and as clinically indicated there after.
5. Maintenance
Buprenorphine dispensing (and administration, if indicated) can occur in clinic or pharmacy with frequency determined by the provider. Once a stable dose is achieved, follow-up pharmacy visits will occur at least every twenty eight (28) days and medical visits occur based on medical need at a minimum of every three months. When stable, buprenorphine dispensing and medication pick-up should be transferred to the Community Behavioral Health Service pharmacy or other community pharmacy at the prescribing physician’s discretion. If buprenorphine treatment was initiated at the OBIC clinic, the OBIC provider will arrange referral to a community-based buprenorphine provider after treatment stability.

E. RECORD KEEPING
All information relevant to patient care will be recorded in the medical record and/or LCR as appropriate.
Protocol #12: Procedure: Colonoscopy (Requires ACLS certification)

A. DEFINITION
Colonoscopy is the examination of the rectum and colon extending to the cecum and possibly terminal ileum through the use of a flexible video scope (and does encompass flexible sigmoidoscopy). It is performed as a screening measure, as a diagnostic tool and for research purposes. For the purposes of this protocol, these examinations are conducted at the 3D GI Endoscopy Center Clinic, and the 5B Research Unit, or designated endoscopy center at the San Francisco General Hospital and Trauma Center.

Indications:
Colonoscopy is usually indicated, but not limited to:
1. Colon cancer screening in individuals over age 50 at average-risk for development of cancer.
2. Colon cancer surveillance in individuals who have had a previous history of adenomatous polyps or cancer.
3. Colon cancer surveillance in persons with increased risk for development of cancer (inflammatory bowel disease, personal/family history of colon cancer).
4. Evaluation of the colon for symptoms or signs referable to the colon and/or terminal ileum.
5. Documentation of inflammatory disease of the rectum, colon or small intestine.
6. To determine extent and/or severity inflammatory bowel disease.
7. Presence of occult or overt blood in the stool.
8. Radiographic demonstration of possible neoplasm in the rectum or colon.
9. Malignant or benign neoplastic lesion in the colon and rectum demonstrated by sigmoidoscopy.

Contraindications:
1. Inability to obtain informed patient consent.
2. When patient's cardiovascular status will not permit positioning in a recumbent position.
3. Biopsy/polypectomy in patients with an INR >1.5 or platelets <50,000.
4. Perforated or suspected perforated viscous.

Therapeutic techniques:
The following table outlines endoscopic therapies associated with colonoscopy and the level of attending physician participation within the...
procedure room that is required if a nurse practitioner/physician assistant is performing the endoscopic procedure and such therapy is required.

<table>
<thead>
<tr>
<th></th>
<th>No attending physician required</th>
<th>Attending physician presence required, but NP/PA can perform therapy</th>
<th>Attending physician only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic (no therapy)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biopsy</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Polypectomy for polyps &lt; 1 centimeter (e.g., cold snare, etc.)</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Tattooing for tumor marking</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polypectomy for polyps &gt; 1 centimeter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argon plasma coagulation (APC) therapy</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Saline lift for polypectomy</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement of endoscopic clips</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Endoscopic banding</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Sclerotherapy</td>
<td>X</td>
<td></td>
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<tr>
<td>Inability to complete the procedure</td>
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<td>X</td>
<td></td>
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<tr>
<td>Adverse event that develops during the procedure</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include drug allergies.
   b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
   c. Personal/family history related to the colon, and colorectal disease.

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 guidelines and an attending physician must be physically present and readily available for consultation in the endoscopy center or research unit when a colonoscopy is being performed by an NP/PA.

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

Determine the indication for Colonoscopy

1. Diagnostic Evaluation:
   History and/or physical examination findings suggestive of colorectal pathology.

2. Screening Evaluation:
   The individual is asymptomatic and 50 years of age or over.

3. Preparation:
   Bowel cleaning: utilize departmental approved regimen.
   Aspirin/NSAIDs/antiplatelet/anti-thrombin/Coumadin: will be determined on a case by case basis and in accordance with ASGE guidelines for the Management of Antithrombotic Agents for Endoscopic Procedures. Iron supplementation stopped 7 days prior to exam. No intake by mouth for 8 hours (solids) and 2 hours (clear liquids).

4. Antibiotic prophylaxis for bacterial endocarditis may be indicated for patients with prosthetic heart valves, surgically constructed systemic-pulmonary shunts, or previous history of endocarditis. Need for antibiotic prophylaxis is assessed on a case-by-case basis utilizing current American Society for Gastrointestinal Endoscopy antibiotic prophylaxis recommendations.

D. PLAN

1. Therapeutic Plan
   a. Discuss with patient the objectives, alternatives, limitations, risks and benefits of the procedure.
   b. Patient consent must be obtained before the procedure is performed. A “time out” is performed prior to each procedure to verify the right test is being performed on the right patient.
   c. Biopsied/removed tissue is labeled and sent to pathology.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings.
c. Uncommon, unfamiliar, unstable, and complex patient conditions

d. Upon request of patient, NP, PA, or physician

e. Initiation or adjustment of medication other than those in the formularies.

f. Problem requiring hospital admission or potential hospital admission.

g. Notify consulting physician of any suspected neoplasm (polyp over 10 mm or any suspected cancer) or other diagnostic findings that appear abnormal.

h. Uncontrolled bleeding.

29. Education: Discharge information, instructions and follow-up appropriate to examination findings.

34. Follow-up: Pathology results will be reviewed from patients whom biopsies or polypectomies were performed. The patient will be provided pathology results via the primary care provider, letter, telephone, or an appointment in the GI clinic.

E. RECORD KEEPING

a. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointment and procedure information, if indicated.

b. Document all findings, impression and recommendations in the computerized procedure database. Procedure documentation is automatically exported to the Lifetime Clinical Record (LCR).

F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

<table>
<thead>
<tr>
<th>Prerequisites</th>
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<tbody>
<tr>
<td>A. Specialty Training</td>
</tr>
<tr>
<td>The NP/PA will be able to demonstrate knowledge of the following:</td>
</tr>
<tr>
<td>1. Indications for procedures.</td>
</tr>
<tr>
<td>2. Risks and benefits of procedures.</td>
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<tr>
<td>3. Related anatomy and physiology.</td>
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<tr>
<td>5. Informed consent process.</td>
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<tr>
<td>6. Use of required equipment.</td>
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<tr>
<td>7. Steps in performing procedures.</td>
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<tr>
<td>8. Ability to interpret results and formulate follow-up plans.</td>
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<tr>
<td>10. Ability to recognize a complication.</td>
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<tr>
<td>11. Prostate examination in males 50 years of age and older with referral of significant abnormalities to the Supervising Physician.</td>
</tr>
<tr>
<td>12. The ability to take a medical history, perform a physical</td>
</tr>
</tbody>
</table>
examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.

13. Proof of ACLS certificate

B. Protocol Specific Training
1. View the videotapes from the ASGE Video Library: colonoscopy and polypectomy (GE-10), colonoscopy – insertion to cecum (GE-53), colonoscopy – polypectomy techniques I (GE-54), colonoscopy – polypectomy techniques II (GE-55), colonoscopy polyps and tumors of the colorectum and management of large colorectal polyps (GE-56).
2. Observe and demonstrate by repeat performance the proper set-up, usage and sterilization of the colonoscope and the proper use of the video processor.
3. Read Hospital Policy 19.8" Procedural Sedation: Moderate and Deep" and take test on Procedural Sedation. Learn the GI Division Protocol for moderate sedation, and achieve competency for administration of moderate sedation based on the SFGH privileging process.
4. Learn the use of the clinical software in order to capture procedure images and generate procedure reports.
5. Review appropriate infection control guidelines pertaining to colonoscopy.

Proctoring

Initial Proctoring Period: NP/PA’s will be proctored through direct observation by a GI attending physician credentialed in endoscopy for a minimum of 150 colonoscopy procedures with administration of moderate sedation (including the performance of at least 540 routine colonic mucosal biopsies and 540 colonoscopic polypectomies). An experienced practitioner to colonoscopy requires a minimum of 105 successful observed demonstrations (including the performance of at least 53 colonic mucosal biopsies and 53 colonoscopic polypectomies. As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent colorectal anatomy and pathology. At the conclusion of the standardized procedure training the Clinical Chief of Gastroenterology Medical Director or designated Physician will assess the NP/PA’s ability to practice, including an evaluation of the NP/PA’s clinical skills in taking a history, performing an appropriate physical examination, obtaining informed consent, the ordering and interpretation of laboratory and radiographic studies pertinent to the specific clinical situation, documentation of an endoscopic procedure and initiating a treatment plan.

Competency in Performing Standardized Procedure
a. Review of the post test of Education Module by the Clinical Chief of Gastroenterology Medical Director.
b. Review of 7550 procedure notes by the Clinical Chief of Gastroenterology.

Reappointment Competency
1. Biannual Evaluation (every 6 months):
   a. Review will include chart review, collaboration with and eliciting information from attending physicians and advanced practice staff.
   b. Ongoing competency will include the successful observed completion of ten (10) colonoscopies, five (5) colonoscopies with mucosal biopsy's and five (5) colonoscopic polypectomies procedures.
   c. One (1) direct observation of NP/PA patient clinic encounters will be conducted by the Medical Director or other designated attending physicians.
   d. 203 chart reviews.
   e. Maintenance of ACLS Certification.
   f. Passing of Procedural Sedation test with passing score of 80%.
   g. Review of any adverse event(s) that occurred during a colonoscopy.
   h. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of a colonoscopy.
   i. Successful achievement of all OPPE metrics with no identified deficiencies.
   j. Documentation of required continuing medical education (CME).
Protocol #13 Procedure: Esophagogastroduodenoscopy (EGD)  (Requires ACLS certification)

A. DEFINITION

EGD is the examination of the esophagus, stomach and proximal duodenum through the use of a flexible video scope. It is performed as a screening measure, as a diagnostic tool and for research purposes. For the purposes of this protocol, these examinations are conducted at the 3D GI Endoscopy Center, and 5B Research Unit, or designated endoscopy center at the at San Francisco General Hospital and Trauma Center.

Indications:
1. Evaluation of the esophagus, stomach or duodenum for symptoms or signs referable to the upper gastrointestinal tract.
2. Presence of occult or overt blood in the stool.
3. Performance of endoscopic biopsies for research purposes.

Contraindications:
1. Inability to obtain informed patient consent.
2. When patient’s cardiovascular status will not permit positioning in a recumbent position.
3. Biopsy/polypectomy is contraindicated in patients with an INR >1.5 or platelets <50,000.
4. Perforated or suspected perforated viscous.

Therapeutic techniques:

The following table outlines endoscopic therapies associated with upper endoscopy (e.g. EGD) and the level of attending physician participation within the procedure room that is required if a nurse practitioner/physician assistant is performing the endoscopic procedure and such therapy is required.

<table>
<thead>
<tr>
<th>Therapy</th>
<th>No attending physician required</th>
<th>Attending physician presence required, but NP/PA can perform therapy</th>
<th>Attending physician only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic (no therapy)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biopsy</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polypectomy for polyps &lt; 1 centimeter</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polypectomy for polyps &gt; 1 centimeter</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Argon plasma coagulation (APC) therapy
Placement of endoscopic clips
Endoscopic banding
Sclerotherapy
Inability to complete the procedure
Adverse event that develops during the procedure

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include drug allergies.
   b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
   c. Family history related esophageal, gastric or intestinal disease.

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 guidelines and an attending physician must be physically present and readily available for consultation at the endoscopy center or research unit when upper endoscopy is being performed by an NP/PA.
   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

Determine the indication for EGD:

1. Diagnostic Evaluation:
   History and/or physical examination findings suggestive of esophageal, gastric or duodenal pathology.

2. Preparation:
   a. No intake by mouth for 86 hours (solids) and 2 hours (clear liquids).
   b. Aspirin/NSAIDs/antiplatelet/anti-thrombin/Coumadin: will be determined on a case by case basis and in accordance with ASGE guidelines for the Management of Antithrombotic Agents for Endoscopic Procedures. Aspirin/NSAIDs stopped 7 days prior to exam.
   c. Antibiotic prophylaxis:
Need for prophylaxis is assessed on a case-by-case basis utilizing current American Society for Gastrointestinal Endoscopy (ASGE) antibiotic prophylaxis recommendations.

D. PLAN

1. Therapeutic Plan
   a. Discuss with patient the objectives, alternatives, limitations, risks and benefits of the procedure.
   b. Patient consent must be obtained before the procedure is performed. A "time out" is performed prior to each procedure to verify the right test is being performed on the right patient.
   c. Biopsy tissue/specimens are labeled and sent to pathology.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings.
   c. Uncommon, unfamiliar, unstable, and complex patient conditions.
   d. Upon request of patient, NP, PA, or physician.
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.
   g. When ordering complex imaging studies or procedures.
   h. Notify consulting physician of any suspected neoplasm (polyp over 10 mm or any suspected cancer) or other diagnostic findings that appear abnormal.
   i. Uncontrolled bleeding.

3. Education: Provide discharge instructions and follow-up that is appropriate to examination findings.

4. Follow-up: Pathology results will be provided to patients by the primary care provider, via telephone, letter or provided an appointment in the GI clinic.

E. RECORD KEEPING

a. Provide patient with discharge instructions at the end of the procedure, as well as any follow-up appointments and procedure information, as indicated.

b. Document all findings, impression and recommendations in the computerized procedure database. Procedure documentation is automatically exported to the Lifetime Clinical Record (LCR).
### F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

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<tbody>
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<td>The NP/PA will be able to demonstrate knowledge of the following:</td>
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</tr>
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<td>2. Risks and benefits of procedures.</td>
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<td>3. Related anatomy and physiology.</td>
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<tr>
<td>5. Informed consent process.</td>
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<tr>
<td>6. Use of required equipment.</td>
</tr>
<tr>
<td>7. Steps in performing procedures.</td>
</tr>
<tr>
<td>8. Ability to interpret results and formulate follow-up plans.</td>
</tr>
<tr>
<td>10. Ability to recognize a complication.</td>
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<tr>
<td>11. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Protocol Specific Training</th>
</tr>
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<tbody>
<tr>
<td>1. View the videotapes from the ASGE Video Library: Upper GI Endoscopy (Video 5 of series: Fundamentals of Endoscopic Techniques), UGI Strictures: Benign and Malignant (GE-18), Upper GI Bleeding (GE-35), Upper GI Disorders (GE-36), Duodenoscopic Differentiation of Various Ampullary Lesions (GE-49)</td>
</tr>
<tr>
<td>2. Observe and demonstrate by repeat performance the proper set-up, usage and sterilization for the upper endoscope and the proper use of the video processor.</td>
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<tr>
<td>3. Read hospital policy 19.8 “Procedural Sedation: Moderate and Deep”. Learn the GI Division Protocol for procedural sedation, and achieve competency for administration of procedural sedation by passing Procedural Sedation test with a passing score of 80%.</td>
</tr>
<tr>
<td>4. Learn the use of the endoscopic documentation clinical software in order to capture procedure images and generate procedure reports.</td>
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<tr>
<td>5. Review appropriate infection control guidelines pertaining to EGD.</td>
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</table>

<table>
<thead>
<tr>
<th>Proctoring</th>
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</thead>
<tbody>
<tr>
<td><strong>Initial Proctoring Period:</strong> NP/PA’s will be proctored through direct observation</td>
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</table>
by a GI attending staff physician credentialed in endoscopy for a minimum of 1530 diagnostic EGD with administration of moderate sedation. An experienced NP/PA to EGD is required to perform a minimum of 15 successful observed demonstrations. As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent nasopharyngeal, esophageal and stomach anatomy and pathology. At the conclusion of the standardized procedure training the Medical Director Clinical Chief of Gastroenterology or designated Physician will assess the NP/PA's ability to practice, including an evaluation of the NP/PA's clinical skills in taking a history, performing an appropriate physical examination, obtaining informed consent, the ordering and interpretation of laboratory and radiographic studies pertinent to the specific clinical situation, documentation of an endoscopic procedure and initiating a treatment plan.

Competency in Performing Standardized Procedures
a. Review of the post test of Education Module by the Medical Director.
b. Review of 7550 procedure notes by the Clinical Chief of Gastroenterology.

Reappointment

Reappointment Competency
1. Biannual Evaluation:
   a. Review will include chart review, collaboration with and eliciting information from attending physicians and advanced practice staff.
   b. Ongoing competency will include the successful observed completion of ten (10) upper endoscopies and five (5) upper endoscopies with mucosal biopsy's.
   c. 20 chart reviews.
   d. Maintenance of ACLS Certification.
   e. Passing of Procedural Sedation test with passing score of 80%.
   f. Review of any adverse event(s) that occurred during an upper endoscopy.
   g. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of an upper endoscopy.
   h. Successful achievement of all OPPE metrics with no identified deficiencies.
   i. Documentation of required continuing medical education (CME)
      1. Ongoing competency will include the successful observed completion of three EGD procedures every 2 years.
      2. Direct observation of 3 patient clinic encounters will be conducted by the Medical Director or other designated attending physicians every 2 years.
      4. Passing Procedural Sedation test with a passing score of 80%.
Protocol #14: Procedure: Esophageal Manometry and Prolonged Ambulatory pH-Monitoring (ACLS required)

A. DEFINITION
Esophageal manometry is the clinical evaluation of esophageal contractile activity, and is performed to assess esophageal motor function (often preoperatively) and for the diagnosis of suspected esophageal motor disorders. The study measures the strength, function, and coordination of the upper and lower esophageal sphincters (UES and LES, respectively), and the body of the esophagus in response to swallows. Recordings are made of the amplitude and coordination of contractions within the pharynx and esophagus. Ambulatory Esophageal pH monitoring (24-hour pH probe) is sometimes performed in conjunction with esophageal manometry. During this procedure, an intra-nasal catheter is placed in reference to the manometrically-defined lower esophageal sphincter, and records acid reflux events over a 24-hour period. Esophageal manometry is conducted in the 3D-GI Endoscopy Center Clinic at San Francisco General Hospital and Trauma Hospital. Ambulatory Esophageal pH catheters are inserted in 3D-GI and the patient carries the recording unit and catheter at home for a 24 hour period. After 24 hours the probe is removed on 3D-GI.

Indications:
Esophageal Manometry is usually indicated, but not limited to:
1. Evaluation of suspected esophageal motor dysfunction, such as esophageal spasm, achalasia, or the ‘nutcracker’ esophagus.
2. Evaluation of patients with unexplained (‘non-cardiac’) chest pain or dysphagia.
3. Preoperative evaluation of esophageal motor function prior to esophageal/gastric surgery.
5. Evaluation of patients with neuromuscular disorders affecting esophageal function and/or swallowing (e.g., scleroderma, muscular dystrophy, and strokes).
6. Evaluation of patients with symptoms that may represent reflux disease, such as chronic cough, asthma, hoarseness.
7. Evaluation of patients with unexplained (‘non-cardiac’) chest pain.
8. Preoperative evaluation of esophageal reflux prior to esophageal/gastric surgery.
9. Assess reflux patients not responding to standard medical/pharmacologic therapy.

Contraindications to Esophageal Manometry/pH Monitoring:
1. Inability to obtain informed patient consent.
2. Undiagnosed potential trauma to the nasal passages, nasopharynx, oropharynx, esophagus and/or the stomach.
3. When patient’s health status/physical limitations will not permit placement of a flexible catheter through the nose and/or into the esophagus.

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include diet, medications, and allergies.
   b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
   c. Family history to include peptic ulcer disease (PUD), cancer, diabetes.

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) and an attending physician must be physically present and readily available for consultation on the endoscopy center or research unit when an esophageal manometry is being performed by an NP/PA.
   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
1. Obtain patient’s medical history to determine indications for esophageal manometry and/or pH monitoring.
2. Preparation: Patient is to be NPO after midnight before the procedure.

D. PLAN
1. Therapeutic Treatment Plan
   a. Discuss with patient the objectives, alternatives, risks and benefits of the procedure.
   b. Verify NPO status so that procedure can be performed in a safe and appropriate manner.
   c. Obtain informed consent, utilizing interpreter services as necessary.

2. Patient conditions requiring Attending Consultation:
   a. Emergent conditions requiring prompt medical intervention.
   b. Acute decompensation of the patient.
   c. Historical, physical or diagnostic findings that seem unusual.
   d. A problem, which is not resolving as anticipated.
   e. Upon request of patient, NP, PA, or physician
f. Initiation or adjustment of medication other than those in the formularies.
g. Problem requiring hospital admission or potential hospital admission.
h. When ordering complex imaging studies or procedures.

3. Education: Discharge information, instructions and follow-up appropriate to examination findings.

4. Follow-up: Patients will be evaluated in the appropriate gastroenterology clinic to follow up on the results of pH and manometry tests.

E. RECORD KEEPING
   1. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointments and procedure information, if any.
   2. Document all findings in the computerized procedure database. Procedure documentation is automatically exported to the Lifetime Clinical Record (LCR).

F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

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<td>1. Indications for procedures.</td>
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<td>2. Risks and benefits of procedures.</td>
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<tr>
<td>3. Related anatomy and physiology.</td>
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<tr>
<td>5. Consent process.</td>
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<tr>
<td>6. Use of required equipment.</td>
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<td>7. Steps in performing procedures.</td>
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<td>8. Ability to interpret results and formulate follow-up plans.</td>
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<tr>
<td>10. Ability to recognize a complication.</td>
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<td>11. Ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.</td>
</tr>
<tr>
<td>13. Observe and demonstrate by repeat performance the set-up, calibration, and operational procedures for esophageal Manometry and pH catheter assembly.</td>
</tr>
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</table>
### 14. Possession of an ACLS Certificate

**Proctoring**

NP/PA’s will be proctored through direct observation by GI attending staff credentialed in endoscopy for a minimum of 5 esophageal manometry and pH monitoring procedures prior to performing such procedures independently, whereas an experienced practitioner to the procedure will require a minimum of 3 successful observed demonstrations. As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent nasopharyngeal, esophageal and stomach anatomy.

**Competency in Performing Standardized Procedures**

- a. Review of the post test of Education Module by the Medical Director.
- b. Review of 20 procedure notes by the Clinical Chief of Gastroenterology.

**Reappointment Competency**

1. Evaluation:
   - a. Ongoing competency will include completion of \( \text{five} \times 2 \) (52) esophageal Manometry and pH monitoring procedures every 2 years.
   - b. Direct observation of 2 NP/PA patient clinic encounters will be conducted by the Medical Director or other designated attending physicians every two years.
   - c. Review of any adverse event(s) that occurred during an esophageal manometry.
   - d. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of an esophageal manometry.
   - e. Successful achievement of all OPPE metrics with no identified deficiencies.
   - f. Documentation of required continuing medical education (CME)
Protocol #15: Procedure: Exercise Treadmill Test (ACLS required)

A. DEFINITION

This test is to use incremental exercise modality to diagnose, evaluate and assess the following:

a. Aid in the diagnosis of coronary artery disease
b. Evaluate severity of ischemia in patients with known coronary artery disease (angina, post infarction, positive angiogram, post-AC bypass or PCI).
c. Effort tolerance (EKG may or may not be normal)
d. Chronotropic competence
e. Exercise BP
f. Exercised - induced arrhythmia

1. Location to be performed: This test will be done in: Cardiology outpatient setting.

2. Patient preparation
a. Patient must be able to walk unassisted (i.e. without cane or other aid).
b. For patients who had chest pain, when in the Emergency Department, must have had a negative troponin test.
c. Nothing by mouth if test is done in AM, light meal for PM.
d. Stop smoking one hour prior the test.
e. Hold anti-glycemic medication prior the test as indicated.
f. For the purpose of diagnosis of CAD, beta-blockers should be discontinued 24-36 hours prior the test, if possible.

3. Performance of procedure
a. Precautions: Never push the patient above his/her exercise capability.
b. Contraindications
   1. Severe or critical aortic stenosis
   2. Unstable angina with rest
   3. Suboptimum treated congestive hearth failure
   4. Pericarditis
   5. Uninterruptible ECG for any reason, e.g. LVH, LBBB or WPW
   6. Patient with murmur, unknown reason
   7. Uncontrolled HTN (Baseline SBP>180

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 myocardial ischemia during the exercise treadmill test.

D. PLAN

1. Therapeutic Treatment Plan
   a. Diagnostic tests for purposes of disease identification.
   b. Screening tests performed as part of appropriate health maintenance.
   c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   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, laboratory or study 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
   a. Patient education as appropriate to procedure
   b. 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. There will be documentation of all vital signs, blood pressure, heart rate, oxygen saturation, as well as any symptomatology during testing. All changes in 12 lead EKG during procedure will be documented. The attending cardiologist will complete final reading and sign the report in the LCR. 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

<table>
<thead>
<tr>
<th>Prerequisites:</th>
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<tbody>
<tr>
<td>a. Review of departmental policy and procedure.</td>
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<tr>
<td>b. Two direct observations of procedure being performed by a qualified provider.</td>
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<tr>
<td>c. Completion of a 12 lead EKG Course or completion of 12 lead EKG training by qualified Cardiology staff.</td>
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<tr>
<th>Proctoring Period:</th>
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<tr>
<td>a. 3 successful observed demonstrations for provider new to this procedure.</td>
</tr>
<tr>
<td>b. 2 successful demonstrations for provider experienced in this procedure.</td>
</tr>
<tr>
<td>c. Chart review of all observed cases.</td>
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<thead>
<tr>
<th>Reappointment Competency Documentation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Perform 2 procedures every 2 years.</td>
</tr>
<tr>
<td>b. 2 chart reviews every 2 years.</td>
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</table>
Protocol #16 Procedure: High Resolution Anoscopy

A. DEFINITION
Men and women with abnormal anal pap smears will be evaluated by high resolution anoscopy (HRA) with biopsy of suspicious lesions and treatment or referral as indicated.

1. Location to be performed: Positive Health Clinic.

2. Performance of procedure:
   i. Indications: Patients with abnormal anal pap smears, anal lesion visible by gross examination or a history of anal warts or anal dysplasia.
   ii. Precautions/Contraindications: Consult an MD before performing biopsies on patients with Thrombocytopenia, Neutropenia, infection of anal canal, use of anti coagulants, history of abnormal heart valve or endocarditis.

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.
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. As specified under precautions.
   b. Upon request of patient, NP, PA, or physician
   c. Initiation or adjustment of medication other than those in the formularies.
   d. 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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<th>Prerequisite:</th>
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<tbody>
<tr>
<td>a. Completion of a one week course in theory and practice of cervical colposcopy from the University of California or a recognized university.</td>
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<tr>
<th>Proctoring:</th>
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<tbody>
<tr>
<td>a. Performance of 50 high resolution anoscopy procedures (anal colposcopy with biopsy) under supervision of an experienced colposcopist.</td>
</tr>
<tr>
<td>b. Review of 3 medical records.</td>
</tr>
</tbody>
</table>
Reappointment Competency Documentation:
  a. Minimum of 20 procedures that must be completed every two years.
  b. Minimum of 3 chart reviews needed every two years.
Protocol #17: Procedure: Incision and drainage of skin abscesses with administration of local anesthesia

A. DEFINITION
Abscesses resolve with drainage. Abscesses that do not respond to more conservative measures may need incising in order to facilitate drainage and hasten resolution. For the purposes of this protocol, the procedure may be completed in the Positive Health Clinic and in the Emergency Department.

1. Performance of procedure.
   a. Indications:
      Palpable, fluctuant skin abscesses
   b. Precautions:
      Large abscesses that require extensive incising or debridement
   c. Contraindications:
      1. Deep abscesses that may require more extensive anesthesia
      2. Abscesses that invade the palmar or plantar spaces
      3. Suspected pseudo aneurysm (must be ruled out by further diagnostic evaluation)
   d. Exclusions:
      Abscesses on the face, neck, perirectal area, and genitalia

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   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 and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical, or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. 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 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

<table>
<thead>
<tr>
<th>Prerequisite:</th>
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<tbody>
<tr>
<td>a. The NP/PA will be trained to successfully perform the procedure through instruction and proctoring by the Medical Director or his/her designee.</td>
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</table>

<table>
<thead>
<tr>
<th>Proctoring:</th>
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<tbody>
<tr>
<td>a. New practitioner to procedure, a minimum of 2 successful observed demonstrations.</td>
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<tr>
<td>b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstrations.</td>
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<tr>
<td>c. Chart review of all observed procedures.</td>
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<tr>
<th>Reappointment Competency:</th>
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<tbody>
<tr>
<td>a. The number of procedures needed to maintain proficiency will be 1 procedure every 2 years.</td>
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<tr>
<td>b. The number of chart reviews needed to monitor ongoing competency for annual review will be 1 chart every 2 years.</td>
</tr>
</tbody>
</table>
Protocol #18: Procedure: Intraperitoneal Chemotherapy

A. Definition – The administration of chemotherapy into the peritoneal cavity through a catheter, placed by interventional radiology, specially designed for removing or adding fluid from the peritoneum or through an implanted port.
   1. Performed in the 4C Infusion Center and in the Hematology/Oncology Clinic.
   2. Performance of procedure:
      a. Indications: for administration of chemotherapy into the peritoneal cavity through implanted port, drainage of peritoneal fluid in patients experiencing ascites, and collection of peritoneal fluid for cytology.

B. Data Base
   1. Subjective Data
      a. History and review of symptoms relevant to the presenting complaint and/or disease process.
      b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
   2. Objective Data
      a. Physical exam appropriate to presenting symptoms.
      b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

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, and uncontrolled).

D. Plan
   1. Therapeutic Treatment Plan
      a. Obtain informed consent prior to procedure and according to hospital policy.
      b. Time out performed per hospital policy.
      c. Cytology may be sent periodically for evaluation of disease.
   2. Patient conditions requiring attending consultation:
      a. Acute decompensation of patient during procedure,
      b. Upon the request of patient, NP, PA or physician.
3. Education  
Appropriate and relevant patient and family education/counseling in written and/or verbal format.

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

E. Documentation  
Post-procedure note recorded in the medical record and LCR as appropriate and will include informed consent. 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 that 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

<table>
<thead>
<tr>
<th>Prerequisite</th>
<th>Training will be through direct observation of clinical director or physician/NP designee.</th>
</tr>
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</table>
| Proctoring Period | a. New practitioners will have a minimum of 3 successful observed demonstrations and experienced practitioners will have a minimum of 2 successful observed demonstrations.  
b. Chart review of all observed cases. |
| Reappointment | a. A minimum number of 2 procedures every 2 years to maintain proficiency.  
b. If minimum number of procedures is not completed within given time period, the NP/PA will be proctored through 1 successful procedure.  
c. Two chart reviews needed to monitor ongoing competency every 2 years. |
Protocol #19: Procedure: Intraventricular Chemotherapy Administration via Ommaya Reservoir

A. Definition - The administration of chemotherapy via Ommaya Reservoir into cerebrospinal fluid (CSF) for treatment of previously diagnosed central nervous system (CNS) involvement by leukemia and lymphoma or other malignancies. The procedure is also used for withdrawal of CSF for laboratory analysis in patients with known CNS malignancy.

1. May be performed in the Hematology/Oncology Clinic or the 4C Infusion Center.
   i. Indications
      a. Patients with surgically implanted Ommaya reservoir and recent diagnosis or history of CNS malignancy.
      b. Patients with Ommaya reservoir and meningeal signs or symptoms such as nuchal rigidity and headaches, without evidence of increased intracranial pressure.
      c. Withdrawal of CSF may be done as part of evaluation of fever (as indicated) in patients with Ommaya reservoir.
   ii. Precautions
      a. Precautions: Evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, papilledema, bulging Ommaya or significant decrease in the level of consciousness; evidence of focal neurological findings.
   iii. Contraindication: Cutaneous infection as the site of puncture.

B. Data Base:

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.
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, and uncontrolled).

D. Plan
1. Therapeutic Treatment Plan
   a. Obtain informed consent prior to procedure and according to hospital policy.
   b. Time out performed according to hospital policy.
   c. CSF may be sent for evaluation for infection or malignancy.

2. Patient conditions requiring attending consultation:
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings.
   c. Initiation or adjustment of medication other than those in the formularies.

3. Education
   a. Appropriate and relevant patient and family education/counseling in written and/or verbal format.

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

E. Documentation
Post-procedure note recorded in the medical record in addition to consent forms and other procedure specific documents 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 PA 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

<table>
<thead>
<tr>
<th>Prerequisite</th>
<th>Training will consist of instruction by clinical directors or physician/NP designee.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proctoring Period</td>
<td>a. Proctoring period for new practitioners will be a minimum of 3 successful observed demonstrations within the proctoring period, if there are insufficient opportunities within the proctoring period, and then procedure will be supervised until the minimum requirement is met.</td>
</tr>
<tr>
<td>Reappointment</td>
<td>a. A minimum of 2 procedures within a 2 year period. If no opportunities occur within a 2 year period, provider will be supervised for 1 additional procedure when the opportunity occurs.</td>
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<td></td>
<td>b. 2 chart reviews every 2 years.</td>
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Protocol # 20: Procedure: Lumbar Puncture

A. DEFINITION
A diagnostic procedure used to identify infectious and neoplastic processes of the central nervous system. Lumbar puncture is also used to administer diagnostic as well as therapeutic agents. Lumbar puncture can also be done to determine the intracranial pressure.

1. Location to be performed: Inpatient Units and the Hematology/Oncology Clinic.

2. Performance of Lumbar Puncture
   a. Indications
      Lumbar puncture should be performed 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).
      1. To obtain Cerebral Spinal Fluid (CSF) for diagnosis of infectious, inflammatory or neoplastic diseases
      2. To administer diagnostic and therapeutic agents/drugs such as antibiotics, chemotherapeutic agents, and radiographic isotopes
   b. Precautions
      Indications for brain CT scan prior to LP include the following
      1. Age >60 years
      2. Immune compromised patients
      3. Known CNS lesions
      4. Recent seizure activity
      5. Abnormal level of consciousness
      6. Focal findings on neurological examination
   c. Contraindications
      1. Increased Intracranial Pressure
      2. Soft tissue infection at the entry site
      3. Coagulopathy
      4. Known spinal cord arteriovenous malformations
      5. Patient refusal
B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed including but not limited to presence of headache or meningitic symptoms, motor/sensory deficits, and new/persistent CSF leak.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-containing-products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination, assessment of papilledema, and integrity of the lumbar skin site.
   b. The procedure is performed following standard medical technique according to The Handbook of Neurosurgery by Mark Greenberg, Section 23.7.3. Lumbar Puncture.
   c. Laboratory evaluation to include CBC with platelets, PT, PTT, and INR. Imaging evaluation, including CT head to rule out a mass lesion, a posterior fossa lesion, or subarachnoid hemorrhage, as indicated by history and physical 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. Differential diagnoses would include meningitis, encephalitis, sarcoidosis, subarachnoid hemorrhage, meningeal carcinomatosis, increased intracranial pressure, and decreased intracranial pressure.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent, consistent with hospital policy, obtained before procedure is performed.
   b. Timeout conducted consistent with hospital policy.
   c. Diagnostic tests on the CSF for purposes of disease identification may include protein level, glucose level, gram stain, culture and sensitivity, blood cell count and differential, and measurement of CSF pressure. Additional diagnostic tests may include: cytologic testing, staining for
AFB, cryptococcal antigen, serologic testing for syphilis, lyme disease, viral titers, immunoglobulin profiles, and oligoclonal banding.

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 will receive Attending Consultation

3. Education
   a. Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print outs titled “Lumbar Puncture” and “Having a Lumbar Puncture” can be provided to patients to assist with pre- and post-procedural education.

4. Follow-up
   As appropriate for lumbar puncture.

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.

Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisite</th>
<th>Proctoring</th>
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</thead>
<tbody>
<tr>
<td>a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this minor procedure.</td>
<td>a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations</td>
</tr>
<tr>
<td>b. Completion of onsite training by qualified provider if no prior experience.</td>
<td>b. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations</td>
</tr>
</tbody>
</table>
Reappointment

a. The evaluator will be the Clinical Service Chief or another designated physician that has unrestricted privileges to perform lumbar punctures

b. Ongoing Competency Evaluation
   1. 3 Lumbar Punctures will be needed to maintain proficiency every 2 years.
   2. One chart review will be needed every 2 years.
Protocol #21 Procedure: - Lumbar puncture with the Administration of Intrathecal Chemotherapy

A. Definition – The lumbar puncture (LP) may assist in diagnosis of central nervous system (CNS) infections, malignancies and subarachnoid hemorrhage. The LP also facilitates the intrathecal administration of chemotherapy into CSF in previously diagnosed lymphoma and leukemia patients with CNS involvement or high risk for CNS involvement.

1. Location of procedure may include the Hematology/Oncology Clinic, 4C Infusion Center and fluoroscopy room in Radiology.
   a. Indications - Patients with recent diagnosis of CNS malignancy, history of CNS malignancy, therapy related complications of the CNS, or signs and symptoms of infections of the CNS, acute leukemia or lymphoma (as staging or CNS prophylaxis).

b. Precautions/Contraindications:
   - Patients with evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, altered mental status, or focal neurological deficits should undergo a neuroimaging study before a LP is performed and requires physician consultation.
   - New focal neurologic findings and/or lesions, or imaging studies revealing significant mass effect. Requires physician consultation.
   - Use caution with patients with a history of low back pain, sciatica pain, or lower extremity neuralgia. Any patients with prior back surgery shall be evaluated by the attending physician prior to the procedure.
   - Patients with meningeal signs or symptoms, such as nuchal rigidity and headache with or without evidence of increased intracranial pressure, fever or altered mental status should be done in the hospital after appropriate CT scanning and prior physician consultation.
   - Patients with either thrombocytopenia (platelet count less than 30,000), INR >/= 2.0 or PTT >/= 55 sec. Consult with physician before performing the procedure. Patients may require additional studies or blood products to correct the platelet count and/or coagulation factor deficiencies.

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, hospitalizations, habits, current medications including aspirin, aspirin-containing products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis
   Assessment of data from the subjective and objective findings to identify disease processes.

D. Plan
   1. Therapeutic Treatment Plan
      a. Obtain informed consent prior to procedure and according to hospital policy.
      b. Time out performed per hospital policy.
      c. Diagnostic tests for clarification of disease state or infection.
      d. Initiation or adjustment of medication per chemotherapy order writing protocol.
   2. Patient conditions requiring attending physician consultation
      a. Acute decompensation of patient.
      b. Unexplained physical or laboratory findings
      c. Upon request of patient, NP, PA or physician
   3. Education
      Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print outs titled "Lumbar Puncture" and "Having a Lumbar Puncture" can be provided to patients to assist with pre and post-procedural education.
   4. Follow-up
      As indicated and appropriate to client health status and diagnosis.

E. Documentation
   Post-procedure note recorded in the medical record and LCR as appropriate and will include all necessary documentation. 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 PA 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

<table>
<thead>
<tr>
<th>Prerequisites</th>
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<tbody>
<tr>
<td>a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this minor procedure.</td>
</tr>
<tr>
<td>b. Completion of onsite training by a qualified provider if no prior experience.</td>
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<table>
<thead>
<tr>
<th>Proctoring</th>
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<tbody>
<tr>
<td>a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations.</td>
</tr>
<tr>
<td>b. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations.</td>
</tr>
<tr>
<td>c. A minimum of 2 chart reviews.</td>
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<tr>
<th>Reappointment</th>
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<tbody>
<tr>
<td>a. The evaluator will be the Clinical Service Chief or another designated physician that has unrestricted privileges to perform lumbar punctures.</td>
</tr>
<tr>
<td>b. Ongoing Competency Evaluation</td>
</tr>
<tr>
<td>1. 2 Lumbar Punctures will be needed every 2 years.</td>
</tr>
<tr>
<td>2. 1 chart review will be needed every 2 years.</td>
</tr>
</tbody>
</table>
Protocol #22: Procedure: Procedural Sedation (ACLS required)

A. DEFINITION
Procedural Sedation/Analgesia: is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light or tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation (SFGH policy number 19.8 titled, “Procedural Sedation: Moderate and Deep”) by the Nurse Practitioner/Physician Assistant during procedures in adults within a monitored setting. For the purpose of this protocol, the setting is specifically in the Gastroenterology Department. The Nurse Practitioner/Physician Assistant practices under the supervision of the Chief of Gastroenterology or designee. Practitioners producing a level of sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes, and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedure may only be done in 3D GI Service or in the 5B Research Unit.

Materials necessary for procedural sedation and rescue include:
  a. Appropriate monitoring equipment.
  b. Emergency medications and equipment for care and resuscitation, including cardiac defibrillator must be immediately available. Medications include, but are not limited to reversal agents (naloxone and flumazenil) and vasoactive medications (phenylephrine and dopamine).
  c. Supplemental oxygen and positive pressure ventilation equipment.
  d. Suction equipment/supplies.
  e. Intravenous access.

Indications:
  a. Procedural sedation may be indicated, but not limited to colonoscopy and esophagogastroduodenoscopy (EGD).

Precautions/Contraindications:
  a. Inability to obtain informed patient consent.
  b. Anticipated difficult intubation.
  c. The patient’s American Society of Anesthesiologists (ASA) physical status; consultation with Anesthesia Service should be considered for patients who have an ASA score of 3 or above. A procedure requiring sedation would not be done on a patient with an ASA score above a three (3) without anesthesia assistance.
d. When the patient’s cardiovascular status will not permit positioning in a recumbent position.

e. Undiagnosed potential trauma to the gastrointestinal tract.

B. DATA BASE
1. Subjective Data
   a. Obtain a history within 7 days of the procedure and sedation.
   b. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
   c. Pertinent past medical history, surgical history, hospitalizations, habits, anesthetic, allergy and drug history.

2. Objective Data
   a. Physical exam within 7 days of procedure and sedation. The exam is to include airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight), and IV access.
   b. Diagnostic data, as appropriate.
   c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.
   d. Laboratory and imaging results, as indicated, relevant to the history and physical exam.

C. DIAGNOSIS/ASSESSMENT
1. A judgment as to the appropriateness of the procedure and safety of sedation for the particular patient, that includes consideration of the patient’s age, medical condition, and the procedure and sedation side effects and risks.
2. Assignment of an ASA physical status. Patients with a Physical ASA class of IV or V will not undergo conscious sedation by the Nurse Practitioner/Physician Assistant in the Gastroenterology Department.
3. Assignment of the pre-procedure Modified Aldrete Score.
4. Evidence of verification of compliance with the NPO status (adult: minimum 6 hours (solids) and 2 hours (liquids) before procedure to decrease risk of aspiration).
5. Assess and document the benefits of sedation against the risk of possible aspiration.
6. A responsible adult is available to take the patient home after the procedure.

D. PLAN
1. Therapeutic Treatment Plan shall follow SFGH policy number 19.8 titled “Procedural Sedation: Moderate and Deep”
   a. Informed consent for the procedure and sedation must be obtained and documented by the nurse practitioner/physician assistant prior to the delivery of sedation. The consent form must
list the procedure to be performed as well as the sedation planned.

b. Pre-Procedure patient education shall be given and documented, to include, but not be limited to:
   1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
   2. Risks, benefits, and alternatives.
   3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
   4. Date/time of procedure.
   5. Necessity of an escort for discharge to home and/or an appropriate mode of transportation home.

c. Re-assessment immediately prior to the procedure to include:
   1. Indication for procedure.
   2. Two patient identifiers.
   3. A "time out" documented.
   4. Vital signs (blood pressure, heart rate and oxygen saturation).
   5. An assessment of level of movement and consciousness, and responsiveness.

d. The Procedure:
   1. Verify pre-procedure assessment and monitoring guidelines.
   2. Administer appropriate medications as indicated.
   3. Continuously assess the patient's response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, and pain level).
   4. Cardiac monitoring if patient has any cardiac history.
   5. Reversal agents, if indicated.

e. Post-procedure
   1. Monitor level of consciousness, respiratory and cardiovascular parameters, and pain level.

f. Termination of Treatment
   1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.

2. Patient conditions requiring Attending Consultation
   a. Physical ASA status 3 or above.
   b. Aspiration.
   c. Acute decompensation of patient situation.
   d. Unexplained historical, physical or laboratory findings.
   e. Upon request of patient, NP, PA, or physician.
   f. Problem requiring hospital admission or potential hospital admission.
3. Education
Patient will be instructed on signs and symptoms of complications. A 24 hour emergency advice number will be given to the patient for any post-procedural problems. Examination findings/pathology results will be provided to the patient by the primary care provider, telephone, or during an appointment in the GI Clinic.

4. Follow-up
A. If the patient is transferred to the recovering unit:
   1. The patient must be accompanied by trained and/or licensed personnel.
   2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:
      a. The procedure performed.
      b. The condition of the patient; including pain score.
      c. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
      d. Any significant clinical events occurring during and post-procedure.
      e. Any additional physician orders relating to the post-procedural/moderate sedation care.

B. Any patient receiving a reversal agent (narcan or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re-sedation. In addition an Unusual Occurrence Report must be completed.

C. The outpatient is discharged “to home”:
   1. By a specific discharge order from a physician or nurse practitioner/physician assistant; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.
   2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
   3. Outpatients who are discharged to home must be accompanied by a responsible adult and have an appropriate mode of transportation.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the Medical record and LCR as appropriate. The patient status and compliance with discharge criteria must be documented in the patient’s medical record by the physician, nurse practitioner, physician assistant, or registered nurse discharging the patient. Document all findings in the computerized procedure
database. Procedure documentation is automatically exported to the Lifetime Clinical Record (LCR).

F. Summary of prerequisites, proctoring & reappointment of competency

<table>
<thead>
<tr>
<th>Prerequisites</th>
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<tbody>
<tr>
<td><strong>A. Specialty Training</strong></td>
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<tr>
<td>The NP/PA will be able to demonstrate knowledge of the following:</td>
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<tr>
<td>1. Indications for procedures.</td>
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<tr>
<td>2. Risks and benefits of procedures.</td>
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<td>3. Related anatomy and physiology.</td>
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<td>5. Informed consent process.</td>
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<tr>
<td>6. Use of required equipment.</td>
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<tr>
<td>7. Steps in performing procedures.</td>
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<tr>
<td>8. Ability to interpret results and formulate follow-up plans.</td>
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<tr>
<td>10. Ability to recognize a complication.</td>
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<tr>
<td>11. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.</td>
</tr>
<tr>
<td><strong>B. Training Program</strong></td>
</tr>
<tr>
<td>1. Completion of the SFGH Procedural Sedation Test with a passing score of 80%.</td>
</tr>
<tr>
<td>2. Completion of Advanced Cardiac Life Support (ACLS) training.</td>
</tr>
<tr>
<td>3. Completion of the Registered Nursing Moderate Sedation Education Module.</td>
</tr>
<tr>
<td>4. Furnishing License and/or DEA number.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proctoring</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Direct observation by GI attending staff credentialed in moderate sedation for a minimum of 50 procedures with moderate sedation, while an experienced practitioner to moderate sedation requires a minimum of 10 successful observed demonstrations.</strong></td>
</tr>
<tr>
<td><strong>B. Successful completion of Education Module post test.</strong></td>
</tr>
<tr>
<td><strong>C. Review of 50 procedure notes by the Chief of Gastroenterology.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reappointment</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Ongoing competency will include the successful observed completion of three procedures every 2 years.</strong></td>
</tr>
<tr>
<td><strong>B. Direct observation of one patient clinic encounter will be conducted by the Medical Director or other designated attending physicians every 2 years.</strong></td>
</tr>
<tr>
<td><strong>C. Maintenance of ACLS Certification.</strong></td>
</tr>
<tr>
<td><strong>D. Passing of Procedural Sedation test with a passing score of 80%</strong></td>
</tr>
</tbody>
</table>
A. DEFINITION
Ordering the administration of whole blood or blood components i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate. Exchange transfusion is the withdrawal of blood prior to a transfusion to keep the hgb unchanged.

1. Location to be performed: Inpatient hospital units, Hematology/Oncology Clinic, 4C Infusion Center and the Positive Health Clinic. Exchange transfusions will only be done in the 4C Infusion Center or Positive Health Clinic.

2. Performance of procedure:
   a. Indications
      1. Anemia
      2. Thrombocytopenia or platelet dysfunction
      3. Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means.
      4. Exchange transfusions for sickle cell patients with the following, but not limited to: acute chest syndrome, stroke, severe infection, severe anemia, preoperatively, during pregnancy and to prevent recurrent acute chest pain.
   b. Precautions
      1. Blood and blood components must be given according to SFGH guidelines.
      2. 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 thrombocytopenia 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 review of symptoms 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. 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 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

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

   4. Follow-up
      As appropriate for patients condition and reason transfusions were given.

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, ICIP, 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 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

<table>
<thead>
<tr>
<th>Prerequisite:</th>
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<tbody>
<tr>
<td>a. Successful completion of the San Francisco General Hospital and Trauma Center Transfusion Training course.</td>
</tr>
<tr>
<td>b. Successful completion of Transfusion Training course test on blood ordering and informed consent.</td>
</tr>
<tr>
<td>c. Must have an 80% test score on both examinations.</td>
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<thead>
<tr>
<th>Proctoring:</th>
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<tbody>
<tr>
<td>a. Read and Sign the SFGH Administrative Policy and Procedure 2.3 “Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options”.</td>
</tr>
<tr>
<td>c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.</td>
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<thead>
<tr>
<th>Reappointment:</th>
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<tbody>
<tr>
<td>a. Completion of the two education modules and completion of the two examinations with a passing score of 80%.</td>
</tr>
<tr>
<td>b. Performance of 2 transfusion orders every 2 years and 2 medical record reviews every 2 years.</td>
</tr>
<tr>
<td>c. Review of any report from the Transfusion Committee.</td>
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</tbody>
</table>
PROTOCOL #24: Procedure: - Ordering Chemotherapy

A. Definition: Chemotherapy is the use of anti-cancer, immunotherapy and growth factor drugs to treat malignancies. Selection of specific drugs or protocols is based on results of prior and on-going clinical trials.

1. Location for ordering chemotherapy: Hematology/Oncology Clinic and the 4C Infusion Center.
2. Policy – The standardized procedures enables the NP/PA to initiate or change, in consultation with the attending physician(s) as appropriate, chemotherapy regimens. The NP/PA shall also write chemotherapy orders.

B. Data Base:

1. Subjective Data
   a. 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.
   b. 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, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

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. Chemotherapy orders procedure
   • Verify patient height and weight and calculate BSA.
   • Confirm doses and dose parameters specific to chemotherapy protocols.
   • Write anti-emetics and pre-medication orders appropriate to chemotherapy protocol.
   • Write chemotherapy orders in consultation with the Attending Physician as appropriate.

2. Client conditions requiring consultation
   a. Acute decompensation of patient situation
b. Unexplained physical or laboratory findings

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

4. Follow-up
   Patients shall be closely monitored, as indicated, for excessive toxicities appropriate to the drug and/or regimen, progression of disease, or development of new or exacerbation of concurrent medical problem that would contraindicate receiving treatment or necessitate an appropriate change in the regimen.

E. Record Keeping
Chemotherapy orders are written on the standard SFGHMC Chemotherapy Order Sheet and will include all necessary documentation according to hospital policy. Patient visit, consent forms and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistant, using protocols for supervision the supervising physician shall review, countersign and date a minimum of five (5%) sample of medial records of patients treated by the physician assistant within 30 days after completion of proctoring period. The physician shall select for review those cases that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisite, Proctoring, and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisites</th>
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<tbody>
<tr>
<td>Training will include a weekly didactic meeting with the clinical director during the three month proctoring period and may be extended depending upon the evaluation of the clinical director at the completion of proctoring.</td>
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<tr>
<th>Proctoring</th>
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<tbody>
<tr>
<td>a. All NPs/PAs who are recently hired will have their chemotherapy orders cosigned for the duration of their proctoring period, 3 months for full time employees and 6 months for part time employees.</td>
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<tr>
<td>b. Experienced practitioner will have 2 chemotherapy orders reviewed by clinical director.</td>
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</tbody>
</table>
Reappointment

a. Evaluation will be done by the Medical Director or designated Physician.
b. Ongoing competency evaluation.
   1. Three procedures needed every 2 years.
   2. Two chart reviews needed every 2 years.
Protocol #25: Procedure: Skin Biopsies

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

This procedure can be done in the Positive Health Clinic.

1. Performance of procedure:
   a. Indications
      1. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.
   b. Precautions
      1. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
      2. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
      3. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.
   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, 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.
   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 if indicated.
   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
   Pre-procedure 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

<table>
<thead>
<tr>
<th>Prerequisites</th>
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<tbody>
<tr>
<td>a. Onsite training of procedures by a qualified provider.</td>
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<tr>
<td>b. Review of aseptic technique</td>
<td></td>
</tr>
<tr>
<td>c. Review of departmental policy and procedure</td>
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<table>
<thead>
<tr>
<th>Proctoring Period</th>
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<tbody>
<tr>
<td>a. New practitioner to procedure, a minimum of 3 successful observed demonstrations of each procedure</td>
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<tr>
<td>b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations of each procedure</td>
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<tr>
<th>Reappointment Competency</th>
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<tbody>
<tr>
<td>a. Evaluator will be the Medical Director or other qualified provider</td>
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<tr>
<td>b. Competency</td>
<td>1. Perform 1 procedures of each type every 2 years.</td>
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<tr>
<td></td>
<td>2. 1 chart review of each type every 2 years.</td>
</tr>
</tbody>
</table>
Protocol #26: Procedure: Surface Trauma and Wound Care

A. DEFINITION
This protocol covers the initial assessment of wounds by the NP/PA.

1. Location to be performed: Inpatient hospital units, 4C Infusion Center, Adult Medical Clinic, Specialty Clinics on Ward 92 and Positive Health Clinic.

2. Performance of procedure:
   a. Indications
      • This protocol covers patients presenting to the location for assessment and treatment of lacerations, abrasions, avulsions, bites and stings, burns and abscesses
   b. Precautions (The following require consultation with the attending physician)
      • Wounds requiring repair of cartilage
      • 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 vermilion borders)
      • Lacerations penetrating into joints
      • Patients requiring conscious sedation
      • Children under age of 10
      • Wounds requiring repair of cartilage
      • Closure of an infected wound

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

<table>
<thead>
<tr>
<th>Prerequisite:</th>
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<tbody>
<tr>
<td>a. New practitioner will attend wound care/suturing course or a lab at an outside facility or attend a course at SFGH.</td>
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</table>

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<thead>
<tr>
<th>Proctoring Period:</th>
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</thead>
<tbody>
<tr>
<td>a. New practitioner to procedure must perform a minimum of 3 successful observed procedures.</td>
</tr>
<tr>
<td>b. An experienced practitioner to procedure must perform a minimum of 1 successful observed demonstration. One procedure should require suturing.</td>
</tr>
<tr>
<td>c. Chart review of all observed cases.</td>
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</table>

<table>
<thead>
<tr>
<th>Reappointment Competency Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Perform wound care/suturing a minimum of 4 times every two years.</td>
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</table>
Protocol #27: Procedure: Thoracentesis

A. DEFINITION: Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid. This procedure can be done in the Inpatient hospital units.

1. Performance of procedure
   Indications
   a. For the purposes of this protocol, thoracentesis may be used to determine the cause of a pleural effusion or
   b. To relieve the symptoms of non-acute respiratory distress
   Contraindications
   a. Infection in the tissues near the puncture site.
   b. Acute respiratory compromise
   c. Coagulopathy
   d. Significant pulmonary parenchymal disease

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

   2. Objective Data
      a. Physical exam appropriate to the procedure to be performed.
      b. 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. 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
   All patients needing 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 Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisite</th>
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<tbody>
<tr>
<td>a. Onsite training by a qualified provider.</td>
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<table>
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<tr>
<th>Proctoring Period</th>
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<tbody>
<tr>
<td>a. New provider to procedure, a minimum of 3 successful observed demonstrations</td>
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</tr>
<tr>
<td>b. Experienced provider to procedure, a minimum of 2 successful observed demonstrations</td>
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</table>
Reappointment Competency

a. The evaluator will be an Attending Physician or Chief Resident
b. Ongoing competency evaluation.
   1. Perform a minimum of 2 procedures every 2 years.
   2. Two chart reviews every 2 years.
Procedure #28: 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: Adult Medical Clinic, Specialty Clinics on Ward 92, 4C Infusion Center, 5B Research Unit, Occupational Health Services, Positive Health Clinic, Ward 17 Renal Dialysis Center and Inpatient Units.

2. The following non-instrument based waived tests are currently performed at SFGH:
   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.
   c. SP® Brand Urine Pregnancy
      Indication: Assist with the diagnosis of pregnancy.
   d. Chemstrip® Urine Dipstick
      Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

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 in-date? Have necessary controls been done and come out as expected?

1. **Test Results requiring Attending Consultation**
   a. Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

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

3. **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

<table>
<thead>
<tr>
<th>Prerequisites:</th>
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<tbody>
<tr>
<td>Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,</td>
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<tr>
<th>Proctoring:</th>
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<tbody>
<tr>
<td>Successful completion of Health stream quizzes for each of the waived tests the practitioner is performing at SFGH, achievement of passing scores of at least 80% on each module.</td>
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</table>

<table>
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<tr>
<th>Reappointment Competency Documentation:</th>
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<tbody>
<tr>
<td>Renewal required every two years with documentation of successful completion of the required Health stream quizzes. Provider must have passed each required module with a score of 80%.</td>
</tr>
</tbody>
</table>
Procedure #29 Tattoo Removal

A. DEFINITION

The removal of a tattoo (or multiple tattoos) from a patient's skin using the medlite CB laser. The treatment is always conducted in conjunction and consultation with a laser technician from PRI, the company which rents the laser to the City and County of San Francisco. Treatment is scheduled every six to eight weeks, until such time as the desired cosmetic outcome is achieved or complications arise requiring the cessation, suspension, or modification of therapy.

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

2. Performance of procedure:
   a. Indications:
      1. The presence of one or more tattoos on the patients skin, with a primary focus on gang-related tattoos or tattoos which convey gang-affiliation, especially in areas not usually covered by clothing (face, neck, hands, forearm's etc.)
   b. Precautions:
      1. A health screening questionnaire is completed by all program participants prior to acceptance into the program.
      2. Providers check in with patients prior to each treatment session.
      3. Extensive post-treatment counseling regarding after-care is conducted following each treatment session, along with any supplies needed to properly care for the treatment site.
   c. Contraindications:
      1. Immunodeficiency
      2. Pregnancy
      3. Acute intoxication
      4. Open wounds at or near treatment site
      5. Acute infection at or near treatment site.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to tattoo removal
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
   a. Physical exam appropriate to tattoo removal.
   b. The tattoo removal is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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

D. PLAN
   1. Therapeutic Treatment Plan
      a. Patient consent obtained before procedure is performed.
      b. Time out performed.
      c. Diagnostic tests for purposes of disease identification.
      d. Referral to physician, specialty clinics, and supportive services, as needed.
   2. Patient conditions requiring Attending Consultation
      a. Acute decompensation of patient situation.
      b. Unexplained historical, physical or laboratory findings
      c. Uncommon, unfamiliar, unstable, and complex patient conditions
      d. Upon request of patient, NP, PA, or physician
      e. Problem requiring hospital admission or potential hospital admission.
   3. Education
      Discharge information and instructions.
   4. Follow-up
      Six to eight weeks following treatment or as needed to address any concerns or complications.

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

| Prerequisite: |  
|---|---|
| a. Observation of twenty five tattoo removal clinic sessions. 
Completion of the laser safety module prepared by the SFGH Laser Safety Committee and baseline eye examination within the previous 1 year. |  

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

| Reappointment Competency Documentation: |  
|---|---|
| a. Completion of 5 procedures every 2 years. 
b. Completion of 5 chart reviews every 2 years. |