Community Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE
NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: FAMILY COMMUNITY MEDICINE

I. Policy Statement

A. It is the policy of the Community Health Network and San Francisco General Hospital and Trauma Center (SFGH) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Family Health Center Clinic, Adult Urgent Care Center Policies and Procedures Manual, in the Adult Urgent Care Center Practice Manager's office, in the office of the consulting physician and nurse practitioner at the Behavioral Health Center/Mental Health Rehabilitation Center (BHC/MHRC), the 4A Skilled Nursing Unit Nurse Managers office, the credentialing liaison of Family Community Medicine's office and on file in the Medical Staff Office.

II. Functions To Be Performed

The following standardized procedures are formulated as process protocols to explain the overlapping functions performed by the NP/PA in their practice. Each practice area will vary in the functions that will be performed, such as primary care in a clinical setting or inpatient care on 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

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medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every six years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Delegation of Services Agreement (documents supervising agreement between supervising physician and PA).

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

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

1. Location of practice is Family Health Center, Behavioral Health Unit, 4A Skilled Nursing Unit and Adult Urgent Care Center.
2. Role in each setting may include primary care, urgent care services in all settings and inpatient care in the Skilled Nursing Facility.

B. Supervision

1. Overall Accountability:
   The NP/PA is responsible and accountable to: the Physician-in-Charge or the Medical Director at each site, and the Chief of Service of Family and Community Medicine, or other designated physician.
2. A consulting physician, who may include attending physicians or chief residents, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.

3. Physician consultation is to be obtained as specified in the specific protocols and under the following circumstances:
   a. Acute decompensation of patient situation.
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical, or laboratory findings.
   d. Upon request of patient, nurse practitioner, physician assistant, or physician.
   e. Initiation or change of medication other than those listed in or approved by the formulary (ies).
   f. Problem requiring hospital admission or potential hospital admission.
   g. Uncommon, unfamiliar, unstable, and complex patient condition.
   h. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.
   i. Acute, severe respiratory distress
   j. An adverse response to respiratory treatment, or a lack of therapeutic response.

IV. Scope of Practice

Protocol #1: Acute/Urgent Care
Protocol #2: Primary Care
Protocol #3: Prenatal Care
Protocol #4: Discharge of Inpatients
Protocol #5: Furnishing Medications/Drug Orders
Protocol #6: Procedure: Surface Trauma and Wound
Protocol #7: Procedure: Splinting
Protocol #8: Procedure: Incision and Drainage of Abscess
Protocol #9: Procedure: Arthrocentesis and Intraarticular Injections
Protocol #10: Procedure: Nail Debridement
Protocol #11: Procedure: Nail Removal/Matrisectomy
Protocol #12: Procedure: Insertion of Intrauterine Device
Protocol #13: Procedure: Endometrial Biopsy
Protocol #14: Procedure: Contraceptive Implant Insertion
Protocol #15: Procedure: Contraceptive Implant Removal
Protocol #16: Procedure: Skin Biopsy
Protocol #17: Procedure: Trigger Point Injection
Protocol #18: Procedure: Waived Testing

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
   1. Active California Registered Nurse/Physician Assistant license.

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2. Successful completion of a program which conforms to Board of Registered Nurses(BRN)/Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of American Heart Association Basic Life Support for Healthcare Providers (BLS-HCP)
5. Possession of a Medicare/Medi-Cal Billable Provider Identifier, or must have submitted an application.
6. Copies of licensure and certificates 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).

B. Specialty Training
   1. Adult or Family Medicine
   2. At least two (2) years of clinical experience in specialty area desired.

C. Evaluation of NP/PA Competence in performance of standardized procedures

   1. Initial:
      At the conclusion of the standardized procedure training, the Medical Director or designated physician will assess the NP/PA's ability to practice.
      a. Clinical Practice
         - Length of proctoring period will be time needed to do five (5) chart reviews.
         - The evaluator will be the Physician-in-Charge, Medical Director, or other designated clinician.
      - The method of evaluation in clinical practice will be five (5) chart reviews and direct observations, with at least one case representing each core protocol (health care management acute/urgent care, health care maintenance: primary care, health care maintenance: prenatal care, discharge of inpatients, and furnishing medications/drug orders if applicable). Additional proctoring requirements are specified in the remaining protocols.

   2. Biennial Reappointment:
      Physician-in-Charge, Medical Director or designated clinician will evaluate the NP/PA's competence through five (5) chart reviews, with at least one case representing each core protocol (health care management acute/urgent care, health care maintenance: primary care, health care maintenance: prenatal care, discharge of inpatients, and furnishing

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medications/drug orders if applicable). Additional requirements are specified in the remaining protocols.

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3. Follow-up:
   Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Physician-in-Charge, Medical Director or clinician designee at appropriate intervals until acceptable skill level is achieved.

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4. Ongoing:
   a. Physician Assistants have three (3) forms of supervision. Their Delegation of Service Agreement will note which form of supervision 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 physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

VI. Development and Approval of Standardized Procedure

A. Method of Development
   1. Standardized procedures are developed collaboratively by the Nurse Practitioners/Physician Assistants, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

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

C. Review Schedule
    1. The standardized procedure will be reviewed every three years by the NP/PA and the Physician-in-Charge or 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, and problems involving workers' compensation claims. This Protocol will be performed in the Family Health Center, Adult Urgent Care Center, Behavioral Health Center/Mental Health Rehabilitation Center (BHC/MHRC), and the Skilled Nursing Facility.

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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 (e.g. stable, unstable, and uncontrolled).

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.
   d. NP/PAs may also cosign Doctor's First Report of Occupational Injury or Illness (DFR) for a workers' compensation claim to receive time off from work for a period not to exceed three (3) calendar days. The "treating physician" must still sign the DFR,

and must be the one to make any determination of temporary disability.

2. Patient conditions requiring Attending Consultation:

   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical, or laboratory findings
   d. Upon request of patient, nurse practitioner, physician assistant, or physician
   e. Initiation or change of medication other than those listed in or approved by the formulary(ies)
   f. Problem requiring hospital admission or potential hospital admission
   g. Uncommon, unfamiliar, unstable, and complex patient conditions
   h. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.

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

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

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) 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.

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Protocol #2: Health Care Management – Primary Care/Inpatient Units

A. DEFINITION

This protocol covers the procedure for age-appropriate health care management in primary care, and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses. This protocol will be performed in the Family Health Center, Adult Urgent Care Center, and Behavioral Health Center/Mental Health Rehabilitation Center (BHC/MHRC) and in the Skilled Nursing Facility.

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B. DATA BASE

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

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the SFGH 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. Age appropriate screening tests, and /or diagnostic tests for purposes of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   c. Immunization update.
   d. Referral to specialty clinics and supportive services, as needed.

2. Patient conditions requiring Attending Consultation*:*
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies

c. Unexplained historical, physical or laboratory findings
d. Upon request of patient, NP, PA, or physician
e. Initiation or change of medication other than those listed in or approved by the formulary/ies.
f. Problem requiring hospital admission or potential hospital admission.

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (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.

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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. This protocol will be performed in the Family Health Center Clinic.

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 at presentation 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 as needed based on risk factors.
      4. Fetal heart tones
      5. Abdominal exam for fundal height (starting at 20 weeks gestation) and presentation (starting at 28 weeks).
      6. Presence of edema, generalized or dependent.
      7. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
      8. All Point of Care Testing (POCT) will be performed according to the SFGH 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. Age 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, HBsAg, RPR, HIV antibody, pap smear, clean catch urine culture, chlamydia, and gonorrhea and GBS culture.

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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 physician consultation:
   a. Maternal Conditions
      1. Pelvic mass noted by a physical exam or ultrasound. A corpus luteum cyst of 3.0 cm or less noted on ultrasound is a normal finding in the first trimester and does not need referral.
      2. Uterine malformations or lesions that would preclude a vaginal delivery (e.g., a myoma in the lower uterine segment that obstructs the endocervical canal). Certain uterine malformations are associated with miscarriage and preterm delivery. For these patients consultation should be obtained after the first visit. Patients with large fibroids in the lower uterine segment should be seen at 32-34 weeks to discuss delivery plans.
      3. Selected maternal infections with potential fetal sequelae (i.e.: toxoplasmosis, cytomegalovirus, rubella, parvovirus, syphilis, severe primary herpes, HIV).
      4. Recurrent pyelonephritis (more than one episode during pregnancy) or recurrent urinary tract infections (more than three during pregnancy despite antibiotic prophylaxis).
      5. Nephrolithiasis
      6. Persistent proteinuria (+1 or greater on a clean catch) in the absence of a urinary tract infection. A 24-hour urine for protein, serum creatinine and a urinanalysis with microscopy should be obtained prior to consultation.
      7. Persistent severe anemia with hematocrit less than 28% despite iron therapy.
      8. History of thromboembolic disease regardless of etiology.
      9. Hypothyroidism

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10. Preconceptional counseling (type I or Type II diabetics or any maternal disease that could be exacerbated by pregnancy, e.g., SLE,)
11. Seizure disorder which is well controlled on medications.
12. Blood pressure greater than 130/80 or if significant change from baseline in systolic or diastolic blood pressure.

b. Fetal Conditions
1. Suspected IUGR with ultrasound EFW less than or equal to the 10th percentile. Start antenatal testing the same day of diagnosis (if gestational age is greater than 26 weeks). A marked drop off in growth or poor interval growth on interval ultrasound should also be referred for consultation, even if percentile is still above the 10th percentile.
2. Fetal macrosomia with EFW greater than 95th percentile on ultrasound.
3. Oligohydramnios (AFI less than or equal to 5) client needs to be seen for OB consultation the same day (usually at the Birth Center).
4. Polyhydramnios noted on ultrasound (AFI greater than or equal to 24).
5. Any fetal structural abnormality detected by ultrasound. A level 2 ultrasound should be obtained if not already done.
6. Presence of antibodies to C, c, D, Kell, E, e or Duffy. Please call the OB attending or the lab medicine resident at SFGH for rarer or unusual antibodies that you may have questions about.

c. Obstetrical History
1. Recurrent pregnancy loss (history of three or more spontaneous abortions (SABs) if under age 35, two or more SABs if over age 35). Ideally, refer for preconceptional counseling or after initial visit if already pregnant.
2. History of preterm birth, refer to High Risk OB.
3. History of cesarean section. Refer to High Risk OB if undocumented or classical scar, or if two or more prior cesarean sections.

d. Refer to HROB referral guidelines for further conditions requiring consultation from an OB or transfer of care.

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.

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f. Pain management during labor and delivery.
g. Infant nutrition: breast or formula feeding.
h. Postpartum family planning.
i. Antenatal testing when indicated.

4. Follow-up (Intervals determined by risk factors)
   a. Every 4 weeks until 28 weeks gestational age.
   b. Every 2 weeks from 28 to 36 weeks gestational age.
   c. Every week after 36 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.

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Protocol #4: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from San Francisco General Hospital and Trauma Center. Directive to discharge patient will be from the attending physician in charge.

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

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

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

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

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

3. Education
   a. Review inpatient course and what will be needed for follow-up.
   b. Provide instructions on:
      - follow-up clinic appointments
      - outpatient laboratory/diagnostic tests
      - discharge medications

- signs and symptoms of possible complications

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

E. RECORD KEEPING

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

PROTOCOL #5: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II-V with possession of a DEA number. All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient-specific approval if they have completed education standards as defined by the Physician Assistant Committee. If the PA has completed the education module, the certification must be attached to the PA's Delegation of Service Agreement.

Nurse practitioners may order Schedule II-V controlled substances when in possession of a DEA number. Schedule II-III controlled substances may be ordered for, but not limited to, the following conditions: patients presenting with acute and chronic pain and patients presenting with ADHD or other mental health-related disorders requiring the use of controlled substance II medications. The practice site, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol.

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These formularies include San Francisco General Hospital and Trauma Center/ Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal (including Contract Drug List and formularies of managed care Medi-Cal plans), AIDS Drug Assistance Program, Blue Cross, Blue Shield, California Care, Pacific Care, Health Net, Healthy Families, United Healthcare, and Medicare Part D formularies.

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. When ordering respiratory treatments a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device, and frequency of treatments. Patient response will be monitored and documented.
   c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR/eCW, 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, quantity, amount of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      name of medication
      strength
      directions for use
      name of patient
      name of prescriber and title
      date of issue

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quantity to be dispensed
license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical, or laboratory findings
   d. Upon request of patient, nurse practitioner, physician assistant, or physician
   e. Initiation or change of medication other than those listed or approved by the formulary (ies)
   f. Problem requiring hospital admission or potential hospital admission
   g. Uncommon, unfamiliar, unstable, and complex patient conditions
   h. When requesting specialty consultation
   i. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.
   j. Acute, severe respiratory distress
   k. An adverse response to respiratory treatment, or lack of therapeutic response.

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

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

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record/LCR/MAR as appropriate. When a physician assistant writes a drug order for a controlled substance, the supervising physician must sign and date the chart containing such a drug order within seven (7) days.Protocol # 6: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the Family Community Medicine care sites.

1. Location to be performed will be the Family Health Center, Adult Urgent Care Center and on the Skilled Nursing Unit.

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2. Performance of procedure:
   a. Indications: This protocol covers patients presenting to the Adult Urgent Care for assessment and treatment of lacerations, abrasions, avulsions, bites and stings, burns and abscesses.
   b. Precautions
      - Immunocompromised patients.
   c. Contraindications:
      - Wound infection
      - Wound that has remained open for longer than six (6) hours.
      - Vascular compromise or cases when direct pressure does not stop bleeding.
      - Wounds requiring large areas of debridement or excision prior to closure.
      - Wounds with bone fragments involved.
      - Wounds with tendon, ligament, vessel or nerve involvement.
      - Head lacerations where galea disruption is greater than 2 cm.
      - Facial lacerations with cosmetic considerations (i.e., eyelids and vermillion borders).
      - Lacerations penetrating into joints.
      - Patients requiring conscious sedation.

Commented [Km20]: Can this 2nd one be deleted? It seems duplicative of the previous contraindication.

Deleted: <#>Lacerations to the hand greater than 6 hours old.¶

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

   2. Objective Data
      a. Physical exam appropriate to the procedure to be performed.
      b.
      c. Appropriate motor, sensory and vascular exam of the involved area according to the departmental resources (i.e. specialty guidelines).
      d. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
      e. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

Deleted: The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Unexplained historical, physical, or laboratory findings
   c. Upon request of patient, nurse practitioner, physician assistant, or physician
   d. Initiation or change of medication other than those listed in or approved by the formulary(ies)
   e. Problem requiring hospital admission or potential hospital admission

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite
1. New practitioner will attend a wound care/suturing course or lab (at outside facility or through SFGH.

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2. Training will Include:
   a. Indications for procedure and treatment
   b. Risks and benefits of procedure
   c. Related anatomy and physiology
   d. Consent process consistent with hospital policy
   e. Time out process consistent with hospital policy
   f. Wound infection and wound healing mechanisms
   g. Use of required equipment
   h. Steps in performing procedure
   i. Ability to recognize complications.

Proctoring Period

1. New practitioner to procedure, a minimum of 2 successful observed demonstrations. Chart review of all observed cases.
2. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstration. Chart review of all observed cases.
3. Explanation needed for any exceptions to minimum requirements.
4. Documentation of completion of training: orientation checklist, wound care lab letter, documentation of chart reviews.

Reappointment Competency Documentation

1. Evaluator will be the Medical Director, Physician-in-Charge or designated clinician.
2. Ongoing competency evaluation:
   a. Must perform wound care/suturing a minimum of 1 times every 2 years.
   b. One charts review needed to monitor competency every 2 years.

Commented [Km21]: Peer?

Deleted: or other attending physician.

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Commented [AT22]: To align with CPC

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PROTOCOL #7: Procedure: Splinting

A. DEFINITION

Splinting involves the immobilization of joints and/or limbs or appendages to stabilize and protect fractures, and/or to provide comfort for patients with fractures, sprains, or other musculoskeletal injuries.

1. Location to be performed**:** Family Health Center and the Adult Urgent Care Center.

2. Performance of procedure:
   a. Indications: fractures, sprains, tendon injuries, other musculoskeletal injuries and conditions for which splinting may be part of the standard of care for treatment
   b. Precautions: known allergies/adverse reactions to materials used for splinting
   c. Contraindications: open fractures, otherwise complicated fractures or other musculoskeletal conditions, coagulation disorder

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. 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 consistent with hospital policy before procedure is performed.
   b. Time out performed per hospital policy.
   c. Explain procedure to the patient.
   d. Diagnostic tests for purposes of disease identification.

e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical, or laboratory findings
   d. Upon request of patient, nurse practitioner, physician assistant, or physician
   e. Initiation or change of medication other than those listed in or approved by the formulary(ies)
   f. Problem requiring hospital admission or potential hospital admission

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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

Prerequisites
1. Procedure performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
2. Training will include:
   a. Indications for procedure and treatment
   b. Risk and benefits of procedure
   c. Related anatomy and physiology
   d. Obtain Consent consistent with hospital policy
   e. Perform a time Out consistent with hospital policy.
   e. Use of required equipment
   f. Steps in performing procedure

g. Ability to interpret results and formulate follow up plans. h. Ability to recognize complications.
Proctoring Period 1. New practitioners to procedure, a minimum of 2 successful observed demonstrations. Chart review of observed cases. 2. Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstration. Chart review of observed cases 3. Explanation needed for any exceptions to minimum requirements. 4. Documentation of completion of training must be sent to the Medical Staff Office.
Reappointment Competency Documentation 1. The Medical Director, Physician-in-Charge, attending physician or other designated clinician shall be the evaluator. 2. Ongoing competency evaluation a. Practitioner shall complete 1 procedure every 2 years. b. 1 Chart review of procedure must be completed every 2 years.

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PROTOCOL # 8: Procedure: Incision and Drainage (I&D) of Abscess

A. DEFINITION

Incision and Drainage (I&D) of an abscess involves making an incision in the skin in order to drain pus from an abscess. This protocol excludes abscesses on the face, neck, perirectal area and genitalia.

Deleted: Abscess

1. Location to be performed will be The Family Health Center, Adult Urgent Care Center and on the Skilled Nursing Unit.

2. Performance of procedure:
   a. Indications: abscess amenable by size and location to I&D with local anesthesia
   b. Precautions: known allergies/adverse reactions to materials used for incision and drainage, immunocompromised patients
   c. Contraindications: location near major blood vessels, nerves, or other significant anatomical structures that involve palmar or plantar spaces; location or large size of abscess necessitating I&D performed in an operating room under general anesthesia, and/or by specialist; coagulation disorder.

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. Obtain Patient consent consistent with hospital policy before procedure is performed.
   b. Explain procedure to the patient.
   c. 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.
f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Unexplained historical, physical, or laboratory findings
   c. Upon request of patient, nurse practitioner, physician assistant, or physician
   d. Initiation or change of medication other than those listed in or approved by the formulary(ies)
   e. Problem requiring hospital admission or potential hospital admission

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate.

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

F. Summary of Prerequisite, Proctoring and Reappointment Competency Documentation

Prerequisite
1. Procedure performed following standard medical technique according to departmental standards. 2. One year experience in wound care. 3. Training will include: a. Indications for procedure and treatment b. Risks and benefits of procedure and medications c. Related anatomy and physiology d. Consent process consistent with hospital policy e. Wound infection and healing mechanisms f. Use of required equipment

g. Steps in performing procedure h. Ability to interpret results and formulate follow up plans i. Ability to recognize complications
Proctoring 1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations. 2. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration. 3. Explanation will be needed for exceptions to the minimum requirements. 4. Documentation of training or experience will be sent to the Medical Staff Office.
Reappointment Competency Documentation 1. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the proctor. 2. Ongoing competency evaluation a. Completion of 1 procedures every 2 years. b. 1 chart reviews every 2 years.

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PROTOCOL # 9: Procedure: Arthrocentesis and Intraarticular Injections

A. DEFINITION

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

1. Location to be performed will be the Family Health Center and in the Adult Urgent Care Center.

2. Performance of procedure:
   a. Indications:
      Acute and chronic inflammatory musculoskeletal diseases/disorders such as osteoarthritis, tenosynovitis, bursitis, and entrapment neuropathies.

      Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of this will distinguish among hemarthrosis, effusion, fracture and septic arthritis.

   b. Precautions:
      Patients with a coagulopathy

   c. Contraindications:
      Severe dermatitis or soft tissue infection overlying the joint or acute trauma.

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b.
   c. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated.
   d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

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

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained consistent with hospital policy prior to start of procedure.
   b. Time out performed per hospital policy.
   c. The procedure is performed following standard medical technique
   d. Diagnostic tests for purpose of disease identification.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to orthopedic physician, specialty clinic and supportive services, as needed.

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

3. Education
   Patients will be informed that pain relief may occur immediately due to the early onset of certain drug preparations, but the longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

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.

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite 1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times. 2. Training will include; a. Indications for procedure and treatment. b. Risks and benefits of procedure and medication. c. Related anatomy and physiology. d. Consent process consistent with hospital policy. e. Time out policy and procedure f. Wound infection and wound healing mechanisms. g. Use of required equipment. h. Steps in performing procedures. i. Ability to interpret results and formulate follow-up plans. j. Ability to recognize complication.
Proctoring Period: 1. New practitioners to procedure will have a minimum of 2 successful observed demonstrations of each procedure/injection site. 2. Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration for each procedure/injection site. 3. Explanation of any exception to the above requirements will be sent as an attachment to the Proctoring Report. 4. Chart review will be done on all observed procedures. 5. Documentation of competency and proctoring will be sent to the Medical Staff Office at completion of the proctoring period.
Reappointment competency Documentation: 1. Performance of 2 procedures every 2 years. 2. 2 chart reviews every 2 years.

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Commented [Km27]: There are discrepancies across services for proctoring numbers. CPC requires 2; ED 3 new/2 experienced; Med 3 new/2 experienced; Ortho 3 new/1 experienced. Perhaps we should go with 3/2.

Commented [AT28]: Disc'd with CPC and MED, proposed to make no change to this.

Commented [Km29]: Discrepancies across services: CPC 1/1; ED 2/1; MED 4/2. 2/2 seems like a reasonable compromise.

PROTOCOL # 10: Procedure: Nail Debridement

A. DEFINITION

Nail debridement is the removal of elongated overgrown nail material.

1. Location to be performed will be the Family Health Center in the Adult Urgent Care Center and at the Behavioral Health Center/Mental Health Rehabilitation Center (BHC/MHRC) .

2. Performance of procedure:
   a. Indications: Elongated nail material, overgrowth, thick nail, painful fungal nails.
   b. Precautions: Vascular status, caution to amount of nail removed.
   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.
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Trim nails with use of sterile instrumentation.
   b. Diagnostic tests for purposes of disease identification.
   c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:
   a. Acute decompensation of patient situation

Deleted: and Removal/Matrisectomy

Deleted: Nail removal or Matrisectomy is the complete or partial removal of the nail bed and nail plate.¶

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Deleted: <#>Obtain patient consent consistent with hospital policy, before procedure is performed.¶
Explain the procedure to the patient.¶
Time Out performed per hospital policy.¶
The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).¶

b. Unexplained historical, physical, or laboratory findings
c. Upon request of patient, nurse practitioner, physician assistant, or physician
d. Problem requiring hospital admission or potential hospital admission
e. Uncommon, unfamiliar, unstable, and complex patient conditions

3. Education
Discharge information and instructions. Instructions will include signs and symptoms of infection and follow-up if infection occurs.

4. Follow-up
Will be determined based on individual needs for interval palliative survey.

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Deleted: High-risk patients will be followed at intervals for nail care. Post matrisectomy patients will be followed as needed to evaluate healing

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, Training, Proctoring and Reappointment Competency

Prerequisites
1. Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience. If has experience will still require direct observation. 2. Training will include;
a. Indications for procedure and treatment.
b. Risks and benefits of procedure and medication.
c. Related anatomy and physiology.
d. Consent process
e. Wound infection and wound healing mechanisms assessment
f. Use of required equipment.
g. Steps in performing procedures.
h. Ability to interpret results and formulate follow-up plans.
i. Documentation and CPT and ICD-10 coding
j. Ability to recognize complication.

Deleted: 1. Procedure performed following department standards.¶

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Proctoring: 1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations. 2. Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration. 3. Chart review of all observed cases.
Reappointment Competency: 1. Performance of 1 procedure and 1 chart review every 2 years. 2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

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PROTOCOL # 11: Procedure: Nail Removal/Matrisectomy

A. DEFINITION

Nail removal or Matrisectomy is the complete or partial removal of the nail bed and nail plate.

1. Location to be performed will be the Family Health Center, in the Adult Urgent Care Center and at the Behavioral Health Center/Mental Health Rehabilitation Center (BHC/MHRC) .

2. Performance of procedure:
   a. Indications: Chronic or acute nail infection (including fungal) or ingrown nails.
   b. Precautions: Severe infections that would indicate major surgical intervention and vascular status.
   c. Contraindications: Poor blood flow and other diagnoses not ruled out.

B. DATA BASE

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

2. Objective Data
   e. Physical exam appropriate to the procedure to be performed.
   f. The procedure is performed following standard medical technique
   g. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   h. 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

   h. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   i. Time out performed per hospital policy.
   j. Diagnostic tests for purposes of disease identification.
   k. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

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

2. Patient conditions requiring Attending Consultation:
   f. Acute decompensation of patient situation
   g. Unexplained historical, physical, or laboratory findings
   h. Upon request of patient, nurse practitioner, physician assistant, or physician
   i. Problem requiring hospital admission or potential hospital admission

3. Education
   Patient will be informed of post matrisectomy care. Will be instructed in signs and symptoms of infection and follow up if infection occurs.

4. Follow-up
   High risk patients will be followed at intervals for nail care. Post matrisectomy patients will be followed as needed to evaluate healing.

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, Training, Proctoring and Reappointment Competency

Prerequisites 1. Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience. If has experience will still require direct observation. 2. Training will include NP/PA being able to demonstrate knowledge of the following: a. Indications for procedure and treatment. b. Risks and benefits of procedure and medication. c. Related anatomy and physiology. d. Consent process e. Wound infection and wound healing mechanisms assessment f. Use of required equipment. g. Steps in performing procedures.

h. Ability to interpret results and formulate follow-up plans. i. Documentation and CPT and ICD-10 coding j. Ability to recognize complication.
Proctoring: 1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations. 2. Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration. 3. Chart review of all observed cases.
Reappointment Competency: 1. Performance of 1 procedure and 1 chart review every 2 years. 2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

Commented [Km34]: Ortho requires 3/1.

Commented [AT35]: Disc'd with CPC, MED: propose no change

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Commented [AT37]: Disc'd w CPCand MED: propose no change

Commented [Km38]: Peer?

Protocol #12: Procedure: Intrauterine device Insertion

A. DEFINITION
Intrauterine devices offer highly effective, safe, long-term contraception.

1. Location to be performed will be the Family Health Center and in the Adult Urgent Care Center.

2. Performance of procedure:
   i. Indications
      a. Patient desires intrauterine device
   ii. Precautions
      See IUD (Mirena/Skyla/Paragard) prescribing information

   iii. Contraindications
      a. Pregnancy or suspicion of pregnancy
      b. Known or suspected PID or cervical infection
      c. Post-partum endometritis or post abortal endometritis.
      d. Known or suspected uterine or cervical malignancy
      e. Genital bleeding of unknown etiology
      f. Wilson's disease (for Paraguard IUD (TM))
      g. Allergy to any component of Paragard IUD ™ or Mirena or Skyla IUS.
      h. 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 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.

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b. . Postpartum endometritis or postabortal endometritis in the past three months
Deleted: Acute pelvic inflammatory disease or current behavior suggestive of a high risk for pelvic inflammatory disease
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Deleted: e. Mucopurulent cervicitis¶
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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. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

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

Prerequisite: a. Prior experience or training required for this procedure. b. 6 months experience in women's health care. c. Review of departmental policies and procedures.
Proctoring:

Deleted: according to the departmental resources (i.e. specialty guidelines)

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a. Direct observation of a minimum of 2for a new provider and 2 procedures for a provider who has prior experience with independent IUD insertion. b. Documentation of training course completion.
Reappointment Competency: a. Performance of 1 insertion every 2 years. b. One chart review of an insertion every 2 years.

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Protocol #13: Procedure: Endometrial Biopsy

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A. DEFINITION
Evaluation of the endometrium by obtaining tissue for pathological diagnosis.

1. Location to be performed will be the Family Health Center and on the Adult Urgent Care Center.

2. Performance of procedure:
   i. 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.
   ii. Precautions
   Consult a physician before performing biopsies on women with extreme retroversion or anteversion of the uterus. Also consult when procedure requires manual dilation of the cervix.
   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.

Deleted: b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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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 according to the departmental resources (i.e. specialty guidelines).
d. Diagnostic tests for purposes of disease identification.
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.

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2. Patient conditions requiring Attending Consultation
   a. As noted in precautions for procedure.
   b. Acute decompensation of patient situation.
   c. Unexplained historical, physical or laboratory findings
   d. Uncommon, unfamiliar, unstable, and complex patient conditions
   e. Upon request of patient, NP, PA, or physician
   f. Initiation or adjustment of medication other than those listed in or approved by the formularies.
   g. 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

Prerequisites: a. At least 6 months experience in women's health care. b. Provider will observe a qualified provider do procedure 2 times Proctoring Period:

a. New practitioner to procedure, a minimum of 2 successful observed demonstrations b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations c. Chart review of all observed cases.
Reappointment Competency Documentation: a. Performance of 1 procedure every 2 years. b. 1 chart review every 2 years.

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Protocol #14: Procedure: Contraceptive Implant Insertion

A. DEFINITION

The transdermal 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 will be the Family Health Center and on the Adult Urgent Care Center.

2. Performance of procedure:
   i. Indications
      a. Women desires long acting, reversible contraceptive.
   ii. Precautions
      a. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.
      b. May have drug interactions with anti-HIV medications and some herbal products.
      c. See drug precautions/interactions in contraceptive implant prescribing information.
   iii. Contraindications
      a. Known or suspected pregnancy
      b. Current or past history of thrombotic disease
      c. Hepatic tumors, active liver disease
      d. Known, suspected or history of breast cancer
      e. Undiagnosed abnormal genital bleeding
      f. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to presenting complaint or procedure/surgery to be performed, including sexual history to rule out preexisting pregnancy.
   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, including a negative pregnancy test.

c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

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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. Timing of insertion: see prescribing information.
   c. Implant insertion as described in prescribing information.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Difficult insertions
   b. Acute decompensation of patient situation.
   c. Upon request of NP, PA or physician

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

Prerequisites: a. Completion of a company sponsored training program
Proctoring: a. Direct observation of 2 insertions by a qualified provider for providers new to this procedure.

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b. Direct observation by a qualified provider of 2 1 insertion for an experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years). 2. Chart review of all observed cases.
Reappointment Competency Documentation: a. A minimum of 6 insertions every 2 years. b. 1 chart review =needed every 2 years.

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Protocol #15: 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. 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 is not readily palpable.

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

Prerequisite: a. Completion of a company sponsored training class
Proctoring Period: a. Performance of a minimum of 6 removals for a new provider and 2 removals for a provider who has prior experience with independent removal. b. Proctor must be a qualified provider. *c. Chart review of all observed cases*
Reappointment Competency Documentation: a. Performance of 8 removals every 2 years. b. 2 chart review needed every two years.

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A. DEFINITION

Removal of a small portion of abnormal skin to be treated in a laboratory. There are three types of skin biopsy:

- Shave biopsy: the outer part of the suspect area is removed.
- Punch biopsy: a small cylinder of skin is removed using a punch tool.
- Excision biopsy: the entire area of abnormal growth is removed.

1. Location to be performed: is in the Family Health Center, Adult Urgent Care Center and on the Skilled Nursing Unit.

2. Performance of procedure:
   i. Indications
      a. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.
   ii. Precautions
      a. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
      b. Immunosuppresion, 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.

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

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

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

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites a. 2 direct observations of a qualified provider doing each procedure b. Review of aseptic technique c. Review of departmental policy and procedure
Proctoring Period a. New practitioner to procedure, a minimum of 2 successful observed demonstrations of each procedure b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations of each procedure c. Chart review of all observed cases.
Reappointment Competency a. Evaluator will be the Medical Director or other qualified provider b. Competency 1. Perform 1 of each procedure every 2 years. 2. 1 chart review of each procedure every 2 years.

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PROTOCOL #17: Procedure: Trigger Point Injection

A. DEFINITION:
A trigger point injection is the insertion of a needle into a trigger point, with or without injection of solution (e.g. saline, steroids, and anesthetics) into the region of the trigger point.

1. Indications:
   - When a trigger point (a focal area of soft tissue hyperirritability refers pain with palpation or elicits a twitch response) or a taut area of skeletal muscle, is felt to be contributing to pain

2. Precautions/contradictions:
   - Allergy to injectable medication
   - Close proximity to vital organs (e.g. potential risk of pneumothorax)

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
   b. Pertinent past medical history, injury event 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 such as myofascial pain with trigger points.

D. PLAN

1. Therapeutic Treatment Plan
   a. Explain the procedure to the patient.
   b. Patient consent obtained before procedure is performed.
   c. Time Out performed per hospital policy.
   d. The procedure is performed following standard medical technique according to the departmental guidelines.

   e. Diagnostic tests for purposes of disease identification.

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f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
g. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Patient will be informed that pain relief may occur immediately if anesthetics or steroids are injected. Baseline pain may recur upon clearance ("wearing out") of the medications from the area of injection. Patient will be instructed in signs and symptoms of infection or allergy and procedures to follow if they occur.

4. Follow-up
   Patients will be seen in follow up within 4-6 weeks.

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 a five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days.

F. Prerequisite, Proctoring and Reappointment Competency

Prerequisite:
Training by 3 direct observations of a qualified provider performing trigger point injections will occur.

Standardized Training will include NP/PA being able to demonstrate knowledge of the following for all noted injection sites:

1. Indications for procedure and treatment
2. Risks and benefits of procedure and medication
3. Related anatomy and physiology
4. Consent process
5. Wound infection and wound healing mechanisms
6. Use of required equipment
7. Steps in performing procedures
8. Ability to interpret results and formulate follow-up plans

9. Documentation and CPT and ICD-10 coding 10. Ability to recognize complication
Proctoring: a. New practitioners to procedure will have a minimum of 2 successful observed demonstrations of each injection site. b. Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstrations of each injection site. c. Chart review of all observed cases.
Reappointment Competency a. Performance of 2 injections every 2 years. b. 2 chart reviews every 2 years.

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Procedure #18: Waived Testing

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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: Urgent Care Clinic and Family Community Health Clinic.

2) The following non-instrument based waived tests are currently performed at SFGH:

a. Fecal Occult Blood Testing (Hemoccult ®)
Indication: Assist with detection or verification of occult blood in stool.

b. Vaginal pH Testing (pH Paper)
Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.

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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 Attending Consultation

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

3. Education

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

4. Follow-up

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

E. RECORD KEEPING

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,
Proctoring: Successful completion of Halogen quizzes for each of the waived tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module.
Reappointment Competency Documentation: Renewal required every two years with documentation of successful completion of the required Halogen quizzes. Provider must have passed each required module with a score of 80%.
Any additional comments: N/A

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Deleted: Procedure #17*:* Tattoo Removal¶
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A. DEFINITION¶
¶
The removal of a tattoo (or multiple tattoos) from a patient's skin using the medlite CB laser. The treatment is always conducted in conjunction and consultation with a laser technician from PRI, the company which rents the laser to the City and County of San Francisco. Treatment is scheduled every six to eight weeks, until such time as the desired cosmetic outcome is achieved or complications arise requiring the cessation, suspension, or modification of therapy.¶
¶
1. Location to be performed: San Francisco General Hospital and Trauma Center and affiliated SFDPH ambulatory settings..¶
¶
2. Performance of procedure:¶
a. Indications:¶
1. The presence of one or more tattoos on the patients skin, with a primary focus on gang-related tattoos or tattoos which convey gang-affiliation, especially in areas not usually covered by clothing(face, neck, hands, forearm's etc.)¶
b. Precautions:¶
1. A health screening questionnaire is completed by all program participants prior to acceptance into the program.¶
2. Providers check in with patients prior to each treatment session.¶
3. Extensive post-treatment counseling regarding after-care is conducted following each treatment session, ...