



**Zuckerberg San Francisco General Hospital and  
Trauma Center  
Committee on Interdisciplinary Practice**

**STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN  
ASSISTANT**

**PREAMBLE**

**Title: Neurology Nurse Practitioner/Physician Assistant**

**I. Policy Statement**

- A. It is the policy of the **San Francisco** Health Network and **Zuckerberg** San Francisco General Hospital and Trauma Center (**ZSFG**) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse –Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, **Pharmacists**, **Psychologists** 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 Neurology Department Office and on file in the Medical Staff Office.

**II. Functions to be Performed**

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

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

**Commented [JK1]:** Replacing SFGH with ZSFG throughout document

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

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

#### A. Setting

1. Location of practice is the outpatient Neurology Clinic ~~outpatient settings~~ and Inpatient units at Zuckerberg San Francisco General Hospital and Trauma Center.
2. Role in the outpatient and inpatient setting may include performing physical exams, diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications or issuing drug orders for the Neurology patient. Will only be seeing adult patients.

#### B. Supervision

1. Overall Accountability:  
The NP/PA is responsible and accountable to the Chief of Neurology.
2. A consulting physician which may include attending's and fellows, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:

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

**Commented [JK2]:** CIDP recommended review of FCM.SP wording of this item to wording that an Attending did not have to review every time. FCM wording: "Initiation or change of medication other than those listed in or approved by the formulary (ies)." done

#### IV. Scope of Practice

Protocol #1	Core – Neurology Clinic
Protocol #2	Core – Acute/Urgent Care
Protocol #3	Core - Furnishing Medications/Drug Orders
Protocol #4	Lumbar Puncture
Protocol #5	Ordering Transfusions
Protocol #6	eReferral eConsult Review
Protocol #67	Core - Discharge Inpatients

#### V. Requirements for the Nurse Practitioner/Physician Assistant

- A. Basic Training and Education
  - 1. Active California Registered Nurse/ Physician Assistant license.
  - 2. Successful completion of a program, which conforms to the Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.
  - 3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
  - 4. Maintenance of certification of Basic Life Support (BLS) by an approved American Heart Association provider.
  - 5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
  - 6. Copies of licensure and certificates must be on file in the Medical Staff Office.
  - 7. Furnishing Number within 12 months of hire.
  - 8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each practice site for each PA.
- B. Specialty Training

1. Specialty requirements
    - a. NP specialty certification as a ANP, FNP, ACNP
    - b. Certification as a Certified Neuroscience Registered Nurse (CNRN) within 3 years of hire
  2. Amount of previous experience in specialty area expected for this position.
    - a. Two years experience as a Registered Nurse or Nurse Practitioner in an acute care hospital or clinic within six months of hire
    - b. Two years experience as a PA in an acute care hospital or clinic within six months of hire.
- C. Evaluation of NP/PA Competence in performance of standardized procedures.
1. Initial: at the conclusion of the standardized procedure training, the Medical Director, supervising physician and other supervisors, as applicable will assess the NP/PA's ability to practice.
    - a. Clinical Practice
      1. Length of proctoring period will be three months. The term may be shortened or lengthened (not to exceed six months CCSF probationary period) at the discretion of the supervising physician. At the end of the proctoring term, the NP/PA will be generally supervised by Chief of Neurology, Neurology Service Attending, Neurology Fellow and Senior Neurology Residents.
      2. The evaluator will be the Chief of Neurology or designated Neurology Physician or **designated clinician**.
      3. The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
        - a. All cases are presented to the evaluator
        - b. Evaluator reviews co-signs orders and progress notes
        - c. Co-signatures by a licensed physician must be concurrent to patient care
        - d. Medical record review is conducted for out-patient discharge medication
        - e. Medical Record review may be conducted retrospectively by the Clinical Supervising Physician
        - f. Proctoring will include a minimum evaluation of five (5) chart reviews and direct observations, with at least one case representing each core protocol (core - neurology clinic, core

**Commented [JK3]:** In this section, the FCM SP s read: - Length of proctoring period will be time needed to do five (5) chart reviews.  
See next comment where the 5 case reviews are described for each of the core SPs. (I am also attaching the FCM SP so you can see how they worded this section).

acute/urgent care neurology inpatient service), lumbar puncture, ordering transfusions, discharge of inpatients, and furnishing medications/drug orders if applicable). Forty cases must be evaluated to complete proctoring

- g. Procedural skills are incorporated into the competency assessment orientation

- 2. Follow-up: areas requiring increased proficiency as determined by the initial or reappointment evaluation will be re-evaluated by the Medical Director and supervisor at appropriate intervals until acceptable skill level is achieved.
- 3. Ongoing Professional Performance Evaluation (OPPE)  
Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.
- 4. Biennial Reappointment  
Medical Director, and/or designated physician must evaluate the NP/PA's clinical competence. The number of procedures and chart reviews will be done as noted in the specific procedure protocols.

4.5 Ongoing:

- a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are 1) Examination of the patient by Supervising Physician the same day as care is given by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review

**Commented [JK4]:** CIDP concerned at the number of cases. Asked to consult other recently passed SP so that the minimum requirements were standardized across Services, with the understanding that if more review required due to experience, for example, with the SP. FCM-- "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.

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 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 Core – Neurology Clinic

A. DEFINITION

This protocol covers the procedure for health care management in the Neurology outpatient clinic. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses.

B. DATA BASE

1. Subjective Data

- a. Screening 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 symptoms.
- b. Ongoing/Continuity: review of symptoms and history relevant to the presenting complaint and/or disease process.
- c. Pain history to include onset, location and intensity.

2. Objective Data

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

C. DIAGNOSIS

Assessment of data from the subjective and objective findings, identification of risk factors and knowledge of disease processes will be used to derive a list of differential diagnoses. Status of disease may be stable, unstable, or 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. 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 physical or laboratory findings
- d. Uncommon, unfamiliar, unstable, and complex patient conditions
- e. Upon request of patient, NP, PA, or physician
- f. Initiation or change of medication other than those in the formularies.
- g. Problem requiring hospital admission or potential hospital admission.

3. Education

- a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling.
- b. Anticipatory guidance and safety education that is risk factor important.

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 percent (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.

Commented [VT5]: To keep consistent with V.C.4.a



Protocol #2: Core – 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. Patients will be seen in the Outpatient Neurology Clinic and Inpatient Units

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 ZSFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of disease.

D. PLAN

1. Therapeutic Treatment Plan

- a. Diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- c. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation
- b. Problem that is not resolved after reasonable trial of therapies
- c. Unexplained historical, physical or laboratory findings
- d. Uncommon, unfamiliar, unstable, and complex patient conditions

- e. Upon request of patient, NP, PA, or physician
- f. Initiation or change of medication other than those in the formularies.
- g. Any Problem requiring hospital admission or potential hospital admission.)

3. Education

Patient education should include treatment modalities.  
Discharge information and instructions.

4. Follow-up

As appropriate regarding patient health status and diagnosis.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)  
For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five percent (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.

Commented [VT6]: To keep consistent with V.C.4.a

Protocol #3: Core - 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. A copy of the Certificate must be attached to the physician assistants Delegation of Service document.

Nurse practitioners may order Schedule II - V controlled substances when in possession of 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 Schedule II medications.

Commented [VT7]: ?? Substitute "that may benefit from"

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The practice site scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies that will be used are: San Francisco General Hospital and Trauma Center, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

1. Subjective Data

- a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
- b. Pain history to include onset, location, and intensity.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Describe physical findings that support use for CSII-III medications.
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to the ZSFGHMG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.

D. PLAN

1. Treatment

- a. Initiate, adjust, discontinue, and/or renew drugs and devices.
- b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
- c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
  - i. location of practice
  - ii. diagnoses, illnesses, or conditions for which medication is ordered
  - iii. name of medications, dosage, frequency, and route, and quantity, amount of refills authorized and time period for follow-up.
- d. To facilitate patient receiving medications from a pharmacist provide the following:
  - i. name of medication
  - ii. strength
  - iii. directions for use
  - iv. name of patient
  - v. name of prescriber and title
  - vi. date of issue
  - vii. quantity to be dispensed
  - viii. license no., furnishing no., and DEA no. if applicable

Commented [JK8]: CIDP suggested changing to "EMR"

2. Patient conditions requiring Consultation
  - a. Problem which is not resolved after reasonable trial of therapies.
  - b. Initiation or change of medication other than those in the formulary.
  - c. Upon request of patient, NP, PA, or physician.
  - d. Failure to improve pain and symptom management.
3. Education
  - a. Instruction on directions regarding the taking of the medications in patient's own language.
  - b. Education on why medication was chosen, expected outcomes, side effects, and precautions.
4. Follow-up
  - a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. **RECORD KEEPING**

All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record ~~LCR/MAR~~ as appropriate. The medical Record of any patient cared for by a P.A. for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.

**Commented [JK9]:** Suggest EMR

Protocol #4: Procedure: Lumbar Puncture

A. DEFINITION

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

1. Location to be performed: Neurology Service Lumbar Puncture Clinic

2. Performance of Lumbar Puncture

a. Indications

1. To obtain Cerebral Spinal Fluid (CSF) for diagnosis of infectious, inflammatory or neoplastic diseases
2. To determine the presence of subarachnoid hemorrhage
- ~~3. To administer diagnostic and therapeutic agents/drugs such as antibiotics, chemotherapeutic agents, and radiographic isotopes~~
- ~~5. To facilitate closure of a CSF fistula~~

~~b~~ b. Precautions

1. Obtain brain imaging study ~~a CT head~~ to rule out mass effect, subarachnoid hemorrhage or obstructive hydrocephalus
2. Aseptic technique / avoid chemical meningitis, abscess
3. Platelets should be greater than or equal to 100,000
4. Patients on anticoagulants or who have bleeding tendencies (F.F., Von Willebrand's, Hemophilia, Liver disease)
5. ASA/NSAIDS/Cox II Inhibitors
6. Withdraw CSF slowly and only the amount that is needed (1 ml/tube)

c. Contraindications

1. Increased ~~i~~ intracranial ~~p~~ Pressure secondary to mass or mass effect
- ~~2. Intracranial mass or mass effect~~
3. Therapeutic anticoagulation or blood dyscrasias
- ~~4. Soft tissue infection at the entry site / spinal osteomyelitis~~
- ~~5. Known spinal subarachnoid block~~
- ~~7. Papilledema in the presence of supratentorial mass~~
- ~~9. Patient refusal~~

B. DATA BASE

**Commented [JK10]:** CIDP wondered with the detailed items in this list, would you also want to include INR since platelets are listed and the INR is listed in section B. Data base, 2. Objective data, item c. in this protocol?

1. Subjective Data

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

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination, assessment of papilledema, and integrity of the lumbar skin site.
- b. The procedure is performed following standard medical technique according to The Handbook of Neurosurgery by Mark Greenberg, Section 23.7.3. Lumbar Puncture.
- c. Laboratory evaluation to include CBC with platelets, PT, PTT, and INR. Brain i-Imaging evaluation, including CT head to rule out a mass lesion, a posterior fossa lesion, or subarachnoid hemorrhage, as indicated by history and physical exam.
- d. All Point of Care Testing (POCT) will be performed according to ZSFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes. Differential diagnoses would include but not limited to meningitis, encephalitis, sarcoidosis, subarachnoid hemorrhage, meningelial carcinomatosis, increased intracranial pressure, and decreased intracranial pressure.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent, consistent with hospital policy, obtained before procedure is performed.
- b. Timeout conducted consistent with hospital policy.
- c. Diagnostic tests on the CSF for purposes of disease identification may include protein level, glucose level, gram stain, culture and sensitivity, blood cell count and differential, and measurement of CSF pressure. Additional diagnostic tests may include: cytologic testing, staining for

AFB, cryptococcal antigen, serologic testing for syphilis, Lyme disease, viral titers, immunoglobulin profiles, and oligoclonal banding.

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

2. Patient conditions requiring Attending Consultation

- a. All patients requiring this procedure will receive Attending Consultation

3. Education

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

4. Follow-up

As appropriate for procedure performed.

- a. Assess for signs and symptoms of insertion site infection
- b. Assess for signs of CSF leak
- c. Assess for complaints of headache in the upright position

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 Documentation

Prerequisites Completion of standardized procedure training on site
Proctoring Period a. Minimum of 3 successful observed demonstrations b. Minimum of 3 chart reviews



Reappointment Competency

- a. Evaluation will be performed by Supervising Physician and/or his or her designee
- b. Ongoing competency evaluation.
  - 1. Completion of three procedures every 2 years.
  - 2. Three chart reviews needed every 2 years

## Protocol #5: Ordering Blood Transfusions

### A. DEFINITION

Ordering the administration of whole blood or blood components i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate.

1. Location to be performed: Neurology Clinic.
2. Performance of procedure:
  - a. Indications
    1. Anemia
    2. Thrombocytopenia or platelet dysfunction
    3. Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means.
  - b. Precautions
    1. Blood and blood components must be given according to ZSFGH guidelines.
    2. Emergency exchange transfusion orders are not covered by this standardized procedure. – these must be countersigned by the responsible physician.
    3. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.
  - c. Contraindications
    1. Absolute: none
    2. Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenia purpura ( TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.

### B. DATA BASE

1. Subjective Data
  - a. History and review of symptoms relevant to the presenting complaint and reason for transfusion.
  - b. Transfusion history, including prior reactions, minor red cell antibodies and allergies.
2. Objective Data
  - a. Physical exam relevant to the decision to transfuse.
  - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

#### C. DIAGNOSIS

Assessment of subjective and objective data to direct transfusion therapy and identify contraindications to transfusion.

#### D. PLAN

1. Therapeutic Treatment Plan
  - a. Patient consent must be obtained before writing transfusion orders.
  - b. Outpatients must be provided with post-transfusion instructions. (ZSFGH Form).
  - c. Appropriate post-transfusion laboratory studies are ordered to assess therapeutic response.
  - d. Referral to physician, specialty clinics and supportive services as needed,
2. Patient conditions requiring Attending Consultation
  - a. Acute decompensation of patient situation.
  - b. Unexplained historical, physical or laboratory findings
  - c. Uncommon, unfamiliar, unstable, and complex patient conditions
  - d. Upon request of patient, NP, PA, or physician
  - e. Problem requiring hospital admission or potential hospital admission.
3. Education  
Discharge information and instructions, post-transfusion orders for outpatients.
4. Follow-up  
As appropriate for patients condition and reason transfusions were given.

#### E. RECORD KEEPING

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

**Commented [JK11]:** Suggested striking this phrase out to just state medical record which would include paper and EMR.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisite:</p> <ol style="list-style-type: none"><li>a. Successful completion of the San Francisco General Hospital Transfusion Training course.</li><li>b. Successful completion of Transfusion Training course test on blood ordering and informed consent.</li><li>c. Must have an 80% test score on both examinations.</li></ol>
<p>Proctoring Period:</p> <ol style="list-style-type: none"><li>a. Read and Sign the <u>ZSFGH</u> Administrative Policy and Procedure 2.3 "Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options".</li><li>b. Read <u>ZSFGH</u> Transfusion Guidelines in Laboratory manual.</li><li>c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.</li></ol>
<p>Reappointment Competency Documentation:</p> <ol style="list-style-type: none"><li>a. Completion of the two education modules and completion of the two examinations with a passing score of 80%.</li><li>b. Performance of 1 transfusion order per year and 1 medical record review per year.</li><li>c. Review of any report from the Transfusion Committee.</li><li>d. Evaluator will be the medical director or other designated physician.</li></ol>

PROTOCOL #56: ~~eReferral-eConsult~~ Review

Commented [JK12]: April eConsult went live – replaced eReferral with eConsult or eConsults where applicable

A. DEFINITION

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

1. Prerequisites:

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

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the ~~eReferral-eConsult~~ system.

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

4. Reappointment: 5 chart reviews will be needed for reappointment every 2 years.

Commented [JK13]: Referrals?

B. DATA BASE

1. Subjective Data

- a. History: age appropriate history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems relevant to the presenting disease process as provided by the referring provider on the electronic referral. ~~eReferral-eConsult~~ review will be confined to data found in the submitted eReferral form. Data contained in the paper or electronic medical record, but not

in the [eReferral-eConsult](#), is specifically excluded from the [eReferral-eConsult](#) review. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

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

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Review of eReferral

- a. Algorithms or referral guidelines developed and approved by the Chief of Service will be used to facilitate screening, triaging and prioritizing of patients in the [eReferral-eConsult](#) system.
- b. All data provided via the [eReferral-eConsult](#) consultation request will be reviewed and assessed for thoroughness of history, adequacy of work up, and urgency of condition.
- c. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient conditions requiring Attending Review

- a. Upon request of the referring NP, PA, or physician
- b. Problem requiring hospital admission or potential hospital admission
- c. When recommending complex imaging studies or procedures for the referring provider to order
- d. Problem requiring emergent/urgent surgical intervention

e. As indicated per the algorithms developed by the Chief of Service

3. Education

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

4. Scheduling of Appointments

a. Dependant upon the urgency of the referral, the [eReferral](#) [eConsult](#) will be forwarded to the scheduler for either next available clinic appointment scheduling or overbook appointment scheduling.

5. Patient Notification

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

E. RECORD KEEPING

All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the ~~lifetime clinic record (LCR)~~[electronic medical record \(EMR\)](#) upon scheduling or after a period of six months.

During the proctoring period, the ~~eReferral consultation~~[eConsult](#) request will be printed and the provider recommendations will be written on the print out. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into the ~~LCR-EMR~~ and forwarded to the scheduler.

Protocol #67: Core - Discharge of Inpatients

A. DEFINITION

This protocol covers the discharge of inpatients from Zuckerberg San Francisco General Hospital.

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) has been made.
    - d. Referral to specialty clinics and supportive services, as needed.
  2. Patient conditions requiring Attending Consultation
    - a. Acute decompensation of patient situation.
    - b. Problem that is not resolved after reasonable trial of therapies.
    - c. Unexplained historical, physical or laboratory findings.
    - d. Upon request of patient, NP, PA or physician.
    - e. Initiation or change of medication other than those in the formulary.
  3. Education
    - a. Review inpatient course and what will need follow-up.
    - b. Provide instructions on:
      - follow-up clinic appointments
      - outpatient laboratory/diagnostic tests
      - discharge medications
      - signs and symptoms of possible complications
  4. Follow-up
    - a. Follow-up appointments
- b. Copies of relevant paperwork will be provided to patient.

E. RECORD KEEPING



All information from patient hospital stay will be recorded in the medical record (e.g.: discharge summary, discharge order sheet, progress notes ) For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five percent (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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