Community Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE NURSE PRACTITIONER / PHYSICIAN
ASSISTANT/ CERTIFIED NURSE-MIDWIFE

PREAMBLE

Title: OBSTETRICS AND GYNECOLOGY

I. Policy Statement

A. It is the policy of the Community Health Network and San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, 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 all appropriate sites within the OB/GYN service.

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).

A Certified Nurse-Midwife (CNM) is a registered nurse with additional training in midwifery and who has met the requirements of Section 1460 of the Nurse Practice Act. The scope of practice of the CNM includes the care of women during the antepartum, intrapartum, postpartum, and interconceptual periods. A CNM provides family planning, conducts deliveries and cares for the newborn and infant.

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

III. Circumstances Under Which NP/CNM/PA May Perform Function

A. Setting
   1) Location of practice is all sites within the OB/GYN service.

B. Supervision
   1. Overall Accountability:
      The NP/CNM/PA is responsible and accountable to the Medical Director of Women's Health Center, Medical Director of Obstetrics, and the Medical Director of Women's Option Center.
   2. A consulting physician, who may be an attending, chief resident, or fellow, will be available to the NP/CNM/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. Uncommon, unfamiliar, unstable, and complex patient conditions.
   e. Upon request of patient, affiliated staff, or physician.
   f. Initiation or change of medication other than those in the formularies.
   g. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.
   h. Acute, severe respiratory distress.
   i. An adverse response to respiratory treatment, or a lack of therapeutic response.

IV. Scope of Practice

1. Health Care Management: Acute/Urgent Care
2. Health Care Management: Primary Well Woman Care
3. Health Care Management: Prenatal Care
4. Furnishing Medications/Drug Orders
5. Discharge of Inpatients
6. eReferral Review
7. Colposcopy and Cryotherapy
8. Endocervical Polyp Removal
9. Endometrial Biopsy
10. Episiotomy and Perineal Laceration Repair
11. High Resolution Anoscopy
12. Contraceptive Implant Insertion
13. Contraceptive Implant Removal
14. Intrauterine Device Insertion and Removal
15. Pre-op Evaluation for Second Trimester Abortion
16. Limited Obstetric Ultrasound: <14 Weeks Gestational Age
17. Limited Obstetric Ultrasound: >14 Weeks Gestational Age Assessment
18. Limited Obstetric Ultrasound: Third Trimester Assessment of Cardiac Activity, Presentation, and Amniotic Fluid
19. Waived Testing
20. First-Trimester Aspiration Abortion
21. Procedural Sedation
22. Vulvar Skin Biopsy

Comment [GS1]: The reference to respiratory complications is too specific, given that other complications are not specified.

Comment [GS2]: CIDP and Credentials have already decided that removal of IUDs does not require an SP given its relative lack of complexity and risk.
V. Requirements for the Nurse Practitioner / Certified Nurse Midwife/Physician Assistant

A. Basic Training and Education
   1. Active California Registered Nurse/Nurse Practitioner/Certified Nurse-Midwife/Physician Assistant license.
   2. Successful completion of a program, which conforms to the Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.
   4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
   5. Possession of a 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 FNP, ANP, WHNP, OB/GYN NP, CNM or Physician Assistant.

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/CNM/PA’s ability to practice.
      a. Clinical Practice
- Length of proctoring period will be 3 months.
- The evaluator will be the Medical Director, Chief of Service, and/or designated supervising physician, and/or designated peer.
- The method of evaluation in clinical practice will be 3 observations and associated chart reviews representing for each core procedure (HCM acute/urgent care, HCM primary care, HCM prenatal care, furnishing, and discharge of inpatients), with no less than 10 observations/chart reviews in total. Additional procedurally specific observations requirements are as specified in individual protocols.

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

3. Ongoing Professional Performance Evaluation (OPPE)

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

4. Biennial Reappointment: Medical Director, and/or designated physician must evaluate the NP/CNM/PA’s clinical competence as described in each procedure.

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 that 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 their implementation.

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

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

A. DEFINITION
This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions in all appropriate sites within the OB/GYN 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.

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. May include 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. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble, section IIIb.3
   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, affiliated staff or physician
f. Initiation or change of medication other than those in the formularies.

g. **With the exception of labor-related diagnoses**, any problem requiring hospital admission or potential hospital admission.

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

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

**E. RECORD KEEPING**

All information from patient visits will be recorded in the electronic 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 that 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 \underline{Well Woman Care} \underline{outpatientInpatient 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 related to well woman, gynecologic, reproductive, and breast care in all sites within the OB/GYN service.

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. 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.
   c. Immunization update.
   d. Referral to specialty clinics and supportive services, as needed.
2. Patient conditions requiring consultation as per Preamble, section IIIb\(^3\),
   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, affiliated staff, or physician
   f. Initiation or change of medication other than those in the formulary/ies.
   g. 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.

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). 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: Health Care Management – Prenatal Care

A. DEFINITION
   This protocol covers the procedure for the routine prenatal care of essentially healthy women. This includes the provision of comprehensive education and primary care during the prenatal and postpartum period and the promotion of a healthy pregnancy and optimal outcome in all appropriate sites within the OB/GYN service.

B. DATA BASE
   1. Subjective Data
      a. Complete appropriate history.
      b. Symptoms relevant to the prenatal health process.
   2. Objective Data
      a. Initial prenatal visit includes a complete physical examination with sizing of uterus and fetal heart tones if at least 10 weeks.
      b. Routine follow-up visits, the physical exam to include:
         1. Blood pressure
         2. Weight and weight gained or lost since last visit.
         3. Urinalysis at initial visit and then at every visit ≥ 26 weeks gestation or prn based on risk factors.
         4. Fetal heart tones
         5. Abdominal exam for fundal height (starting at 20 wks gestation) and presentation (starting at 36 weeks).
         6. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
         7. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.
      c. Pelvic examination when indicated by history.

C. DIAGNOSIS
   Assessment and diagnosis of pregnancy status, risk factors, or disease process consistent with the subjective and objective findings.

D. PLAN
   1. Therapeutic Treatment Plan
      a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
         1. Routine prenatal labs, including but not limited to: blood type and screen, Rubella titer, CBC, hemoglobinopathy evaluation, HBsAG, RPR, HIV antibody, pap smear (if
indicated), clean catch urine culture, chlamydia, gonorrhea and GBS culture.  If indicated, VZV titer.

2. First and Second Trimester integrated genetics screening, if desired by patient

3. Glucose Load Test (GLT) at 24 to 28 weeks Gestational Age. Do 1 hr. GLT at 1st visit if at high-risk for Diabetes (as per SFGH GDM Screening Protocol). Do a 3 hr GTT if 1 hr GLT elevated.

4. If patient is RH Negative repeat antibody screen and order Rhogam at 28 weeks.

5. Order and review all imaging studies as appropriate.

b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.
   1. Furnishing of prenatal vitamins.

c. Immunization update.

d. Referral to specialty clinics and supportive services as needed (e.g. nutritionist, social work, health education WIC).

2. Patient conditions requiring consultation as per Preamble, IIIb3:
   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 (as per established departmental guidelines, including diagnosis-specific criteria)
   e. Upon request of patient, affiliated staff, or physician.
   f. Initiation or change of medication other than those in the formularies.
   g. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.

3. Education
   a. Normal process and progression of pregnancy.
   b. Psychosocial issues pertinent to pregnancy, age of client and home situation.
   c. Signs and symptoms of complications
   d. Fetal kick counts.
   e. Stages of labor.
   f. Pain management during labor and delivery.
   g. Infant nutrition: breast or formula feeding.
   h. Postpartum family planning.

4. Follow-up (Intervals determined by risk factors)
   a. Every 4-8 weeks until 28 weeks gestational age.
b. Every 2 to 4 weeks from 28 to 38 weeks gestational age.
c. Every week after 38 weeks gestational age.

E. RECORD KEEPING
All information from patient visits 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 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. MANAGEMENT OF HIV-INFECTED PREGNANT WOMEN AT THE BAY AREA PERINATAL AIDS CENTER (BAPAC)/HIVE
Obstetric and HIV care of BAPAC/HIVE patients by the BAPAC nurse practitioner will be co-managed by the BAPAC attending, Reproductive Infectious Disease fellow and/or other OB attending designee.

Obstetric care will be transferred to an OB attending or fellow (with continued NP management of HIV care co-managed by the OB attending) for the following conditions:

a. Renal insufficiency or failure.
b. Heart disease, Class II or greater.
c. Hyperthyroidism.
d. Rh isoimmunization.
e. Uncontrolled seizure disorder.
f. Neoplasia.
g. High order multiple gestation (>2 fetuses)
h. Twin gestation other than dichorionic, diamniotic, concordant growth.
i. Acute hepatitis.
j. Psychiatric conditions with psychosis.
k. Isoimmune thrombocytopenia.
l. Severe anemia (hemoglobin <7, not responding to iron and nutrition therapy).
m. Uterine or cervical malformation or incompetence.
n. Significant chronic illness (i.e., Lupus, RA, Crohns).
o. Preterm pre-eclampsia.
p. Severe pre-eclampsia.

G. RECORD KEEPING
a. Patient visit, consent forms, and other procedure specific documents will be recorded in HERO and LCR/eCW as
A. DEFINITION
"Furnishing" of drugs and devices by nurse practitioners and nurse midwives 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 and midwives may order Schedule II - V controlled substances when in possession of a BRN furnishing certificate and an appropriate DEA license. Schedule II - III medications need a patient specific protocol. The practice site (clinic or inpatient), scope of practice of the NP/CNM/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formularies used will be: San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, 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 and Nurse Midwives 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. 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 as per Preamble, section IIIb2.
   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. Uncommon, unfamiliar, unstable, and complex patient conditions.
   e. Upon request of patient, affiliated staff, or physician.
   f. Failure to improve pain and symptom management.
   g. Acute, severe respiratory distress.
   h. 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/CNMs 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 #5: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from the Birth Center at San Francisco General Hospital and Trauma Center.

B. DATA BASE
1. Subjective Data
   a. Review: health 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 LCR.

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.

2. Patient conditions requiring Consultation as per preamble, section IIIb2.
   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, affiliated staff, or physician.
   f. Initiation or change of medication other than those in the formularies.
3. Education
   a. Review inpatient course and need for outpatient 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 that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
Protocol #6: 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 being 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 designated consulting physician or supervising NP proctor concurrently for the first 20 eReferrals (minimum). More eReferral reviews may be required depending on performance.

4. Reappointment Competency:
   A review of five eReferral consultations every 2 years by the consulting physician or supervising Nurse Practitioner.

5. Location to be performed: all sites with the OB/GYN service.

B. DATA BASE

1. Subjective Data
   a. History: 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 consultation as per Preamble, section IIIb2.
      a. Unexplained historical, physical or laboratory findings
      b. Uncommon, unfamiliar, unstable, and complex patient conditions
Upon request of the referring affiliated staff, or physician
Problem requiring hospital admission or potential hospital admission
When recommending complex imaging studies or procedures for the referring provider to order
Problem requiring emergent/urgent surgical intervention
As indicated per the algorithms developed by the Medical Director

3. Education
   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
   Depend 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
   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 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. Is this standard practice? Actually being done?
Protocol # 7: Procedure: Colposcopy and Cryotherapy

A. DEFINITION
Women with abnormal Pap smears or suspicious lesions in the lower genital tract will be evaluated by colposcopy with biopsy of suspicious lesions and treatment or referral as indicated. Cryotherapy is a treatment for cervical dysplasia or large condylomatous lesions.

1. Location to be performed will be all appropriate sites within the OB/GYN service and the 5M dysplasia clinic.

2. Performance of procedure:
   i. Indications
      Patients with certain abnormal Pap smears, cervical cancer screening results, cervical, vaginal or vulvar lesions visible by gross examination, may or a history of dysplasia should be referred for colposcopy. Cryotherapy can be used to treat high grade dysplasia (CIN 2 or 3) in women with satisfactory colposcopy, no dysplasia on ECC and when the lesion can be completely covered by cryo probe during treatment. Cryotherapy can also effectively treat large condylomatous lesions found in the vulvar or perianal area.
   ii. Precautions/Contraindications
      Consult an MD before performing biopsies on patients used anticoagulants or with a clotting disorder. Women who are pregnant who require biopsy due to lesion suspicious for malignancy should be referred to an MD. Cryotherapy of the cervix should not be performed in pregnant women, women with unsatisfactory colposcopy, dysplasia found on ECC or in women with large cervical lesions that cannot be completely covered by the cryo probe.

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   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 identify disease processes.

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

2. Patient conditions requiring consultation as per section, IIIb2.
   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, affiliated staff or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which 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>Prerequisite</th>
<th>Proctoring Period</th>
<th>Reappointment Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. One week course (14 hours) in theory and practice of cervical colposcopy. Certificate of course completion required.</td>
<td>a. New practitioner to procedure performance under supervision of an experienced colposcopist, a minimum of 25 colposcopies at least 10 of which include biopsy and a minimum of 3 cryotherapy. b. Experienced practitioner to procedure must show documentation of 25 proctored studies at previous institution and be proctored for a minimum of 5 colposcopies and 1 cryotherapy. Cryotherapy will be observed at SFGH by an experienced colposcopist/board certified OB/GYN. c. Proctor must be a qualified colposcopist.</td>
<td>a. Evaluation will be done by a qualified colposcopist/board-certified OB/GYN. b. Minimum number of 4 procedures must be completed every two years. c. Minimum number of 2 chart reviews needed every two years.</td>
</tr>
</tbody>
</table>
Protocol #8: Procedure: Endocervical Polyp Removal

DEFINITION: Evaluation of a cervical polyp seen on pelvic speculum exam by removing the polyp for pathological diagnosis.

1) Location to be performed: all appropriate sites with the OB/GYN service,

2) Performance of procedure:
   1. Indications
      Endocervical polyp seen on pelvic speculum examination
   2. Precautions
      Consult a GYN attending MD if polyp is especially large or site of origin is unclear
   3. 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. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
      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 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. The procedure is performed following standard medical technique.
      d. Diagnostic tests for purposes of disease identification.
      e. Biopsy tissue is sent to pathology

Comment [GS4]: Hospital policy does not list polyp removal among those procedures requiring time out, however it does list biopsy.
f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
g. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Consultation, as per Preamble, section IIIb2.
   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, CNM, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
   Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which 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>
</tr>
</thead>
<tbody>
<tr>
<td>a. 6 months prior experience in women’s health care experience, training or expertise is required.</td>
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<tr>
<td>b. Completion of training on site by a qualified provider or at another site with documentation of competency.</td>
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<table>
<thead>
<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>a. Observation of a minimum of 1 (one) procedure for both new and experienced providers.</td>
</tr>
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</table>
b. Charts of all observed cases during initial proctoring will be reviewed.

<table>
<thead>
<tr>
<th>Reappointment Competency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Minimum number of 2 procedures must be completed every two years.</td>
</tr>
<tr>
<td>b. Minimum number of 2 chart reviews needed every two years.</td>
</tr>
</tbody>
</table>
Protocol #9: Procedure: Endometrial Biopsy

A. DEFINITION
Evaluation of the endometrium by obtaining tissue for pathological diagnosis.
1. Location to be performed: all appropriate sites with the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Women considered at risk for endometrial cancer including but not limited to: abnormal uterine bleeding, endometrial cells on Pap Smear, unopposed estrogen therapy, Tamoxifen therapy and others needing evaluation of endometrial tissue (infertility, infection) will be evaluated by endometrial biopsy.
   b. Precautions
      Consult a physician before performing biopsies on women with extreme retroversion or anteversion of the uterus. Also consult with physician when the procedure requires manual dilation of the cervix.
   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. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   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 identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan
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- Patient consent obtained before procedure is performed and obtained according to hospital policy.
- Time out performed per hospital policy.
- Diagnostic tests for purposes of disease identification.
- **The procedure is performed following standard medical technique.**
- Biopsy tissue is sent to pathology
- Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Consultation, as per Preamble, IIIb2.
   - Acute decompensation of patient situation.
   - Unexplained historical, physical or laboratory findings
   - Uncommon, unfamiliar, unstable, and complex patient conditions
   - Upon request of patient, affiliated staff, or physician
   - Initiation or adjustment of medication other than those in the formularies.
   - 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. 6 months prior experience, in women's health care.</td>
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<tr>
<td>b. Completion of training on site by a qualified provider or training at another site with documentation of competency.</td>
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<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>a. Observation of a minimum of 3 procedures for a new provider and 1 procedure for a provider who has prior experience with independent endometrial biopsy.</td>
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</tr>
<tr>
<td>b. Chart review of all observed cases.</td>
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<tr>
<th>Reappointment Competency:</th>
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<tbody>
<tr>
<td>a. Perform 6 procedures every 2 years.</td>
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<tr>
<td>b. 2 chart reviews needed every two years.</td>
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</table>
Protocol #10: Procedure: Episiotomy & Perineal Laceration Repair

A. DEFINITION
1. Episiotomy - A surgical incision of the perineal body done in order to facilitate delivery of the fetus by enlarging the outlet.
2. Laceration - Spontaneous tear in the perineal body, peri-urethral area or walls of the vagina.
   a. Peri-urethral laceration of the area surrounding the urethra.
   b. Peri-clitoral laceration of the area surrounding the clitoris.
   c. Labial laceration of the labia majora or minora.
   d. 1st degree laceration involving the vaginal mucosa, posterior fourchette, perineal skin.
   e. 2nd degree laceration includes above and the perineal muscles.
   f. Sulcus tears - 2nd degree lacerations involving the vaginal walls.

3) Location to be performed: Birth Center, 6C.

4) Performance of procedure:
   Indications
   a. Episiotomy is performed in circumstances when the condition of the fetus (as indicated by decelerations of the fetal heart rate or potential for shoulder dystocia) requires shortening the time to delivery.
   b. Repair of episiotomy is indicated after performance of episiotomy.
   c. Repair of lacerations by the nurse-midwife is indicated when there is active bleeding from minor lacerations or for all second degree lacerations.
   d. For the purposes of this procedure, the attending physician and surgeon on 6C may supervise up to 2 CNMs concurrently.

B. DATA BASE
1. Subjective Data
   Pt. history reviewed prior to admission in labor including medication allergies. Focused review of symptoms relevant to episiotomy or repair as needed.

2. Objective Data
   a. Prior to NSVD: position and station of fetus, force and control of maternal expulsion efforts, estimated time to

Comment [GS5]: Unclear why this was included; supervision ratios are not prescribed for laceration repair.
delivery, fetal heart tracing, clinical assessment of perineum (elasticity of tissue, length of perineal body)
b. Following NSVD: status of vagina, vulva, perineum, and rectum; estimated blood loss, maternal vital signs. The uterine cervix is to be assessed if indicated by bleeding and/or if clinical situation suggests risk for cervical laceration.

C. DIAGNOSIS
Assessment of subjective and objective data to identify need for episiotomy (based on indicators identified above) and need for repair of laceration, as indicated by type of laceration and extent of bleeding.

D. PLAN
1. Therapeutic Treatment Plan
   a. Performance of episiotomy and their repair or repair of lacerations is conducted using sterile technique.
   b. Local anesthesia of area using up to 25 cubic centimeters of 1% lidocaine is provided before episiotomy and/or repair, whenever indicated. The maximum total dose should not exceed 4.5 mg/kg and the maximum total dose of 300 mg should not be exceeded (prior doses e.g. with epidural need to be considered).
   c. During recovery period, Tylenol 650mg every six hours, Ibuprofen 600mg every 6 hours, oxycodone 5 mg-10 mg every 3 hours for pain unrelieved by ibuprofen or acetaminophen, Tylenol with codeine 1-2 every 4 hours pm pain. (See Furnishing/Drug Order SP) and stool softeners as appropriate. (See Furnishing/Drug Order SP).

2. Patient conditions requiring consultation, as per Preamble, IIIb2.
   a. Extensions of episiotomy or lacerations into rectal mucosa or rectal sphincter.
   b. Cervical lacerations
   c. Inability to assess origin of vaginal bleeding and/or control hemorrhage
   d. Evidence of perineal or vaginal hematoma (pain, bruising, swelling)
   e. Breakdown of repair
   f. Evidence of infection at site of repair-malodorous discharge, fever, pain, edema
   g. Unexplained historical, physical or laboratory findings
h. Uncommon, unfamiliar, unstable, and complex patient conditions

3. Education
   a. Wound care of episiotomy/laceration reviewed with client
   b. Signs and symptoms of normal healing, infection and wound breakdown reviewed at discharge
   c. Bowel habits

4. Pain management—reference therapeutic treatment plan above

5. Follow-up
   a. Assessment of perineum postpartum day 1 & 2
   b. Assessment of healing of perineum at 2 and/or 6-week post partum outpatient visits. Earlier assessment is indicated if there is evidence of infection at site of laceration

E. RECORD KEEPING
   CNM completes delivery note, including indication for and performance of procedures. Postpartum notes include evaluation of repair site.

F. Summary of Prerequisite, Proctoring and Reappointment Evaluation of Competency

<table>
<thead>
<tr>
<th>Prerequisite</th>
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<tbody>
<tr>
<td>No special training is required for performance of this procedure. Education and training in conduct of episiotomy and laceration repair is basic to all nurse-midwifery programs accredited by the BRN and American College of Nurse-Midwives (ACNM). This standardized procedure does not cover a new skill or practice but is developed in compliance with SB 1738.</td>
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<tr>
<th>Proctoring Period</th>
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<tr>
<td>Initial: Within 3 months of hire the Medical Director, designated physician, and/or designated peer will assess the CNM’s ability to practice. This assessment is based upon concurrent observation of a minimum of 3 cases of vaginal delivery, including episiotomy and/or repair of laceration, with chart review.</td>
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<tr>
<th>Reappointment Competency</th>
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<tbody>
<tr>
<td>a. Evaluator: Medical Director, designated physician, and/or</td>
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</table>
Protocol #11: Procedure: High Resolution Anoscopy

A. DEFINITION
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: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications: Patients with abnormal anal pap smears, anal lesion visible by gross examination or a history of anal warts or anal dysplasia.
   b. 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. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   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 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. The procedure is performed following standard medical technique.
   e. Biopsy tissue is sent to pathology.
   f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   g. Referral to physician, specialty clinic, and supportive services, as needed.

2. Patient conditions requiring Consultation, as per Preamble, section IIIb2.
   a. As specified under precautions.
   b. Upon request of patient, affiliated staff 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

Prerequisite:
   a. One week course (14 hours) in theory and practice of cervical colposcopy. Certificate of course completion required.
Proctoring Period

a. New practitioner to procedure, a minimum of 25 successful observed demonstrations. 5 examinations should be on women with high-grade lesions.
b. Experienced practitioner to procedure must show documentation of 25 proctored studies at previous institution and a minimum of 5 observed studies at SFGH.
c. Proctor must be a qualified colposcopist/Board Certified OB/GYN
d. Chart reviews of all observed cases

Reappointment Competency Documentation:

Evaluation by an experienced colposcopist/Board Certified OB/GYN

a. Minimum number of 4 procedures must be completed every two years.
b. Minimum number of 2 chart reviews needed every two years
Protocol #11: Procedure: Contraceptive Implant Insertion

A. DEFINITION
The contraceptive implant is placed under the skin of the upper arm via a preloaded inserter and remains effective for three years. Insertion is performed under local anesthetic using aseptic technique.

1. Location to be performed: all appropriate sites with the OB/GYN service

2. Performance of procedure:
   a. Indications
      Woman desires long-acting, reliable contraceptive
   b. Precautions
      Chronic use of drugs that are potential inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy. May have drug interactions with some herbal products. See drug precautions/interactions in prescribing information.
   c. Contraindications:
      1. Known or suspected pregnancy
      2. Hepatic tumors, active liver disease
      3. Known, suspected or history of breast cancer
      4. Undiagnosed abnormal genital bleeding
      5. Hypersensitivity to any components of implant

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 including over-the-counter and herbal remedies, allergies.

   2. Objective Data
      a. Physical exam appropriate to the procedure to be performed.
      b. 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. Diagnostic tests for purposes of disease identification.
   d. Timing of insertion: See prescribing information
   e. Insertion as described in prescribing information
   f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   g. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation, as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Difficult insertions
   c. Upon request of patient, affiliated staff or physician

3. Education
   Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.

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. Completion of a company sponsored training class</td>
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<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>a. Performance of a minimum of 3 insertions for a new provider and 2 insertions for a provider who has prior experience with independent insertion.</td>
</tr>
<tr>
<td>b. Proctor must be a qualified provider.</td>
</tr>
<tr>
<td>c. Chart review of all observed cases.</td>
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<tr>
<th>Reappointment Competency Documentation:</th>
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</thead>
<tbody>
<tr>
<td>a. Performance of 6 insertions every 2 years.</td>
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<tr>
<td>b. 1 chart review needed every two years.</td>
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</table>
Protocol #12: Procedure: Contraceptive Implant Removal

A. DEFINITION
   The contraceptive implant is placed under the skin of the upper arm and remains effective for 3 years. Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Woman desires removal of implant or implant is expired.
   b. Precautions: See prescribing information.
   c. Contraindications: See prescribing information.

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

   2. Objective Data
      a. Physical exam appropriate to the procedure to be performed.
      b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
      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 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.
      cb. Diagnostic tests for purposes of disease identification.
      c. Timing of removal: See prescribing information
      d. Removal: as described in prescribing information
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 consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Difficult Implant removal.
   c. Upon request of patient, affiliated staff or physician
   d. If patient desires removal and rod/string is not readily palpable/available.

3. Education
   Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.

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>
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<tr>
<th>Prerequisite:</th>
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<tbody>
<tr>
<td>a. Completion of a company sponsored training class</td>
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<tr>
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<tbody>
<tr>
<td>a. Performance of a minimum of 3 removals for a new provider and 2 removals for a provider who has prior experience with independent removal.</td>
</tr>
<tr>
<td>b. Proctor must be a qualified provider.</td>
</tr>
<tr>
<td>c. Chart review of all observed cases</td>
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Protocol # 13. Procedure: Intrauterine Device Insertion and Removal

A. DEFINITION

Intrauterine devices offer a highly effective, safe and long lasting contraception. Both insertion and Removal can be performed by the NP/CNM/PA with insertion subject to the criteria described below.

1. Location to be performed: all appropriate sites within the OB/GYN service.
2. Performance of procedure:
   a. Indications
      Patient desiries intrauterine device.
   b. Precautions
      See IUD (Mirena/Skyla/Paragard) prescribing information
   c. Contraindications
      1. Pregnancy or suspicion of pregnancy
      2. Acute pelvic inflammatory disease or current behavior suggestive of a high risk for pelvic inflammatory disease.
      3. Post-partum endometritis or post abortal endometritis.
      4. Known or suspected uterine or cervical malignancy
      5. Genital bleeding of unknown etiology.
      7. Allergy to any component of ParaGard IUD or Mirena or Skyla IUS.
      8. A previously placed IUD that has not been removed.

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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 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. The procedure is performed following standard medical technique with or without cervical block depending upon patient preference.
   d. Diagnostic tests for purposes of disease identification.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble section IIIb2.
   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, affiliated staff, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and
date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which 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>
</tr>
</thead>
<tbody>
<tr>
<td>a. 6 months experience in women’s health care.</td>
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<tr>
<td>b. Completion of training on site by a qualified provider.</td>
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<table>
<thead>
<tr>
<th>Proctoring Period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Observed performance of a minimum of 3 procedures for a new provider and 2 procedures for a provider who has prior experience with independent IUD insertion.</td>
</tr>
<tr>
<td>b. Chart reviews of all observed cases.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reappointment Competency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Perform 6 procedures every two years.</td>
</tr>
<tr>
<td>b. 1 chart review needed every two years.</td>
</tr>
</tbody>
</table>
Protocol #14: Procedure: Pre-op Evaluation for Second Trimester Abortion

A. DEFINITION
   1. Pre-operative evaluation:
      The evaluation of patients before abortion procedures, including patient history, physical examination and evaluation of surgical risks. Informed consent is obtained following hospital policy.
   2. Dilator placement:
      The placement of intracervical osmotic dilators using sterile technique and local anesthesia.
   3. Location to be performed: Women's Option Center.

B. DATABASE
   1. Subjective Data
      a. Patient history including: gynecological history (including last menstrual period, menstrual history, history of sexually transmitted infections and abnormal Pap smears)
      b. Obstetric history (including number of vaginal deliveries, number of cesarean deliveries, previous abortions, miscarriages, ectopic pregnancies and any associated complications)
      c. Past medical history
      d. Past surgical and anesthesia history, including any associated complications.
      e. Social history (including substance abuse, homelessness and domestic violence)
      f. Allergies
      g. Medications
   2. Objective Data
      a. Physical examination including:
         1. Review of vital signs
         2. Airway assessment
         3. Auscultation of heart and lungs
         4. Examination of abdomen
         5. Palpation of uterine fundus as measure of gestational duration
         6. Inspection of perineum
         7. Speculum examination of vagina and cervix.
         8. Obtaining cervical specimens for gonorhea and chlamydia testing.
      b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS
Nearly all women who present to the Women's Option Center are requesting pregnancy termination services. A primary goal of the initial pre-operative evaluation is to accurately determine the gestational duration of the pregnancy. Additionally, an accurate medical history and focused physical examination is performed to identify any significant medical problems that might complicate the pregnancy termination procedure. Psychosocial assessment includes determination that the termination is voluntary.

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. Treatment Procedure
      Any women able to undergo second-trimester abortion will undergo dilator insertion one or two days prior to her procedure. After testing for gonorrhea and chlamydia, sterile technique will be used, a paracervical block will be placed, a tenaculum placed on the anterior lip of the cervix and then dilators inserted into the cervical os. Generally, the number of medium laminarias to be inserted = gestational duration in weeks – 10; however the number may be adjusted based on Dilapan or laminaria sizes used and other factors. After all dilators are inserted the tenaculum is removed, the cervix inspected for hemostasis and a 4X4 gauze sponge placed in the vagina to hold the dilators in place.
   d. Diagnostic tests for purposes of disease identification.

2. Patient conditions requiring consultation, as per Preamble section III b2.
   1. Inability to obtain accurate measurements for gestational duration estimation.
   2. History of cardiovascular disease, including uncontrolled hypertension.
   3. Current pulmonary compromise or a history of severe pulmonary disease.
   4. Active or recent hepatic or renal disease.
   5. Insulin-dependent diabetes.
   6. Coagulation disorders or anti-coagulation therapy.
7. Inability to give informed consent.
8. Previous cesarean deliveries with ultrasound findings suspicious for accreta.
9. Termination requested for fetal or maternal indications beyond 24 weeks 0 days.
10. Patients with complicated or active/recent chronic medical and/or psychiatric problems in case additional diagnostic procedures or consultations need to be ordered.
11. Inability to identify cervix or difficulty inserting dilators adequate for the gestational duration.
12. Morbid obesity
13. Upon request of affiliated staff or physician
14. Problem requiring hospital admission or potential hospital admission
15. Rupture of membranes during dilator insertion.

3. Education (primarily reviewed with the counselor and RNs)
   a. Explain to the patient that the dilator insertion is the first part of the abortion. Explain to the patient that she should not undergo laminaria osmotic dilator insertion if she is unsure about her decision to terminate the pregnancy.
   b. Explain the dilator insertion procedure, expected discomforts and possible complications (including bleeding, infection and ruptured membranes).
   c. Explain what the patient can expect overnight before her abortion procedure.
   d. Give patient precautions and telephone numbers to call in case of emergency overnight.

5. Follow-up
   a. All patients return to the clinic the day of their scheduled D&E. Post-abortion follow-up is scheduled at the clinic of the patient’s choice.
   b. All women must have at least one telephone number at which they can be reached. Women without access to a telephone must leave some method by which they can be reached in case of emergency. Women can request complete confidentiality, in which case if the clinic needs to call them a code word is used (usually a women's name) and no mention is made of the clinic. If a patient with dilators in place does not show up for her scheduled abortion procedure, at least three attempts are made to reach her by telephone. If she is unreachable by telephone, all appropriate parties will be contacted to reach here. If
neither of these approaches works and the patient is missing, a registered letter is sent to her residence.

E. RECORD KEEPING
All patients complete a self-administered medical history form. This form is reviewed and signed by the NP/CNM/PA evaluating the patient for an abortion. Additional medical history (as described above), the physical examination (as described above) are recorded on the standardized abortion Pregnancy Consultation and Evaluation form. For women with any complex medical problems (as described above) that may influence surgical risk, physician consultation is obtained and this is documented in the patient's medical record. The number of dilators and gauze sponges placed in the cervix and vagina respectively are recorded on the Pre-Operative and Operative Note for Abortion form. 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>
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<tbody>
<tr>
<td>a. Training in paracervical blocks and osmotic dilator placement.</td>
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<tr>
<td>b. One-on-one directly supervised on-the-job training in dilator insertion.</td>
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<tr>
<th>Proctoring Period:</th>
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<tr>
<td>a. A minimum of 5 observed procedures with 3 chart reviews.</td>
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<tr>
<td>b. If proficiency is demonstrated after 5 procedures, the NP/CNM/PA can independently perform the procedure. If proficiency is not demonstrated after 5 procedures, the NP/CNM/PA will continue to be proctored until competence is achieved. The proctoring should be completed within the first 6 months of initial granting of new privileges and must be completed within the first year (12 months) of initial granting of new privileges.</td>
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<tr>
<th>Reappointment Competency:</th>
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<tbody>
<tr>
<td>a. 5 procedures must be completed every two years.</td>
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<tr>
<td>b. 2 chart reviews needed every 2 years.</td>
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</table>
Protocol #15: Procedure: Trigger Point Injections for Pelvic Pain

A. DEFINITION
Relief of chronic myofascial pain by injecting local anesthesia or saline into areas of tenderness called "trigger points". Injection of trigger points has been found to be 60 to 90% successful in relieving myofascial pain.

1. Location to be performed: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Identification of a trigger point on examination in a chronic pelvic pain patient presenting with myofascial pain. Trigger points will be identified in the abdomen, groin and perineum and injections are limited to subcutaneous and soft tissues. No internal (vaginal) injections will be given.
   b. Precautions
      Avoid injection into blood vessel by performing aspiration after insertion of needle.
   c. Contraindications
      Allergy to local 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. 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. Explain procedure to patient
b. Patient consent obtained before procedure is performed and obtained according to hospital policy.

c. The procedure is performed following standard medical technique. Time out performed per hospital policy.

d. Diagnostic tests for purposes of disease identification.

e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Upon request of patient, affiliated staff, 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

| Prerequisite: | Training will provided by an experienced provider. |
| Proctoring Period: |  |
| a. | Proctoring by a qualified provider. |
| b. | New practitioner to procedure: observation of a minimum of 2 injections for each site. |
| c. | Practitioner who has prior experience with independent performance of this procedure: observation of a minimum of 1 injection for each site. |
| d. | Chart review of all observed cases. |

| Reappointment Competency: |  |
| a. | Minimum of 2 procedures every 2 years. |
| b. | Minimum number of 1 chart review every two years. |
Protocol # 16: Procedure: LIMITED OBSTETRIC ULTRASOUND <14 Weeks
Gestational Age

A. DEFINITION
A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service

2. Performance of procedure:
   a. Indications for limited obstetric ultrasound include a need to identify:
      - Intrauterine pregnancy
      - Fetal number
      - Fetal cardiac activity
      - Gestational age
   b. Precautions: None
   c. Contraindications: Previously diagnosed multiple gestation

B. DATA BASE
1. Subjective Data
   a. Review history of last menstrual period

2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS
Diagnosis must be supported by diagnostic images obtained

D. PLAN
1. Review patient identification, procedure to be conducted, adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation:
   - Multiple gestation
   - No evidence of cardiac activity
   - Gestational age assessment not correlated to other subjective and objective data
• Vaginal bleeding
• Abdominal pain
• Inability to confirm intrauterine location of pregnancy
• Inability to obtain adequate image for diagnostic interpretation
• Unclear or abnormal findings
4. Education
Discuss findings with patient; establish need for follow-up consultation; examination or referral; give discharge information and instructions
5. Follow-up
As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisites:</th>
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<tbody>
<tr>
<td>a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR</td>
</tr>
<tr>
<td>b. Recent (within 5 years) experience in limited obstetric ultrasound at gestational age &lt;14 weeks (including &gt; 40 ultrasound exams), and/or privileges to perform limited obstetric ultrasound at gestational age &lt;14 weeks granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising SFGH physician who has been designated as an evaluator by the Director of Obstetrics.</td>
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<tr>
<th>Proctoring:</th>
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<tr>
<td>Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently performing limited obstetric ultrasonography. These exams must be of gestational sacs, embryos, or fetuses &lt;14 weeks gestational age and must include assessment of the location and dating of pregnancy, cardiac motion and fetal number.</td>
</tr>
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</table>

Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review and sign the clinical report before the patient is discharged. If the evaluator is an NP/CNM/PA, all reports will additionally be reviewed by the Director of Obstetrics or
Reappointment Competency:

Clinicians will be evaluated for continued competency through peer or consultant (as per Preamble section III2b) chart review on a biennial basis. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness and will include three ultrasound exams at <14 weeks gestational age that include assessment of the location and dating of pregnancy, cardiac motion and fetal number.

Any additional comments:

If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed.

All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.
A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service

2. Performance of procedure:
   a. Indications for limited obstetric ultrasound include a need to identify:
      • Gestational age (≥14 weeks gestation)
      • Placental location
   b. Precautions: None
   c. Contraindications: Previously diagnosed multiple gestation

C. DATA BASE
1. Subjective Data
   a. Review of history of last menstrual period
2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS
1. Diagnosis must be supported by diagnostic images obtained

D. PLAN
1. Review patient identification, procedure to be conducted, and adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation:
   • Multiple gestation
   • No evidence of cardiac activity
   • Gestational age assessment not correlated to other subjective and objective data
   • Inability to confirm intrauterine location of pregnancy
   • Vaginal bleeding
Abdominal pain
• Increased risk for accreta (previa and previous cesarean delivery at >16 weeks gestation)
• Inability to obtain adequate image for diagnostic interpretation
• Unclear or abnormal findings
• BPD close to 58 mm or when inconsistent measurements between the BPD and FL might allow or disallow a pregnancy termination (6G only)

4. Education
Discuss findings with patient, establish need for follow-up consultation, examination or referral, and give discharge information and instructions

5. Follow-up
As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisites:</th>
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<tbody>
<tr>
<td>a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR</td>
</tr>
<tr>
<td>b. Recent (within 5 years) experience in limited obstetric ultrasound for &gt;14 week gestational age assessment (including ≥ 40 ultrasound exams), and/or privileges to perform limited obstetric ultrasound for &gt;14week gestational age assessment granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising SFGH physician who has been designated as an evaluator by the Director of Obstetrics.</td>
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<tr>
<th>Proctoring:</th>
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<tbody>
<tr>
<td>Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently using limited obstetric ultrasonography to date a ≥14week pregnancy.</td>
</tr>
</tbody>
</table>

Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review and sign the clinical report prior to the patient's discharge. If the evaluator is an NP/CNM/PA, all
reports will later also be reviewed by the Director of Obstetrics or his/her physician designee(s) within 24 hours.

Reappointment Competency Documentation:

Clinicians will be evaluated for continued competency through peer or consultant chart review on a biennial basis. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness, and will include three dating ultrasounds at ≥14 weeks gestation.

Any additional comments:

If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed.

All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.
Protocol #18: Procedure: LIMITED OBSTETRIC ULTRASOUND: Third Trimester Assessment of Cardiac Activity, Presentation, and Amniotic Fluid

A. DEFINITION
A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service

2. Performance of procedure:
   i. Indications for limited third trimester obstetric ultrasound include a need to identify:
      • Fetal cardiac activity
      • Fetal presentation
      • Amniotic fluid volume
   ii. Precautions: None
   iii. Contraindications: Previously diagnosed multiple gestations.

B. DATA BASE
1. Subjective Data
   a. Review history of last menstrual period

2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS
2. Diagnosis must be supported by diagnostic images obtained

D. PLAN
1. Review patient identification, procedure to be conducted, adequacy of privacy for exam, readiness and cleanliness of equipment

2. Perform limited obstetric ultrasound

3. Patient conditions requiring Attending or Senior Resident consultation:
   • No evidence of cardiac activity
   • Fetal position other than cephalic (if ≥35 weeks gestation)
   • Amniotic fluid index outside of normal range (≤5 or ≥20/24)
   • Fetal heart rate of <110 beats per minute
   • Inability to obtain adequate image for diagnostic interpretation
• Unclear or abnormal findings

4. Education
Discuss findings with patient, establish need for follow-up consultation, examination or referral, give discharge information and instructions

5. Follow-up
As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisites:</th>
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<tbody>
<tr>
<td>a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR</td>
</tr>
<tr>
<td>b. Recent (within 5 years) experience in limited obstetric ultrasound in the third trimester (including ≥ 40 ultrasound exams), and/or privileges to perform limited obstetric ultrasound in the third trimester granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising SFGH physician who has been designated as an evaluator by the Director of Obstetrics.</td>
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<tr>
<th>Proctoring:</th>
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<tbody>
<tr>
<td>Clinicians must perform a minimum of 5 ultrasounds (including fetal presentation and amniotic fluid volume) to demonstrate competency prior to independently performing limited third trimester obstetric ultrasonography.</td>
</tr>
<tr>
<td>Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review and sign the clinical report prior to the patient’s discharge. If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Obstetrics Medical Director or his/her physician designee(s) within 24 hours.</td>
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| Reappointment Competency Documentation: |
Clinicians will be evaluated for continued competency through peer or consultant chart review on a biennial basis. Limited third trimester obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness, and will include three ultrasound exams in the third trimester, including fetal presentation and amniotic fluid volume.

Any additional comments:

If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed.

All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.
| Protocol #19: 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: any in- or outpatient location providing emergency or primary care

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, yeast 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?

2. Test Results requiring consultation
   a. Follow established site-specific protocols or instructions. When in doubt, consult as per Preamble, section Iib2.

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

4. Follow-up
   a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

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

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.
# Summary of Prerequisites, Proctoring and Reappointment Competency

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<tr>
<th><strong>Prerequisites:</strong></th>
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<tbody>
<tr>
<td>Certification as NP/CNM/PA 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><strong>Proctoring:</strong></th>
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<tr>
<td>Successful completion of Healthstream quizzes for each of the waived tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module.</td>
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<tr>
<th><strong>Reappointment Competency Documentation:</strong></th>
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<tbody>
<tr>
<td>Renewal required every two years with documentation of successful completion of the required Healthstream quizzes. Provider must have passed each required module with a score of 80%.</td>
</tr>
</tbody>
</table>
A. DEFINITION
First-trimester aspiration abortion includes manual and electric vacuum procedures for women with an intrauterine pregnancy confirmed by ultrasound for gestational ages 5.0 weeks through 12.6 weeks

1) Location to be performed: San Francisco General Hospital: 6G, 5M, ED.

2) Performance of procedure:
   i. Indications: Women desiring aspiration abortion in the first trimester for a normal or abnormal intrauterine pregnancy confirmed by ultrasound between 5.0 and 12.6 weeks’ gestation.
   ii. Contraindications
      a. ASA classes 3 and 4
      b. Hemodynamic instability or other evidence suggesting a problem that might require hospital admission

3) Supervision
   i. Overall Accountability:
      The NP/CNM/PA is responsible and accountable to the Medical Director of Women’s Options Center.
   ii. An in-house attending gynecologist will be available to the NP/CNM/PA in person, by phone or by other electronic means at all times.

B. DATA BASE
1. Subjective Data
   a. Obtain patient’s/caregiver’s description of:
      Last menstrual period history
      Medical history
      Obstetrical history
      Gynecologic history, including hx STDs
      Surgical history
      Current medications; allergies; tobacco, alcohol and illicit drug use
      Contraception history and counseling
      Contraception plans after abortion
      Psychosocial factors as indicated after counseling assessment
2. Objective Data
   a. Perform physical assessment to include:
      - Limited pelvic ultrasound to assess gestational age and confirm intrauterine pregnancy (if not already performed)
      - Review of vital signs
      - Vaginal and cervical exam
      - Uterine position and size
      - Airway assessment
   b. Obtain/review the following laboratory tests as indicated:
      - GC/CT screening
      - RPR
      - Hemoglobin, CBC or hemoglobin/hematocrit
      - Type and hold (or Type and Screen if clinically indicated)
      - Qualitative or quantitative beta HCG
      - HIV
      - Cervical cancer screening
      - Review pelvic ultrasound results for gestational dating and confirmation of intrauterine pregnancy
   c. All Point of Care Testing (POCT) will be performed according to SFGH POCT Policy and Procedure 16.20.

C. DIAGNOSIS
   Assessment and diagnosis of pregnancy status, risk factors or disease process consistent with the subjective and objective findings.

D. PLAN
   1. Therapeutic Treatment Plan
      a. Obtain separate patient consents for abortion and procedural sedation (and any long-acting reversible contraceptive method) before procedure 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.
      f. Provide local anesthesia via paracervical block, with additional pain control via oral medications, intravenous medications and/or procedural sedation to be administered according to patient preference, hospital- and department-specific protocols.
      g. Perform first-trimester manual or electric vacuum aspiration
h. Visual inspection of products of conception, with specimens sent to Pathology as per protocol
i. Provide Rh immunoglobulin (RhoGAM) to Rh-negative women
j. Provide contraception as appropriate

3. Patient Conditions Requiring Pre-Operative Attending Consultation
   1. Difficulty determining gestational duration
   2. Unexplained historical, physical or laboratory findings
   3. Known or suspected cervical or uterine abnormalities
   4. Evidence or suspicion of ectopic pregnancy
   5. Suspected molar pregnancy
   6. Suspected uterine or pelvic infection
   7. Client requests general anesthesia for uterine evacuation
   8. Client hemoglobin less than 8 g/dL
   9. Upon request of patient, NP, CNM or physician

4. Patient Conditions Requiring Intra- or Post-Operative Attending Consultation
   a. Evidence or suspicion of uterine perforation during procedure
   b. Difficulty obtaining adequate cervical dilation
   c. Excessive pain during procedure
   d. Intra- or post-operative hemorrhage
   e. Cervical laceration requiring repair
   f. Evidence of hemodynamic instability or other evidence suggesting the need for potential hospital admission
   g. Respiratory distress

5. Procedures for Provision of Emergency Care
   a. For any acute deterioration in patient condition, the in-house Gynecology attending will be paged to assume care of the patient.
   b. If emergency services are required in the interim, the protocols of the Women’s Options Center will be implemented, which include paging the Airway STAT pager or the MERT or calling a Code Blue.

6. Education
   a. Instruct patient/family/caregiver to:
      Limit physical activity for 24 hours
      Implement pelvic rest for 2 weeks
      Resume or initiate contraception prescribed
      Call or go to ED with fever or chills, heavy bleeding
(soaking 2 or more pads per hour for more than 2 hours), abdominal pain unrelieved by medications

7. Follow up
   Follow-up appointment to be scheduled, if indicated.

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 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>
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<tbody>
<tr>
<td>a. Consistent with Section 2725.4 of CA Business and Professions Code, completion of the Health Workforce Pilot Project curriculum and clinical competencies (see Appendix)</td>
</tr>
<tr>
<td>b. Completion of training on site related to unit workflow, documentation and protocols</td>
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<tr>
<td>c. State the number of procedures provider must observe being done by a qualified provider = 5</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>a. Actual number of performances needed to be directly observed: 30</td>
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<tr>
<td>b. Any qualified provider can do the proctoring</td>
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<tr>
<td>c. Until proctoring has been completed and procedural sedation protocol has also been successfully proctored, all procedures must be supervised by an attending physician who holds privileges for both abortion and procedural sedation.</td>
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</table>

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<tr>
<th>Appointment/Reappointment Competency Documentation:</th>
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<tbody>
<tr>
<td>a. Minimum number of procedures that must be completed in two years: 10</td>
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<tr>
<td>b. Is direct observation of procedure needed? No</td>
</tr>
<tr>
<td>c. Chart Review: 3/year</td>
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<tr>
<td>d. Successful renewal of procedural sedation protocol at time of reappointment or ongoing supervision of all procedures by attending physician</td>
</tr>
</tbody>
</table>
Appendix 1 – Health Workforce Pilot Project #171 Curriculum

Curricular Overview can be found here:


First trimester abortion competencies can be found here:


Table of Contents for Curriculum can be found here:
http://www.ansirh.org/training/workbook.php

Includes the following subjects:

Early Abortion Training Workbook

ANSIRH’s Early Abortion Training Workbook was developed for use in a clinical setting where an experienced trainer or provider is available to lead a discussion of its didactic context and exercises. It is intended to help clinicians learn to identify key elements of informed consent counseling, recognize major psychosocial issues of importance for women who seek abortions, understand the basic steps involved with first-trimester vacuum aspiration abortions and early medical abortion service provision, and identify common complications related to first-trimester abortion care.

Now in its fourth edition, the workbook is currently in use at top medical schools around the world. It is designed for use with Management of Unintended and Abnormal Pregnancy.

Supplementary training tools and resources

Additional downloadable chapters:

- Chapter 11: Evaluation
- Chapter 12: Becoming a Trainer
- Chapter 13: Office Practice Integration

Chapter 11: Evaluation—Instruments

- Skills Inventory
- Trainee Agreement and Consent
• Procedure Log
• Training Program Evaluation
• Daily Evaluation Card
• Observed Performance Assessment
• Clinician Feedback Form for Clinic Staff
• Clinic Services Satisfaction Survey
• Basic Ultrasound Evaluation
• New Trainer Skills Evaluation

Chapter 13: Office Practice—Tools

• Abortion Medication Fact Sheet
• Abortion Reimbursement Rates
• Abortion Scheduling Template
• Additional Security Drills
• Bomb Threat Report Form
• Chart Review Form for Medication Abortion
• Comparison of Medication and Aspiration Abortion
• Contraceptive Options Fact Sheet
• Danco (Mifeprex) Patient Agreement
• Disruption/Violence Report for Patients or Visitors
• Disruption/Violence Report for Staff
• Early Medication Abortion Using Methotrexate and Misoprostol
• Ectopic Pregnancy Fact Sheet
• Emergency Contraception Fact Sheet
• FP Insurance Letter
• Insurance Proposal
• Interpreter Agreement
• IV Sedation Client Information and Consent
• Medication Abortion Chart Review
• Medication Abortion Consent Form (English)
• Medication Abortion Consent Form (Spanish)
• Medication Abortion Log
• Medication Abortion Follow-Up Log
• Medication Abortion Visit
• Mifeprex Alternative Treatment Patient Information and Consent
• MVA Chart Review
• MVA Consent Form
• MVA Procedure Notes
• MVA Pre-Procedure Notes
• Phone Script
• Pre-Abortion Patient Instructions
• Post-Abortion Patient Instructions
• Rho(o) Immune Globulin Client Information Form
• Sample Complication Log
• Spreadsheet Tool
• Talking About your Work with Others
• Transfer Agreement
• Unwrapping Sterile Packs (Poster)
• Values Clarification Workshop
• What to Expect After Taking Mifeprex
• When a Small Amount of Pregnancy Tissue was Obtained
• Working with an Interpreter Training Tool
• Wrapping Instruments (Poster)
• Reprocessing Vaginal Ultrasound Probe (Poster)
Protocol/Procedure: 21

Title: Procedural Sedation/Moderate Sedation

A. DEFINITION

Procedural Moderate Sedation/Analgesia is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light 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 19.08 titled, “Procedural Sedation: Moderate and Deep”) by the Nurse Practitioner/Certified Nurse Midwife/Physician Assistant during procedures within the Women’s Options Center. The nurse practitioner (NP)/certified nurse-midwife (CNM)/physician assistant (PA) practices under the supervision of the Medical Director or designee. Practitioners producing inducing a level of moderate 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. Procedures may only be performed in the designated areas for procedural sedation within the Women’s Options Center, which are adequately equipped and staffed, according to departmental and hospital policy.

Materials necessary for procedural sedation and rescue include:

a. Appropriate monitoring equipment.

b. Emergency medications and equipment for care and resuscitation, including a 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:

Procedural sedation may be indicated for first-trimester abortion and other minor gynecologic procedures, such as difficult intrauterine device placement or endometrial biopsy.

Contraindications:

a. Regarding the patient’s American Society of Anesthesiologists (ASA) class, the Anesthesia Service should be consulted for patients who
have an ASA score of 3 or greater. A procedure requiring sedation would not be performed on a patient with an ASA score above a three (3) without anesthesia assistance.

b. Anticipated difficult intubation.

Precautions:

a. Inability to obtain informed patient consent.

B. DATA BASE

1. Subjective Data
   a. Obtain a history within 24 hours of the procedure and sedation, or if earlier, an interim history must be completed.
   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 24 hours of procedure and sedation, or if earlier, an interim physical must be completed. The exam is to include an airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight)
   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 moderate sedation by the NP/CNM/PA in the Women’s Options Center (WOC).

3. Assignment of the pre-procedure Modified Aldrete Score.

4. Evidence of verification of compliance with the NPO status (adult: minimum 8 hours (solids) and 2 hours (clear 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 19.08 titled “Procedural Sedation: Moderate and Deep”
   a. Informed consent for the procedure and sedation must be obtained and documented by the NP/CNM/PA prior to the delivery of sedation. Consent forms must be completed for the procedure to be performed as well as for the planned sedation.
   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 adult escort for discharge to home in an appropriate mode of transportation.
   c. Re-assessment prior to the procedure to include:
      1. Indication for procedure.
      2. Two patient identifiers.
      3. A “time out” documented.
      4. Immediate pre-procedure vital signs (blood pressure, cardiac rhythm, heart rate, oxygen saturation and end-tidal carbon dioxide, or ETCO₂).
      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, ETCO₂, rhythm, and pain level). Vital signs will be documented no less frequently than every 5 minutes beginning with the first administration of sedation.
      5. Reversal agents, if indicated.
   e. Post-procedure
      1. Monitor level of consciousness, respiratory (RR, SaO₂) 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. ASA status 3 or greater.
   b. Aspiration.
c. Acute decompensation of patient.
d. Unexplained historical, physical or laboratory findings.
e. Upon request of patient, NP, CNM, 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.

4. Follow-up
   A. If the patient is transferred to the recovery 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. Pertinent medical history.
         b. The procedure performed.
         c. The condition of the patient; including pain score.
         d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
         e. Any significant clinical events occurring during and post-procedure.
         f. Any additional orders relating to the post-procedural/moderate sedation care.
   B. Any patient receiving a reversal agent (naloxone 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. See Hospital Policy 19.08 for other criteria requiring the submission of an unusual occurrence report.
   C. The outpatient is discharged “to home”:
      1. By a specific discharge order from a physician or NP/CNM/PA; 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.

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, NP/CNM/PA or registered nurse discharging the patient. Document all findings in the computerized procedure database, usually the PACS system.

F. Summary of prerequisites, proctoring & reappointment of competency

<table>
<thead>
<tr>
<th>Prerequisites</th>
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<tbody>
<tr>
<td>A. Specialty Training</td>
<td>The NP/CNM/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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<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. 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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<tr>
<td>B. Training Program</td>
<td></td>
</tr>
<tr>
<td>1. Completion of the SFGH Procedural Sedation module and Test with a passing score of 98%.</td>
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<tr>
<td>2. Completion of Basic Life Support (BLS) training.</td>
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<tr>
<td>3. Completion of the Registered Nursing Moderate Sedation Education Module.</td>
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<tr>
<td>4. Furnishing License and DEA number.</td>
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| Proctoring |  |
| A. Direct observation by WOC attending staff credentialed in moderate sedation for a minimum of 30 procedures under moderate sedation. An experienced practitioner who previously had moderate sedation privileges at another institution requires a minimum of 10 successful observed demonstrations. |  |
| B. Review by WOC attendings of 30 procedure notes. |  |

| Reappointment |  |
| A. Ongoing competency will be demonstrated by observation by the Medical Director of three procedures every 2 years. |  |
| B. Maintenance of BLS Certification. |  |
| C. Passing of Procedural Sedation test with a passing score of 98%. |  |

Comment [Km8]: This was redundant, same as #1.
Protocol/Procedure #22: Vulvar Skin Biopsy (Excision, Punch)

A. DEFINITION
Removal of a small portion of abnormal vulvar skin to be evaluated in the pathology laboratory. Punch biopsy or small excisional biopsy not requiring suturing can be performed in the outpatient clinic; women whose skin requires suturing should have the excisional biopsy performed in the Special Procedures Clinic.

1. Location to be performed: is in the outpatient OB-GYN Clinic.

2. Performance of procedure:
   i. Indications
      • Papular or exophitic lesions, except genital warts
      • Thickened lesions to differentiate VIN vs. lichen simplex chronicus (LSC)
      • Hyperpigmented lesions, unless obvious nevus or lentigo
      • Ulcerative lesions, unless obvious herpes, syphilis or chancre
      • Lesions that worsen or don't respond with treatment
   ii. Precautions
      a. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
      b. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
      c. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.
   iii. Contraindications: None

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
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 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. The procedure is performed following standard medical technique.
   d. Diagnostic tests for purposes of disease identification.
   e. Biopsy tissue is sent to pathology as appropriate.
   f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   g. Referral to physician, and supportive services, as needed.

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

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

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisites:</th>
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</table>
| a. Practitioner will have on-site training at SFGH.

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<thead>
<tr>
<th>Proctoring:</th>
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<tbody>
<tr>
<td>a. Proctoring period will be 6 months in length.</td>
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<tr>
<td>b. Practitioner must have a minimum of 5 successful observed demonstrations, including either type of biopsy, but at least 2 of each type.</td>
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<tr>
<td>c. Will require a minimum of 5 chart reviews.</td>
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<tr>
<td>d. Explanation needed for any exceptions to minimum requirements.</td>
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<thead>
<tr>
<th>Reappointment Competency:</th>
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<tbody>
<tr>
<td>a. Evaluator will be the Medical Director or other qualified physician.</td>
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<tr>
<td>b. Competency evaluation.</td>
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<tr>
<td>2 chart reviews needed to monitor competency every 2 years.</td>
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