PREAMBLE

Title: Combined Otolaryngology

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 Title 16, 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 Otolaryngology/Head and Neck Surgery Office (4M45) and on file in the Medical Staff Office.

II. Functions To Be Performed

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

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.
Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every six years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of 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 on preventative health care, assist in surgery, 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 the inpatient and outpatient settings at San Francisco General Hospital and Trauma Center.
   2. Role in the inpatient and outpatient setting may include performing physical exams, diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventative health care, assisting in surgery, performing invasive procedures and furnishing medications or issuing drug orders for the Otolaryngology patient as well as admitting, transferring, and discharging Otolaryngology patients within the hospital setting.

B. Supervision
   1. Overall Accountability:
      The NP/PA is responsible and accountable to: the Chief of Otolaryngology.
   2. A consulting physician that may include attendings, chief residents, and fellows with Clinical Instructor status 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. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress.
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.

IV. Scope of Practice

1. HCM: Acute/Urgent Care
2. Furnishing Medications/Drug Orders
3. eReferral Review
4. Nasopharyngoscopy
5. Rigid Nasal Endoscopy
6. Chemical Nasal Cautery with Silver Nitrate
7. Manual Cerumen Disimpaction under ear microscope
8. Manual removal of a foreign body under ear microscope
9. Debridement of Nasal Mucous or Crusts with Use of Rigid Endoscope following endoscopic sinus Surgery
10. Nasal Biopsy obtained under guidance of Rigid Nasal Endoscopy
11. Punch Biopsy, Incisional Biopsy or Excisional Biopsy less than 5mm
12. Tracheotomy Tube Change
13. Health Care Management – Otolaryngology Inpatient Service (note: sent as Protocol #2)
14. Discharge of Inpatients (note: sent as Protocol #4)

V. Requirements for the Nurse Practitioner/Physician Assistant

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

4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider and maintenance of Advanced Cardiac Life Support (ACLS) certification within one year of hire.

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 within 12 months of hire.

8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each practice site for each PA.

B. Specialty Training

1. Specialty requirements: ANP, FNP, or Acute Care
   a. Certification as a Certified Otorhinolaryngology Nurse (CORLN) within 3 years of hire via the National Certifying Board of Otorhinolaryngology and Head-Neck Nurses (NCBOHN).

2. Experience
   a. NP/PA must have 2 years experience, either as an NP/PA or registered nurse (RN) in an acute care setting, and an interest in head and neck medicine and surgery.
   b. If above criteria in (a) not met (inexperienced NP/PA), additional proctoring is required as further delineated.

VI. Evaluation


1. Initial: at the conclusion of the standardized procedure training, the Medical Director or physician designee will assess the NP/PA’s ability to practice.
   a. Clinical Practice
      1. Length of proctoring period will be three months for an experienced NP/PA and six months for a newly graduated NP/PA. The NP/PA will be supervised by the Chief of Otolaryngology, Otolaryngology Service Attendings and Otolaryngology Fellows with Clinical Instructor status, and Senior Otolaryngology Residents.
      2. The evaluator will be the Chief of Otolaryngology or...
a designated Otolaryngology physician

3. The method of evaluation in clinical practice will be:
   • A total of 10 cases will be evaluated during the proctoring period: 5 from the outpatient clinic and 5 from the inpatient service. For an inexperienced NP, a strict proctoring protocol will be enacted where all cases for the first 3 months of active sessions will be proctored by an attending physician in a concurrent and consecutive manner.
   • Direct supervision by the evaluator will occur while providing patient care during the first three months for an experienced NP and 6 months for an inexperienced NP.
   • All cases will be presented to the evaluating physician.
   • All patient documentation including history and physicals, progress notes, discharge summaries, consultation requests and patient orders will be co-signed concurrently to patient care.
   • In the case of a six month proctoring period, cases may be evaluated by chart review process by the Chief of Otolaryngology or the designated Otolaryngology physician.

2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician, at appropriate intervals.

3. Ongoing Professional Performance Evaluation (OPPE)

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

4. Biennial Reappointment: Medical Director, and/or designated physician must evaluate the NP/PA’s clinical competence as noted in the specific procedures.

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. Nurse Practitioners (NP) have 2 forms of supervision. These methods are 1) Examination of the patient by the Supervising Physician the same day as care is given by the NP and 2) Supervising Physician shall review, sign, and date the medical records of at least 5 patients managed by the nurse practitioner every year. 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, 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 Otolaryngology Service.

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. Pain history to include onset, location and intensity.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of data from the subjective and objective findings to identify disease processes. This may include a statement of current status of disease.

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
d. Upon request of patient, NP, PA, or physician
   e. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.

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.

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

E. RECORD KEEPING
All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)
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: Furnishing Medications/Drug Orders

A. DEFINITION

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

B. DATA BASE

1. Subjective Data
   a. 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:
      1. location of practice
      2. diagnoses, illnesses, or conditions for which medication is ordered
      3. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   c. To facilitate patient receiving medications from a pharmacist provide the following:
      1. name of medication
      2. strength
      3. directions for use
      4. name of patient
      5. name of prescriber and title
      6. date of issue
      7. quantity to be dispensed
      8. license no., furnishing no., and DEA no.

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 #3: 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 not been consulted upon by the Otolaryngology service, admitted to the Otolaryngology service nor seen in the Otolaryngology clinic within the previous two years.

1. Prerequisites:
   a. Providers reviewing eReferrals will have six months experience with patients in the Otolaryngology Service at San Francisco General Hospital and Trauma Center or elsewhere before being allowed to do 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 Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the eReferral system.

3. Proctoring: A review of 5% of the eReferral consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.

4. Reappointment: A review of 5 eReferral consultations every two years.

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.

b. Pain history to include onset, location, intensity, aggravating and alleviating factors, current and previous treatments.

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 Chief of Service and Otolaryngology/Head and Neck Surgery Faculty 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. Acute decompensation in patient condition
   b. Unexplained historical, physical or laboratory findings
   c. Upon request of the referring NP, PA, or physician
   d. Problem requiring hospital admission or potential hospital admission
e. Problem requiring emergent/urgent surgical intervention
f. As indicated per the algorithms developed by the Chief of Service.

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 overbook 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 or after
a period of six months.

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 #4: Procedure: Nasopharyngoscopy

A. DEFINITION

“Nasopharyngoscopy” is the examination of a patient’s nasopharyngeal structures with the use of a flexible, lighted fiberoptic camera that is passed through the patient’s nose and nasopharyngeal space. This is done in order to assess for masses of the head and neck and structural abnormalities of the head and neck that may contribute to the patient’s symptoms—such as a deviated septum, allergic rhinitis, sinusitis, nasal polyps, sources of nasal bleeding, gastroesophageal reflux disease, laryngeal polyps, nodules, or paralysis, or the presence of a foreign body.

1. Location to be performed: Outpatient Otolaryngology Clinic

2. Performance of procedure:
   a. Indications: voice hoarseness, sinusitis, “chronic cough, recurrent expectoration, previous head and neck cancer, recurrent or persistent serous otitis media in adults, hemoptysis, and bad breath not associated with dental disease” (Patton, 1997), allergy symptoms, epistaxis, shortness of breath, aspiration, nasal congestion, and postnasal drip
   b. Precautions: may elicit gag reflex or trigger nosebleed
   c. Contraindications: patient history of croup, patient refusal following thorough explanation of the procedure, history of an allergy to the used preparatory medications (topical decongestant and anesthetic)

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
   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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

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. The prior experience required for this involves a 3 part training program, elaborated in the next point.</td>
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<td>B. The training program for this protocol includes the following:</td>
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<tr>
<td>1. Review of naso-pharyngeal anatomy text book</td>
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<td>2. Observation of the proctor performing this procedure on at least 3 occasions</td>
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<tr>
<td>3. Practicing on models in the temporal bone lab</td>
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<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>1. Length of proctoring period is 1 month (experienced NP) and 3 months for inexperienced NP</td>
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<tr>
<td>2. The completion of the above 3 part training program</td>
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<td>3. 3 (6 for inexperienced NP) successful demonstrations of nasopharyngoscopy on live patients</td>
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<td>4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief</td>
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<td>4. The evaluator will be the chief Otolaryngology resident or an Otolaryngology attending.</td>
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<th>Reappointment Competency Documentation:</th>
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<tr>
<td>1. Ongoing competency is established via 1 successful demonstration of nasopharyngoscopy and 1 chart review every 2 years.</td>
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Protocol # 5: Procedure: Rigid Nasal Endoscopy

A. DEFINITION

Rigid nasal endoscopy is the examination of a patient’s sinonasal structures with the use of a rigid, lighted camera that is passed through the patient’s nose. This is done in order to assess for masses of the nose or sinuses and structural abnormalities of the nose and sinuses that may contribute to the patient’s symptoms such as a deviated septum, allergic rhinitis, sinusitis, nasal polyps, sources of nasal bleeding, or the presence of a foreign body.

1. Location to be performed: Outpatient Otolaryngology Clinic.

2. Performance of procedure:
   a. Indications: nasal congestion/obstruction, sinusitis, previous nasal or sinus cancer/masses, recurrent nose bleeds, allergy symptoms and postnasal drip
   b. Precautions: may trigger nosebleed
   c. Contraindications: patient history of croup, patient refusal following thorough explanation of the procedure, history of an allergy to the used preparatory medications (topical decongestant and anesthetic)

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. Detailed physical exam head and neck.
   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
   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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

4. Follow-up
   As appropriate for procedure performed, pertaining to applicable treatment regimens and/or further diagnostic work-up.

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.
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<td>elaborated in the next point.</td>
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<tr>
<td>2. The training program for this protocol includes the following:</td>
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<tr>
<td>a. Review of nasal and sinus anatomy text book</td>
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<td>b. Observation of the proctor performing this procedure on at least 3</td>
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<tr>
<td>occasions</td>
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<td>c. Practicing on models in the temporal bone lab</td>
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<tr>
<td>inexperienced NP)</td>
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<tr>
<td>2. Competency in performance of rigid nasal endoscopy includes:</td>
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<tr>
<td>a. The completion of the above 3 part training program</td>
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<tr>
<td>b. 3 successful demonstrations of rigid nasal endoscopy on live patients</td>
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<td>for experienced NP and 6 for inexperienced NP</td>
</tr>
<tr>
<td>c. Submission of a letter of competency to the Credentialing Committee</td>
</tr>
<tr>
<td>by the Clinical Service Chief</td>
</tr>
<tr>
<td>d. The evaluator will be the chief Otolaryngology resident or an Otolaryngology attending</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reappointment Competency Documentation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ongoing competency is established via 1 successful demonstration of rigid</td>
</tr>
<tr>
<td>nasal endoscopy and 1 chart review every 2 years.</td>
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</tbody>
</table>
Protocol #6: Procedure: Chemical Nasal Cautery with Silver Nitrate

A. DEFINITION

Chemical nasal cautery is done on occasions of epistaxis or nasal bleeding that persists despite adequate external digital pressure. In treatment of epistaxis, the approach is systematic including: first, external digital pressure, second, chemical or electrical nasal cautery, third nasal packing, and lastly surgical intervention (Ho & Chan, 2008). Chemical nasal cautery is done with the use of silver nitrate sticks that can be applied to the observed points of excoriation or sources of nasal bleeding along the nasal mucosa. Visualization of these points or sources is aided with the use of rigid nasal endoscopy, a rigid, lighted probe that is passed through the patient’s nose. This allows performance of this procedure without disturbing unaffected surrounding nasal mucosa.

1. Location to be performed: Outpatient Otolaryngology Clinic.

2. Performance of procedure:
   a. Indications: epistaxis that has not responded to external digital pressure and can be attributed to specific points/sources of bleeding along the nasal mucosa
   b. Precautions: use of silver nitrate has been associated with an uncomfortable burning sensation as well as septal perforation if over application is attempted
   c. Contraindications: if epistaxis is profuse and specific points/sources of bleeding cannot be identified, the source of bleeding is assessed to be located in the posterior part of nose, or the patient cannot tolerate either the silver nitrate application or rigid nasal endoscopy for whatever reason

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. Detailed physical exam of the head and neck.
   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
   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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

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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</thead>
<tbody>
<tr>
<td>1. The prior experience required for this involves successful completion of the training program for rigid nasal endoscopy.</td>
</tr>
<tr>
<td>2. Ability to perform this procedure requires the following:</td>
</tr>
<tr>
<td>a. Completion of the rigid nasal endoscopy training program (See Rigid Nasal Endoscopy by the Nurse Practitioner/Physicians Assistant)</td>
</tr>
<tr>
<td>b. Observation of the proctor performing this procedure on at least 3 occasions</td>
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<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>1. Length of proctoring period is 3 months for experienced NP and 6 months for inexperienced NP.</td>
</tr>
<tr>
<td>2. Competency in performance of chemical nasal cautery with silver nitrate includes:</td>
</tr>
<tr>
<td>a. The completion of the above 3 requirements</td>
</tr>
<tr>
<td>b. 3 successful demonstrations of chemical nasal cautery on live patients for experienced NP and 6 for inexperienced NP</td>
</tr>
<tr>
<td>c. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief</td>
</tr>
<tr>
<td>d. The evaluator will be the chief Otolaryngology resident or an Otolaryngology attending.</td>
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<tr>
<th>Reappointment Competency Documentation:</th>
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<tbody>
<tr>
<td>1. Ongoing competency is established via one successful demonstration of chemical nasal cautery with silver nitrate every 2 years and 1 chart review.</td>
</tr>
</tbody>
</table>

A. DEFINITION
Ceumen impaction “is defined as an accumulation of cerumen that causes symptoms, prevents a needed assessment of the ear canal/tympanic membrane or audiovestibular system, or both.” (Roland et al., 2008). Often times the patient with cerumen impaction has undergone several attempts of disimpaction by the primary care/referring provider, such as with cerumenolytic agents or irrigation. If these attempts prove unsuccessful, the patient is referred to Otolaryngology for disimpaction, or manual removal of the cerumen under a binocular ear microscope, which enhances visualization. This procedure is also done as a primary course of treatment if the patient cannot tolerate the use of cerumenolytic agents or irrigation, such as patients who have undergone previous ear surgery or have a history of a perforated tympanic membrane.

1. Location to be performed: Otolaryngology Outpatient Clinic

2. Performance of procedure:
   a. Indications: accumulation of cerumen that causes symptoms of otalgia, hearing loss, ear fullness, odor, discharge, or itching or that prevents a necessary evaluation of the ear canal or tympanic membrane
   b. Precautions: cerumen disimpaction can cause trauma to the external auditory canal and/or tympanic membrane, hearing loss, dizziness, bleeding, and/or infection
   c. Contraindications: patients that are unable to tolerate the procedure or unable to sit still during the procedure

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. Detailed physical exam of the head and neck.
   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.

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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

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. The prior experience required for this involves:</td>
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<tr>
<td>1. Observation of an attending chief resident performing this procedure on at least 3 occasions.</td>
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<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>A. Length of proctoring period is until 3 successful observed demonstrations for experienced NP and 6 for inexperienced NP.</td>
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<tr>
<td>B. Completion of the above specified period of observation and demonstration.</td>
<td></td>
</tr>
<tr>
<td>C. The evaluator will be an Otolaryngology attending or chief Otolaryngology resident.</td>
<td></td>
</tr>
<tr>
<td>D. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief.</td>
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<tr>
<th>Reappointment Competency Documentation:</th>
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<tbody>
<tr>
<td>A. Ongoing competency is established via one successful demonstration of manual cerumen disimpaction under ear microscope every 2 years in addition to 1 chart review.</td>
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</tbody>
</table>

A. DEFINITION
A foreign body in the ear is any object or structure that does not naturally occur in the ear or does not belong in the ear. Retention of these foreign bodies is associated with infection, hearing loss, otalgia, ear fullness, and discharge. The binocular ear microscope is used to enhance visualization and help make removal of these foreign bodies more successful (Schulze, S. L., Kerschner, J., and Beste, D., 2002).

1. Location to be performed: Outpatient Otolaryngology Clinic

2. Performance of procedure:
   a. Indications: visualized foreign body in the ear
   b. Precautions: removal of the foreign body can cause trauma to the external auditory canal and/or tympanic membrane, hearing loss, dizziness, bleeding, pain, and/or infection
   c. Contraindications: patients that are unable to tolerate the procedure or unable to sit still during the procedure

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. Detailed physical exam of the head and neck.
   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
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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.
### Summary of Prerequisites, Proctoring and Reappointment Competency

#### Prerequisites:
- The prior experience required for this involves:
  1. Observation of an attending/chief resident performing this procedure on at least 3 occasions.

#### Proctoring Period:
- Length of proctoring period is until 3 successful observed demonstrations for experienced NP and 6 for inexperienced NP.
- Completion of the above specified period of observation and demonstration.
- The evaluator will be an Otolaryngology attending or chief Otolaryngology resident.
- Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief.

#### Reappointment Competency Documentation:
- Ongoing competency is established via one successful demonstration of manual removal of an ear foreign body under ear microscope every 2 years along with 1 chart review.
Protocol #9: Procedures: Debridement of nasal mucous or crusts with use of Rigid Endoscope following endoscopic sinus surgery

A. DEFINITION
Following functional endoscopic sinus surgery, a patient requires regular post operative appointments to debride or remove any secretions, clots, or crusts that may have formed. This is done under visual guidance with rigid nasal endoscopy, a rigid, lighted camera that is passed through the patient’s nose. This is done in order to prevent infection, obstructions, and/or scar formation in the immediate post operative period (Lee, J. Y. and Byun, J. Y., 2008).

1. Location to be performed: Outpatient Otolaryngology Clinic

2. Performance of procedure:
   a. Indications: history of recent endoscopic sinus surgery
   b. Precautions: may trigger nosebleed
   c. Contraindications: patient intolerance of procedure or refusal following thorough explanation of the procedure

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.

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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

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>1. The prior experience required for this involves a 3 part training program,</td>
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<tr>
<td>elaborated in the next point.</td>
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<tr>
<td>2. The training program for this protocol includes the following:</td>
</tr>
<tr>
<td>a. Review of nasal and sinus anatomy text book</td>
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<tr>
<td>b. Observation of the proctor performing this procedure on at least 3</td>
</tr>
<tr>
<td>occasions</td>
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<tr>
<td>c. Practicing on models in the temporal bone lab</td>
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<tr>
<th>Proctoring Period:</th>
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<tr>
<td>1. Length of proctoring period is until 3 successful observed</td>
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<tr>
<td>demonstrations for experienced NP and 6 for inexperienced NP.</td>
</tr>
<tr>
<td>2. The completion of the above 3 part training program</td>
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<tr>
<td>3. 3 successful demonstrations of post operative sinonasal debridement on</td>
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<tr>
<td>live patients for experienced NP and 6 for inexperienced NP.</td>
</tr>
<tr>
<td>4. Submission of a letter of competency to the Credentialing Committee by the</td>
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<tr>
<td>Clinical Service Chief</td>
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<tr>
<td>5. The evaluator will be the chief Otolaryngology resident or an Otolaryngology</td>
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<td>attending.</td>
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<tr>
<th>Reappointment Competency Documentation:</th>
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<tbody>
<tr>
<td>1. Ongoing competency is established via one successful</td>
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<tr>
<td>demonstration of post operative sinonasal debridement every two</td>
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<td>years along with 1 chart review.</td>
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Protocol #10: Procedure: Nasal Biopsy Obtained under Guidance of Rigid Nasal Endoscopy

A. DEFINITION
As part of the diagnostic work up of a unilateral nasal mass, biopsy should be considered. This can be done in the office setting under visual guidance with rigid nasal endoscopy, a rigid, lighted camera that is passed through the patient's nose.

1. Location to be performed: Outpatient Otolaryngology Clinic

2. Performance of procedure:
   a. Indications: physical exam revealing a nasal mass suspicious for malignancy
   b. Precautions: may trigger nosebleed
   c. Contraindications: vascular appearing masses either on exam or imaging consistent with an angiomatous tumor or nasal masses in the adolescent patient highly suspected for a juvenile nasopharyngeal angiofibroma (Tami, T. A., 2002)

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. 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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

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

**Prerequisites:**
1. The prior experience required for this involves a 3 part training program, elaborated in the next point.
2. The training program for this protocol includes the following:
   a. Review of nasal and sinus anatomy textbook
   b. Observation of the proctor performing this procedure on at least 3 occasions
   c. Practicing on models in the temporal bone lab

**Proctoring Period:**
1. Length of proctoring period is until 3 successful observed demonstrations for experienced NP and 6 for inexperienced NP.
2. The completion of the above 3 part training program
3. 3 successful demonstrations of nasal biopsy on live patients for experienced NP and 6 for inexperienced NP.
4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief
5. The evaluator will be the chief Otolaryngology resident or an Otolaryngology attending.

**Reappointment Competency Documentation:**
1. Ongoing competency is established via 1 successful demonstration of nasal biopsy every 2 years and 1 chart review.
Protocol #11: Procedure: Punch Biopsy, Incisional Biopsy or Excisional Biopsy less than 5mm

A. DEFINITION
As part of the diagnostic work up of an oral lesion, biopsy should be considered. This can be done in the office setting. After the procedure is discussed with the patient and the patient is consented, lidocaine with epinephrine is injected in and around the intended biopsy location. After the area is thoroughly anesthetized, the biopsy is obtained with either a punch method or with superficial use of a scalpel. Bleeding is then controlled with silver nitrate cauterization and suturing to the site.

1. Location to be performed: Outpatient Otolaryngology Clinic

2. Performance of procedure:
   a. Indications: physical exam revealing an oral lesion suspicious for malignancy
   b. Precautions: may trigger bleeding
   c. Contraindications: highly vascular appearing masses, patient inability to cooperate, or patient refusal

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. 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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

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

**Prerequisites:**
1. The prior experience required for this involves a 3 part training program, elaborated in the next point.

2. The training program for this protocol includes the following:
   a. Review of head and neck anatomy text book
   b. Observation of the proctor performing this procedure on at least 3 occasions
   c. Practicing on pig parts during a chief resident run workshop

**Proctoring Period:**
1. Length of proctoring period is until 3 successful observed demonstrations for experienced NP and 6 for inexperienced NP.
2. The completion of the above 3 part training program
3. 3 successful demonstrations of oral biopsy on live patients for experienced NP and 6 for inexperienced NP.
4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief
5. The evaluator will be the chief Otolaryngology resident or an Otolaryngology attending

**Reappointment Competency Documentation:**
1. Ongoing competency is established via one successful demonstration of oral biopsy every 2 years and 1 chart review.
Protocol #12: Procedure: Tracheostomy Tube Change

A. DEFINITION
This procedure takes place when a tracheostomy needs to be changed. This may be because the tube is no longer functioning, it has been in place for a long period of time that warrants routine changing of the tube, it has been determined that the patient is safe to undergo weaning and or eventual decannulation, or in order to enable speech.

1. Location to be performed: Outpatient Otolaryngology Clinic, Inpatient Unit

2. Performance of procedure:
   a. Indications: agreement by an otolaryngology attending, at least a five day post-operative stoma maturity level, ventilation independence, patient ability to control their secretions, a good cough reflex, and reasonable mental status (All the criteria listed must be met before this procedure is considered.)
   b. Precautions: may elicit cough, suction should be available at bedside, the tracheostomy site should be inspected for signs/symptoms of infection and/or granulation tissue
   c. Contraindications: patient poor mental status, less than five days post-operative, poor cough, ventilation dependent, acute respiratory infection, or poor oxygen saturation

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.

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 pertaining to applicable treatment regimens and/or further diagnostic work-up.

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

**Prerequisites:**
1. The prior experience required for this involves a period of both observation and demonstration.
2. The training program for this protocol includes the following:
   a. Review of head and neck anatomy textbook
   b. Observation of the proctor performing this procedure on at least 3 occasions.

**Proctoring Period:**
1. Length of proctoring period is 3 successful observed demonstrations for experienced NP and 6 for inexperienced NP.
2. The completion of the above training
3. 3 successful demonstrations of tracheotomy tube changes on live patients for experienced NP and 6 for inexperienced NP.
4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief
5. The evaluator will be the chief Otolaryngology resident or an Otolaryngology attending.

**Reappointment Competency Documentation:**
1. Ongoing competency is established via one successful demonstration of tracheostomy tube change every 2 years and 1 chart review.

13. Health Care Management – Otolaryngology Inpatient Service (note: sent as Protocol #2)
14. Discharge of Inpatients (note: sent as Protocol #4)