STANDARDIZED PROCEDURE – NURSE PRACTITIONER / #7
PHYSICIAN ASSISTANT
Surgery Department

PREAMBLE

Title: Surgery Department

I. Policy Statement

A. It is the policy of the 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, 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 Department of Surgery and in the Integrated Soft Tissue Infection Service (ISIS) and on file in the Medical Staff Office.

II. Functions To Be Performed

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

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

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician

assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every ten years and sit for a recertification examination every ten years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Delegation of Services Agreement (documents supervising agreement between supervising physician and PA).

The NP/PA conduct physical exams, diagnose and treat illness, order and interpret tests, counsel on preventative health care, assist in surgery, perform invasive procedures and furnish medications/issue drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is Outpatient clinics, Specialty Clinics, Inpatient Units, Intensive Care Units, Operating Room and Emergency Department.

B. Supervision

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

   2. A consulting physician, who may include attending, or credentialed 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 or instability as defined by an extreme deviation from normal parameters of standard physiologic variables.
      b. Problem that is not resolved after reasonable trial of therapies.

c. Unexplained historical, physical, or laboratory findings.
d. Upon request of patient, affiliated staff, or physician.
e. Problem requiring hospital admission or potential hospital admission.
f. Acute, severe respiratory distress.
g. An adverse response to treatment, or a lack of therapeutic response.
h. When consultants from any other service are used.

IV. Scope of Practice

1. Protocol #1: Health Care Management: Acute/Urgent Care
2. Protocol #2: Health Care Management: Primary Care/Specialty Clinics/Inpatient Units
3. Protocol #3: Furnishing Medications and Drug Orders
4. Protocol #4: Discharge of Inpatients
5. Protocol #5: eReferral Review
6. Protocol #6: Procedure: Chest Tube Insertion
7. Protocol #7: Procedure: Chest Tube Removal
8. Protocol #8: Procedure: Clinical Clearance of Spine Precautions
9. Protocol #9: Procedure: Incision and Drainage of Skin Abscesses with Administration of Local Anesthesia
10. Protocol #10 Procedure: Ordering Blood Transfusions
11. Protocol #11: Procedure: Sharp Debridement of Necrotic and Nonviable Tissue From a Wound Bed and Periwound Area
12. Protocol #12: Procedure: ~~Surface~~ Soft Tissue Injury ~~Trauma~~ and Wound Care
13. Protocol #13: Procedure: Surgical First Assist
14. Protocol #14. Procedure: Waived Testing
15. Protocol #15: Procedure: Tracheotomy Tube Change
16. Protocol #16: Procedure: Musculoskeletal Soft Tissue Injections / Aspirations

V. Requirements for the Nurse Practitioner (NP)/Physician Assistant (PA)

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. Affiliated staff hired prior to 2003 will be "grandfathered" regarding need for Board Certification.

4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
5. Possession of a National Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number when having a furnishing number.
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. NP: Successful completion of the Trauma Nurse Core Course (TNCC) within one year of hire and/or audit advanced Trauma Life Support (ATLS).
   2. PA: Audit of Trauma Nurse Core Course (TNCC) within one year of hire and/or audit advanced Trauma Life Support (ATLS).

VI. Evaluation

A. Evaluation of NP/PA Competence in performance of standardized procedures.
   1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician as applicable will assess the NP/PA's ability to practice.
      a. Clinical Practice
         - Length of proctoring period will be: three months which can be shortened or lengthened (not to exceed six months CCSF probationary period). Please note numbers as noted in each protocol.

      b. Format
         - All cases presented to proctor
         - Proctor reviews co-signed orders and progress notes.
         - Co-signatures must be concurrent to patient care.
         - Chart review is conducted for inpatient medication ordering and out patient discharge medications.
         - Proctored cases as noted for procedures and 20 cases for Core Protocols 1-4, with a minimum of 5 cases for

each core category. One case may apply to multiple categories including core and special procedures. For reappointment will need 5 chart reviews every 2 years. Charts can include reviews completed for special procedure reviews.

c. The evaluator will be*:* Medical Director, Chief of Service and/or designated supervising physicians as applicable.
d. The method of evaluation in clinical practice will be that needed to demonstrate clinical competence as noted in each protocol.

2. Follow-up: areas requiring increased proficiency as determined by the initial evaluation will be re-evaluated by the Medical Director, and/or designated same discipline proctors as applicable.

3. Ongoing Professional Performance Evaluation (OPPE) Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and report sent to the Medical Staff Office.

4. Biennial Reappointment: Medical Director, designated physician or designated same discipline peer must evaluate the NP/PA's clinical competence as noted in each protocol.

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

sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

VII. Development and Approval of Standardized Procedure

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

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

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

D. Revisions
   1. All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.

Protocol #1: Health Care Management – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions within outpatient clinics, inpatient units, ICU and the Emergency Department.

B. DATA BASE

1. Subjective Data
   a. Screening: age appropriate history that includes but is not limited to: past medical history, pre-hospital incident 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/injury process or presenting complaint.
   c. Pain history to include onset, location and intensity.
   d. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

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 ZSFG 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.

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. Any Problem requiring hospital admission or potential hospital admission.

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

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

E. RECORD KEEPING

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

Protocol #2: Health Care Management – Specialty Clinics/Inpatient Units

A. DEFINITION

This protocol covers the procedure for age appropriate health care management in specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses within outpatient clinics, Emergency Department, Inpatient units, ICU.

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 ZSFG 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. Uncommon, unfamiliar, unstable and complex patient conditions.
   e. Upon request of patient, NP, PA, or physician
   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.
   c. Discharge information and instructions.

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

E. RECORD KEEPING

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

Protocol #3: Furnishing Medications/Drug Orders

A. DEFINITION

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

B. DATA BASE

1. Subjective Data
   a. 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 appropriate to presenting symptoms.
   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 ZSFG POCT policy and procedure 16.20.

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

D. PLAN
1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
   c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
      1. location of practice
      2. diagnoses, illnesses, or conditions for which medication is ordered
      3. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist the following information must be provided:
      1. name of medication
      2. strength
      3. directions for use
      4. name of patient
      5. name of prescriber and title
      6. date of issue
      7. quantity to be dispensed
      8. license no., furnishing no., and DEA no.
   e. Limitations
      1. A prescription for a Schedule II or III controlled substance shall be limited to the number of tablets needed until the next scheduled follow-up clinic appointment.
      2. No refills will be allowed for lost or stolen narcotic prescriptions.

2. Patient conditions requiring Attending Consultation
   a. Problem which is not resolved after reasonable trial of therapies.
   b. Unexplained historical, physical or laboratory findings.
   c. Upon request of patient, NP, PA, or physician.
   d. Failure to improve pain and symptom management.
   e. Acute, severe respiratory distress

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\eCW as appropriate The medical record of any patient cared for by a PA for whom the supervising physician and surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.

Protocol #4: Discharge of Inpatients

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

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

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

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

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

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 need follow-up.

b. Provide instructions on:
- follow-up clinic appointments
- outpatient laboratory/diagnostic tests
- discharge medications
- signs and symptoms of possible complications

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

E. RECORD KEEPING

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

Protocol #5: eReferral Review

A. DEFINITION

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

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

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

3. Proctoring: Concurrent review of the first 20 eReferral consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.

4. Reappointment: A review of five eReferrral consultations every two years.

B. DATA BASE

1. Subjective Data
   a. History: age appropriate history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems relevant to the presenting disease process as provided by the referring provider on the electronic referral. eReferral review will be confined to data

found in the submitted eReferral form. Data contained in the paper or electronic medical record, but not in the eReferral, is specifically excluded from the eReferral review. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

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

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

C. DIAGNOSIS

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

D. PLAN

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

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

e. When recommending complex imaging studies or procedures for the referring provider to order.
f. Problem requiring emergent/urgent surgical intervention.
g. As indicated per the algorithms developed by the Chief of Service.

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

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

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

E. RECORD KEEPING

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

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

Protocol #6: Procedures: Chest Tube Insertion

A. DEFINITION

For the purposes of this protocol, a chest tube is defined as an indwelling catheter placed in the thoracic cavity for therapeutic removal of fluid or air, or a catheter placed by the interventional Radiology service for similar processes.

Pneumothorax: accumulation of air or gas in the pleural cavity occurring as a result of disease or injury.

Hemothorax: accumulation of blood in the pleural cavity.

Effusion: accumulation of excess fluid in the pleural cavity.

The insertion of a chest tube will be performed in the in-patient setting.

1. Location to be performed: inpatient units, ICU and Emergency Department.

2. Performance of procedure:
   a. Indications
      1. Clinically or radiographically significant pneumothorax or fluid collection in the thoracic cavity requiring evacuation.
      2. Some mechanism of injury in concert with clinical observations support empiric chest tube placement (including, but not limited to cardiac dysrhythmias/pulseless electrical activity following blunt force trauma, complications following chest tube removal, penetrating trauma to the chest/upper quadrants of the abdomen).
      3. Patient's current chest radiograph/laboratory studies support procedure.
   b. Precautions/Contraindications
      1. History of multiple previous chest tube insertions on the same side.

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 to include auscultation of breast sounds, inspection of chest wall, oxygen saturation and requirements, respiratory rate and quality.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS
Accumulation of air (pneumothorax) or fluid (hemothorax or effusion) in the pleural cavity requiring evacuation.

D. PLAN
1. Therapeutic Treatment Plan
   a. Explain procedure to the patient, if possible. If patient unable to understand, advise bedside nurse of procedure and plan.
   b. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   c. Time out performed per hospital policy.
   d. If indicated, provide appropriate analgesia prior to the initiation of the procedure.
   e. Diagnostic tests for purposes of disease identification.
   f. Some patients will require urgent chest tube placement based on physical exam, injury history and clinical instability such as decreased oxygen saturation, hypotension, dysrhythmia, uncontrolled bleeding.
   g. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings.
   c. Uncommon, unfamiliar, unstable, and complex patient conditions.
   d. Upon request of patient, NP, PA or physician.
   e. When initial chest tube output exceeds 500 ml.
   f. If insertion of chest tube fails to cause resolution of intra-thoracic collection (e.g. persistent pneumothorax, persistent fluid collection).

3. Education
   Provide patient education related to procedure.

4. Follow-up
   1. Reassess the patient frequently following the procedure.
   2. Obtain a chest x-ray to confirm placement of the chest tube and therapeutic effect of the procedure.

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

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care: ~~Prerequisite~~: a. Completion of standardized training at either ATLS or other approved skills lab.
Proctoring Period: a. A minimum of 5 procedures to be directly observed b. Chart reviews needed of 5 observed cases.
Reappointment Competency Documentation: a. Minimum number of 3 procedures that must be completed every two years. b. Minimum number of 3 chart reviews needed every two years.

Protocol #7: Procedure: Chest Tube Removal

A. DEFINITION

For the purpose of this protocol, a chest tube is defined as and indwelling catheter placed in the thoracic cavity for the therapeutic removal of fluid or air, or a catheter placed by the interventional Radiology service for similar processes.

1. Location to be performed: Inpatient unit or ICU.

2. Performance of procedure:
   a. Indications
      1. Patient symptoms related to intrapleural air/blood have diminished
      2. Patient's current chest radiograph/laboratory studies support procedure.
   b. Precautions
      1. Relevant diagnostic modalities indicate continued presence of air/fluid.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
   b. Relevant history and review of symptoms including but not limited to respiratory comfort, complaining of shortness of breath, exercise tolerance.

2. Objective Data
   a. Appropriate physical exam including but not limited to: results of previous chest imaging, quality and quantity of output from the chest tube evaluation for air leak, oxygen saturation and breath sounds, to confirm appropriateness of procedure.
   b. The procedure is performed following standard medical technique according to the departmental guidelines.
   c. Evaluation of the chest tube insertion site for signs of infection including but not limited to purulence, erythema, induration, fluctunce, foul odor.
   d. Review of current medication regimen including recent analgesia administration.
   e. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

C. DIAGNOSIS

Resolution of pneumothorax, hemothorax, suspected malfunction of the chest tube to function adequately (e.g. suspected clotted tube, proximal hole external to chest wall cavity).

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. This procedure will be performed following standard medical technique according to departmental guidelines.
   e. Observe patient for signs of respiratory compromise immediately following procedure including (as indicated) respiratory rate, respiratory pattern, oxygen saturation and resolution of pain symptoms (if any). For ventilated patients, observe the measured airway pressures post removal.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Evidence of, or suspicion of intra-thoracic air entrapment at the time of or immediately after removal(e.g. audible leaking from the chest wound site at the time of removal, increased intra-thoracic pressures on ventilated patients).
   c. Inability to remove the chest tube, fractured or retained catheter,
   d. Evidence of increasing or unstable pneumothorax on post-pull imaging.
   e. Unexplained historical, physical or laboratory findings.
   f. Uncommon, unfamiliar, unstable, and complex patient conditions.
   g. Upon request of patient, NP, PA, or physician.

3. Education
   Provide patient education related to procedure. If patient is unable to comprehend instructions due to decreased mental status, provide nursing instruction prior to performance. If patient is on a ventilator or positive pressure ventilation advise respiratory therapist prior to performance.

4. Follow-up
   a. Reassess the patient frequently following the procedure.
   b. As appropriate, obtain a follow-up chest radiograph 4-6 hours after the completion of the procedure.
   c. Advise the patient and the nurse not to disrupt the occlusive dressing for at least 72 hours post removal.

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

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care~~Prerequisite~~: a. Completion of training on site
Proctoring Period: a. Minimum of 5 procedures to be directly observed b. Chart review of all observed cases.
Reappointment Competency Documentation: a. Minimum number of 3 procedures must be completed every two years. b. Minimum of 3 chart reviews needed every two years.

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Protocol #8: Procedure: Clinical Clearance of Spine Precautions

A. DEFINITION

Cervical Spine Injury refers to a bony injury of the first through seventh cervical vertebrae. A cervical spine injury is usually identified by plain film x-rays or cervical spine CT scan. For the purposes of this protocol, the patient with significant neck pain will be considered to have a spinal/spinal cord injury until proven otherwise.

A Cervical Spinal Cord Injury refers to an injury to the spinal cord from the first through the eighth cervical spinal root or to the cord itself, as a cord compression. Injuries to the cervical spinal cord are usually identified by physical examination during the trauma resuscitation, and may be confirmed by MRI imagining. Such findings may include sensory and/or motor changes in the dermatomes consistent with the level of injury.

Appropriate Mentation refers to the patient's ability to clearly and competently participate in an examination of the cervical spine and spinal cord function. This implies a Glasgow Coma Scale (GCS) Score of 15 and the absence of drug/alcohol intoxication. In addition, there should be no evidence of head injury or distracting injuries which would render an examination invalid.

1. Location to be performed: inpatient units, outpatient clinics, ICU and Emergency Department.

2. Performance of procedure:
   a. Indications:
      Patients who have sustained a blunt trauma mechanism consistent with potential axial spine injury. Patients who meet all the following criteria may be candidates for clinical exam clearance of the cervical spine without radiographic imaging.
      - Appropriate mentation, cooperative and communicative (no language barrier)
      - No clinical evidence of CNS or focal neurological injury
      - No subjective complaints of shoulder, neck or interscapular pain
   b. Precautions: None
   c. Contraindications:
      - Inappropriate mentation
      - Clinical evidence of CNS or focal neurological injury

- Complaints of shoulder, neck, interscapular pain or another significant distracting injury.

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental guidelines.
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

The patient's cervical spine should be cleared radiographically in the majority of cases. In specific situations where the subjective and objective data support clinical clearance of the cervical spine, the Trauma NP will contact the Trauma Service Attending for consultation.

D. PLAN

1. Therapeutic Treatment Plan
   a. In the event of findings consistent with cervical spine and/or cervical cord injury, the patient will be placed in a rigid immobilization collar and airway management ensured.
   b. If the patient is deemed eligible for cervical spine clinical clearance, allow the patient to actively rotate left and right, flex and extend his/her neck actively. If a normal range of motion is attained with no or minimal pain, the patient's cervical spine does not require imaging.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Inappropriate mentation
   c. Cervical Spine Clearance without imaging
   d. Unexplained historical, physical or laboratory findings

e. Uncommon, unfamiliar, unstable, and complex patient conditions
f. Upon request of patient, NP, PA, or physician
g. Clinical evidence of CNS or focal neurological injury

3. Education
Upon cervical spine clearance, the patient will be instructed to report any symptoms related to cervical spine and/or cervical cord injury (e.g.: onset of cervical pain, numbness or tingling of any extremity, weakness of any extremity, pain that radiates down the arms).

4. Follow-up
The patient with suspected cervical spine injury will be evaluated by the Spine Service of the day.

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

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care~~Prerequisite~~: a, Completion of training on site
Proctoring Period: a. Minimum of 3 procedures needed to be directly observed b. Chart reviews of all observed procedures
Reappointment Competency Documentation: a. Minimum number of 3 procedures must be completed every two years. b. Minimum number of 3 chart review needed every two years.

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Protocol #9: Procedure: Incision and drainage of skin abscesses with administration of local anesthesia

A. DEFINITION
Abscesses resolve with drainage. Abscesses that do not respond to more conservative measures may need incising in order to facilitate drainage and hasten resolution.
1. Location to be performed: For the purposes of this protocol, the procedure may be completed at the outpatient Burn/Wound and ISIS clinics at San Francisco General Hospital and Trauma Center.
2. Performance of procedure:
   a. Indications:
      Palpable, fluctuant skin abscesses
   b. Precautions:
      Large abscess that require extensive incising or debridement
   c. Contraindications:
      -Deep abscess that may require more extensive anesthesia
      -Abscess that invades the palmar or plantar spaces
      -Suspected pseudo aneurysm (must be ruled out by further diagnostic evaluation)
   d. Exclusions:
      Abscesses on the face, neck, perirectal area, and genitalia

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.

b. Time out performed per hospital policy.
c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling.
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.
   c. 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

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care: ~~Prerequisites~~ a. The nurse practitioner will be trained to successfully perform the procedure through instruction and proctoring by the Medical Director of Plastic Surgery Services or his/her designee.
Proctoring Period a. A minimum of 3 successful observed demonstrations. b. Chart review of all observed procedures.

Reappointment Competency Documentation

a. Ongoing competency evaluation.
    1. The number of procedures needed to maintain proficiency will be 2 procedures every two years.
    2. Two chart reviews needed every 2 years.
b. The evaluator will be the Medical Director of Plastic Surgery Services or his/her designee.

Protocol #10: 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: inpatient units, outpatient clinic, ICU and Emergency Department.

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 ZSFG 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 ZSFG 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. (ZSFG 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, ICIA, LCR and other patient data bases, as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The

physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Successful completion of the San Francisco General Hospital Transfusion Training course. b. Successful completion of Transfusion Training course test on blood ordering and informed consent. c. Must have an 80% test score on both examinations.
Proctoring Period: a. Read and Sign the ZSFG Administrative Policy and Procedure 2.03 “Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options”. b. Read ZSFG Transfusion Guidelines in Laboratory manual. c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.
Reappointment Competency Documentation: a. Completion of the two education modules and completion of the two examinations with a passing score of 80%. b. Performance of 1 transfusion order per year and 1 medical record review per year. c. Review of any report from the Transfusion Committee. d. Evaluator will be the medical director or other designated physician.

Protocol #11: Procedure: Sharp debridement of necrotic and nonviable tissue from a wound bed and periwound area

A. DEFINITION

Sharp debridement is the process of removing irreversibly damaged and necrotic/devitalized tissue using surgical instruments in order to promote wound healing and decrease bioburden. A more favorable outcome may be achieved with the administration of a local anesthetic.

1. Location to be performed: For the purposes of this protocol, the procedure may be completed in the outpatient Burn/Wound and ISIS clinics at San Francisco General Hospital and Trauma Center.
2. Performance of procedure:
   a. Indications:
      Patients who present with necrotic, devitalized tissue in and around the wound
   b. Precautions:
      1. Coagulopathy or patients who are taking anticoagulant medications
      2. When debridement may expose viable tendon, bone, ligament or fascia
   c. Contraindications:
      1. Ischemic wounds located in areas with inadequate arterial perfusion

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical, or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Problem requiring hospital admission or potential hospital admission.
3. Education:
   Discharge information and instructions.
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, Reappointment of Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care~~Prerequisite~~:

1. The nurse practitioner will be trained to successfully perform the procedure through instruction and proctoring by the Director of Plastic Surgery Services or his/her designee.

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2. The nurse practitioner will also attend an accredited workshop in instrumental debridement of necrotic wounds.
Proctoring: 1. A minimum of 2 successful observed demonstrations. 2. Explanation needed for any exceptions to minimum requirements
Reappointment Competency Documentation: 1. The number of procedures needed to maintain proficiency will be 2 every two years. 2. The number of chart reviews needed to monitor ongoing competency will be 2 every two years.

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / #7
PHYSICIAN ASSISTANT
Surgery Department

Protocol #12**:** Procedure: ~~Surface Trauma~~Soft Tissue Injury and Wound Care

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

1. Location to be performed**:** inpatient units, outpatient clinics, ICU and Emergency Department.

2. Performance of procedure:
   a. Indications
      - This protocol covers patients presenting to one of the above listed sites for assessment and treatment of lacerations, abrasions, avulsions, bites and stings, burns and abscesses
   b. Precautions (The following require consultation with the attending physician)
      - Wounds requiring repair of cartilage
      - ~~Uncooperative~~ Ppatients with behavioral challenges and high risk wound repairs to the patient and the provider
   c. Contraindications
      - Vascular compromise or cases where direct pressure does not stop bleeding
      - Wounds requiring large area of debridement or excision prior to closure
      - Wounds with bone fragments involved
      - Wounds with tendon, ligament, vessel or nerve involvement
      - Head lacerations where galea disruption is greater than 2 cm.
      - Facial lacerations with cosmetic consideration(i.e. Eyelids and vermillion borders)
      - Lacerations penetrating into joints
      - Patients requiring procedural sedation
      - Children under age of 10 years old
      - Wounds requiring repair of cartilage
      - Closure of an infected wound

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, tetanus prophylaxis history, current medications, allergies, vocation/avocation.

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   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 ZSFG POCT policy and procedure 16.20.

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

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

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

3. Education:
   Discharge information and instructions.

4. Follow-up:
   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

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care~~Prerequisite~~: a. New practitioner will attend wound care/suturing course or a lab at an outside facility or attend a course in the ZSFG. ~~b. The NP/PA will be directly observed and assisted performing the procedure by a qualified provider.~~
Proctoring: a. After the NP/PA has been directly observed and assisted performing the procedure by a qualified provider, they will p~~P~~erform a minimum of 3 successful observed procedures. One procedure should include suturing. b. Chart review of all observed cases. c. Two shifts in the ISIS clinic.
Reappointment Competency Documentation: a. Perform wound care/suturing a minimum of 2 times every two years and 2 chart reviews every 2 years.

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Protocol #13: Procedure: Surgical First Assist

A. DEFINITION

This protocol covers the participation of the NP who is enrolled in RNFA training or is already RNFA certified as a surgical first assist in the setting of the Operating Room at Zuckerberg San Francisco General Hospital and Trauma Center~~, the ISIS clinic~~ and the ~~4E~~ ICU in its capacity as an OR extension site for unstable patients.

1. Location to be performed: Operating Room~~, ISIS Clinic~~ and ~~4E~~ ICU.

2. Performance of procedure:
   a. Indications
      This protocol addresses patients presenting to the Operating Room~~, ISIS Clinic~~ and ~~4E~~ ICU for elective and emergency surgical intervention.
   b. Precautions
      None
   c. Contraindications
      Children under the age of 10 years

B. DATA BASE
1. Subjective Data
   a. History of chief complaint and review of symptoms relevant to the suggested procedure, possible organ systems affected by the procedure, mechanism of injury and type of injury
   b. Pertinent past medical history including current medications, allergies, tetanus history, vocation/avocation, clotting disorders, previous wound history(e.g. previous abscess management and antibiosis history.

2. Objective Data
   a. Physical exam of the wound, or system prescribed for procedure. ~~For wound exploration, grafting procedures, wound vac changes and washouts, a description of the location, extent, depth and appearance of discharge, erythema, swelling or ecchymosis and current state of healing(e.g. granulation tissue, hypergranulation).~~
   b. When a wound vacuum is placed in the operating room, ~~implemented,~~ data will include quantity and quality of wound vac drainage, level of set negative pressure, and

assessment of the site for edema granulation, during sponge/vac changes.

c. Appropriate motor, sensory and vascular exam of the involved area.
d. The operative procedure is performed following standard surgical technique according to departmental guidelines.
e. Laboratory and imaging evaluation, as indicated, relevant to history and exam. Appropriate laboratory values to be considered include (but are not limited to): complete blood count and coagulation studies, nutritional status and electrolytes.
f. All Point of Care Testing (POCT) will be performed according to ZSFG POCT Policy and Procedure 16.2.

C. DIAGNOSIS
Assessment of subjective and objective data to identify injury/wound processes or disease process requiring surgical intervention.

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Explain procedure to the patient (if patient unable to receive information due to mental status, explain to surrogate and/or bedside RN) Explain the procedure to the family.
   c. Diagnostic tests for purposes of disease identification.
   d. Time out per hospital policy.
   e. Biopsy tissue is sent to pathology if specimen collected.
   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
   a. All surgical first assist procedures shall be performed in direct consultation with a surgeon.

3. Education:
   Discharge information and instructions.

4. Follow-up:
   As appropriate for procedure performed.

E. RECORD KEEPING

1. Documentation of a detailed procedure note will be recorded in the medical record. Required follow up of the wound (e.g. suggested suture/staple removal dates, ongoing care to be delivered by nursing/wound care orders, or future wound vac change) will be indicated in the procedure note and in daily progress notes.
2. A log of all surgical first assist procedures will be kept in a locked office and reviewed by the trauma director, chief of surgery or program manager for quality assurance purposes.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. ~~Completion of a training class~~ Successful completion of an accredited RNFA course including completion of 120 proctored hours spent operating with a designated attending surgeon mentor.
Proctoring Period: a. All procedures will have direct supervision from a consulting surgeon. Review will be done after each case. b. Proctoring period will be three months in length.
Reappointment Competency Documentation: a. Minimum number of 5 procedures must be completed every two years under direct observation b. 5 chart reviews needed every two years.

Protocol #14: Procedure: Waived Testing

A. DEFINITION

Waived testing relates to common laboratory tests that do not involve an instrument and are typically performed by providers at the bedside or point of care.

1. Location where waived testing is to be performed: Inpatient units, outpatient clinics, ICU and Emergency Department

2. The following non-instrument based waived tests are currently performed at ZSFG:
   a. Fecal Occult Blood Testing (Hemocult ®)
      Indication: Assist with detection or verification of occult blood in stool.
   b. Vaginal pH Testing (pH Paper)
      Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.
   c. SP® Brand Urine Pregnancy
      Indication: Assist with the diagnosis of pregnancy.
   d. Chemstrip® Urine Dipstick
      Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

1. Subjective Data
   Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed

2. Objective Data
   Each waived test is performed in accordance with approved ZSFG 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 for 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 ZSFG, 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%.

Protocol #15: Procedure: Tracheotomy Tube Change

A. DEFINITION

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

1. Location to be performed: Inpatient units, Outpatient clinics and ICU.

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

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.

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

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

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care~~Prerequisites~~: ~~1. The prior experience required for this involves a period of both observation and demonstration.~~ ~~2.~~ The training program for this protocol includes the following: a. Review of head and neck anatomy text book b. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. Length of proctoring period is 3 successful observed demonstrations. 2. The completion of the above training 3. 3 successful demonstrations of tracheotomy tube changes on live patients
Reappointment Competency Documentation: 1. Ongoing competency is established via one successful demonstration of tracheotomy tube change every 2 years and 1 chart review.

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Protocol #16: Procedure: Musculoskeletal Soft Tissue Injections/Aspirations

A. DEFINITION

This protocol covers the aspiration of and/or injection of medications into soft tissue structures such as bursa, tendon sheaths, and carpal tunnel, for therapeutic or diagnostic purposes.

1. Location to be performed: inpatient, outpatient setting, Emergency Department or ICU.

2. Performance of procedure:
   a. Indications
      i. Acute or chronic inflammatory conditions that impair function or cause discomfort, loss of motion or paresthesias.
   b. Precautions for injection:
      i. Overlying dermatitis
      ii. Close proximity to neurovascular (arterial) structures
      iii. Acute Infection
   c. Contraindications
      i. Allergy to medication

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

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

3. Education
   Patients will be informed that pain relief may occur immediately due to the early onset on xylocaine 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
   Patient follow-up determined based on whether procedure performed was diagnostic versus a therapeutic injection.

E. RECORD KEEPING

Patient visit, consent, 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

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care~~Prerequisite~~: Training in above procedure will occur on site if NP/PA does not have previous experience. 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 pathophysiology d. Consent process e. 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-9 coding j. Ability to recognize complication
Proctoring Period: a. New practitioners to procedure will have a minimum of 3 successful observed demonstrations of each injection site. b. Experienced practitioners to procedure will have a minimum of 1 successful observed demonstration of each injection site. c. Chart review of all observed cases.
Reappointment Competency Documentation: a. 2 procedures must be completed every two years. b. 2 chart reviews must be completed every two years.

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