Community Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Neurosurgery ~~Nurse Practitioner/Physician Assistant~~

I. Policy Statement

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

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Trauma Program Office (3B7) and on file in the Medical Staff Office.

II. Functions to be ~~Performed~~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.

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

III. Circumstances Under Which NP/PA May Perform Functions

A. Setting
   1. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center. Inpatient settings ~~to~~ include ICU, inpatient units. Outpatient settings ~~to~~ include~~;~~ Emergency Department, Neurosurgical Clinic, Traumatic Brain Injury Clinic, Concussion Clinic, and Spinal Cord Injury Clinic.~~,~~
   2. Role in each setting may include admissions, transfers, discharges, as well as ~~and~~, neurosurgical patient evaluation, management and care in the emergency department~~room~~, all inpatient units, and outpatient clinics ~~and inpatient units, including ICU~~

B. Supervision
   1. Overall Accountability~~:~~
      The NP/PA is responsible and accountable to: Chief of Neurosurgery and the Trauma Program Director.

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2. A consulting physician, who may include attendings, chief residents 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~~affiliated staff, or physician.
   e. Initiation or change of medication other than those in the formulary(ies).
   f. Problem requiring hospital admission or potential hospital admission.
   g. Ordering special studies and radiology procedures if required by service: CT Scans, CT Myelogram, MRI, Angiograms, Floroscopic placement of Drains and/or surgical markers.
   ~~h. If ordering Respiratory Care must have co-signature of attending.~~

IV. Scope of Practice

Protocol #1	Health Care Management – Acute/Urgent Care
Protocol #2	Furnishing Medications/Drug Orders
Protocol #3	Discharge of Inpatients
Protocol #4	Procedure: Clinical Clearance of Cervical Spine Precautions
Protocol #5	Procedure: Surface Trauma and Wound Care
Protocol #6	Procedure: Removal of an Intracranial Pressure Device
~~Protocol #7~~	~~Lumbar Puncture/Lumbar Drain Insertion~~
Protocol #7~~8~~	Lumbar Catheter Discontinuation
Protocol #8~~9~~	Removal of CSF from EVD/Administration of Intrathecal Antibiotics/Administration of Intracranial TPA
Protocol #9~~10~~	Ordering Transfusion
Protocol #10~~11~~	eConsult~~Referral~~

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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 .~~Number.
8. Physician Assistants are required to sign and adhere to the Zuckerberg 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. Successful completion of Trauma Nurse Core Course (TNCC) within 1 year of hire.
      b. Audit of Advanced Trauma Life Support Course (ATLS) within 1 year of hire, or when next ~~SFGH~~ ZSFG ATLS course is available.
      c. NP specialty certification as a ANP, FNP, ACNP or AG ACNP
      d. National Certification as a Physician Assistant
   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 emergency department or intensive care unit in an acute care hospital within six months of hire
      b. Two years experience as a PA in an emergency department or intensive care unit in an acute care hospital within six months of hire.

C. Evaluation of NP/PA Competence in performance of standardized procedures. For minor procedures, please refer to the Minor Procedure Protocol.
   1. Initial: A~~a~~t 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. Included in this proctoring period will be 40 chart reviews (20 inpatients, 20 outpatients), and direct observations of cases ~~will be performed~~.
2. The evaluator will be the Chief of Neurosurgery or Clinical Supervising Physician designee.
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 and 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 in-patient medication ordering and out-patient discharge medication
   e) Medical Record review may be conducted retrospectively by the Clinical Supervising Physician
   f) Forty cases (20 inpatients, 20 outpatients) 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 annual 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:~~ 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.

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 procedures 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. Settings to include; Emergency Department, Inpatient Units, and Outpatient Clinics~~, ICU and Inpatient Units~~.

B. DATA BASE
1. Subjective Data
   a. Screening history that includes but is not limited ~~to:~~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 ~~SFGHMC~~ ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of data from the subjective and objective findings to identify disease processes, m~~. M~~ay include statement of current status of disease (e.g. 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 physician 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 (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

Protocol #2: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of 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 medications for management of acute and chronic illness need a patient specific protocol. The practice site scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies that will be used are: Zuckerberg 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~~ ZSFG Administration 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 ~~SFGHMC~~ 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~~electronic record, or in the Medication Administration Record (MAR). The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      i. name of medication
      ii. strength
      iii. directions for use
      iv. name of patient
      v. name of prescriber and title
      vi. date of issue
      vii. quantity to be dispensed
      viii. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation
   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.

Protocol #3: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from Zuckerberg San Francisco General Hospital and Trauma Center. All patients discharged will have approval of an 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.
   d. Referral to specialty clinics and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA or physician.
   c. Referral to Specialty Services not provided by DPH.

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 (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 (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 #4: Procedure: Clinical Clearance of Cervical Spine Precautions

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

Commented [MN1]: neck pain, sensory and/or motor deficits

Cervical Spinal Cord Injury refers to an injury to the spinal cord from the first through the eighth spinal root or to the cord itself, as in cord compression. Injuries to the cervical spinal cord are usually identified by physical examination during the trauma resuscitation, and may be confirmed through MRI. Such findings would 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 Score of 15 and the absence of drug/alcohol intoxication. In addition, there should be no evidence of head injury which would render an examination invalid

1. Location to be performed: For purposes of this protocol, the procedure may be completed in the Emergency Department, Inpatient Units, and Outpatient Clinics~~outpatient and/or the inpatient units~~ at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of procedure:
    a. Indications:
    Patients who have sustained blunt trauma mechanism consistent with potential axial spine injury. Patients who meet ALL of the following criteria may be candidates for clinical exam clearance of the cervical spine:
        i. Appropriate mentation, cooperative and communicative (no language barrier)
        ii. No clinical evidence of CNS or focal neurological injury
        iii. No subjective complaints of shoulder, neck, or interscapular pain
    b. Precautions
    Patients at risk should always remain in a rigid cervical collar.
    c. Contraindications
        i. Inappropriate mentation
        ii. Clinical evidence of CNS or focal neurological injury
        iii. Distracting Injury
        iv. Intoxication or under the influence of drugs
        v. Complaints of shoulder, neck or interscapular pain

B. DATA BASE
   1. Subjective Data
      a. The patient may complain of pain in the neck, specifically with tenderness to palpation of the cervical spine. The patient may also present with clear motor/sensory deficits.

   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 ~~SFGHMC~~ 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/imaging for purposes of disease identification.
      d. Referral to physician as needed.

   2. Patient conditions requiring Attending Consultation
      a. Acute decompensation of patient situation.
      b. Unexplained physical findings
      c. Uncommon, unfamiliar, unstable, and complex patient conditions
      d. Radiologic abnormalities
      e. Midline cervical tenderness on palpation
      f. Neurological deficit found on physical examination
      g. Upon request of patient, NP, PA, or physician

   3. Education
      a. Discharge information and instructions.
      b. The patient should be educated regarding the need for rigid immobilization, imaging, and treatment.

4. Follow-up
    a. As appropriate for procedure performed.
    b. The patient with suspected cervical trauma will be referred to 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 Documentation

Prerequisites: Direct instruction, onsite training of procedure by the Chief of Neurological Surgery. Cervical spine clearance will be based upon the Guidelines set forth by the Eastern Association for the Surgery of Trauma.
Proctoring Period a. A minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation. 1. Three procedures needed every 2 years. 2. Three chart reviews needed every 2 years.

Commented [JK2]: CIDP suggests adding "or Clinical Supervising Physician designee" to allow for flexibility for Chief as in other SP#5 on pg 19 of 39

Protocol #5: Procedure: Surface Trauma and Wound Care

A. DEFINITION
This protocol covers the initial assessment and management of wounds.

~~1.~~ Location to be performed: ~~For purposes of this procedure, the~~

~~3.~~2. Performance of procedure/minor surgery:
   a. Indications
      Patient~~'~~s presenting for assessment and treatment of lacerations, abrasions and avulsions.
   b. Precautions (require physician consultation)
      Coagulopathy
      Potential for Foreign Bodies within wound
      Malnutrition
      Diabetes
      Immunocomprimised State
      Peripheral Vascular Disease

~~4.~~3. Contraindications
   a. Vascular compromise or cases where direct pressure does not stop bleeding
   b. Wounds requiring large area of debridement or excision prior to closure
   c. Wounds with bone fragments involved
   d. Wounds with tendon, ligament, vessel or nerve involvement
   e. Head laceration where galea is disrupted
   f. Facial lacerations with cosmetic consideration (e.g. eyelids and vermillion borders)
   g. Lacerations penetrating into joints
   h. Patients requiring conscious sedation
   i. Children under the age of 10
   j. Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
   k. Wounds requiring repair of cartilage
   l. Through and through lip lacerations

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. Physical exam of the wound including a description of its location, extent, depth and appearance of discharge, erythema, swelling or ecchymosis
    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 ~~SFGHMC~~ 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. Laboratory tests performed for purposes of disease identification.
    e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    f. Referral to physician, clinic, 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 (Coagulopathy,
    Potential for Foreign Bodies within wound,
    Malnutrition,
    Diabetes,
    Immunocomprimised State,
    Peripheral Vascular Disease)
    d. Inability to approximate wound edges
    e. Persistent or uncontrolled bleeding
    f. Scalp wounds involving the galea
    g. Upon request of patient, NP, PA, or physician

Commented [JK3]: CIDP recommended adding items to this section from the Definitions described at the beginning of this SP

h. Initiation or adjustment of medication other than those in the formularies.
i. 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 Documentation

Perquisites: Completion of wound management course approved by the Chief of Neurosurgery. Individual standardized protocol training and proctoring by the Chief of Neurosurgery or Clinical Supervising Physician designee until competency is met
Proctoring a Minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation. 1. Three procedures needed every 2 years. 2. Three chart reviews needed every 2 years.

Protocol #6: Procedure: Removal of an Intracranial Pressure Device

A. DEFINITION
Intracranial pressure device discontinuation is defined as the removal of a Camino Bolt and/or EVD.

1. Location to be performed
   For purposes of this procedure, the protocol will be completed in the ICU at Zuckerberg San Francisco General Hospital Medical Center.

2. Performance of procedure/minor surgery:
   a. Indications
      Removal will be determined by the Neurosurgical team and in accordance with the Attending Neurological Surgeon.
   b. Precautions
      Coagulopathy
   c. Contraindications
      Coagulopathy
      Elevated Intracranial Pressure

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.
      i. Normal coagulation values
      ii. Normal intracranial pressures (≤ 15mmHg) for 24 hours
      iii. Afebrile (≤ 38.5) or with a documented source for febrile state
      iv. No evidence of medical treatment for elevated intracranial pressures for 48 hours
      v. No evidence of infection or discharge from the bolt insertion site
      vi. Evidence of inaccurate device readings as determined by the Neurological Surgery Attending Physician
   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 ~~SFGHMC~~ 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. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient conditions requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Development of uncontrolled bleeding or cerebrospinal fluid leak.
    c. Change in neurological exam following device discontinuation.
    d. Upon request of patient, NP, PA, or physician
    e. Initiation or adjustment of medication other than those in the formularies.

3. Education
    a. Instruct patient on procedure prior to performance (As patient may be unable to comprehend provide nursing instruction prior to performance)
    b. Discharge information and instructions.

4. Follow-up
    a. As appropriate for procedure performed.
    b. Check suture/exit site for drainage 1-2 hours post removal
    c. Obtain report from nursing staff regarding level of consciousness post removal

E. RECORD KEEPING
    a. 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.
    b. The ICP reading before device removal will be documented in the above note

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Prerequisites Completion of standardized procedure training on site.
Proctoring Period a. Minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation. 1. Completion of three procedures every 2 years. 2. Three chart reviews needed every 2 years.

~~Protocol #7: Procedure: Lumbar Puncture/Lumbar Drain Insertion~~

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~~A. DEFINITION~~

~~Lumbar catheter insertion is defined as placement of a lumbar CSF drainage catheter located within the subarachnoid space as decided upon by the Neurosurgical team and in accordance with the Attending Neurological Surgeon.~~

~~1. Location to be performed~~

~~For purposes of this procedure, the protocol will be completed in the inpatient unit at Zuckerberg San Francisco General Hospital and Trauma Center.~~

~~2. Performance of procedure:~~

~~a. Indications~~

~~i. Lumbar puncture should be performed primarily on patients with severe headache with or without fever of unknown origin, especially if an alteration of consciousness is present. Aspiration of the spinal fluid with subsequent analysis may be necessary to the diagnosis of CSF infection, bleeding or embolus (e.g. meningitis, syphilis, subarachnoid hemorrhage, MS).~~

~~ii. A lumbar drain should be placed primarily for the purposes of CSF diversion. This procedures should be considered in the presence of a persistent CSF leak, operative cases requiring temporary decompression/diversion during the postoperative period, in cases of documented mental status improvement following serial high volume LP taps, in lieu of or until a definitive mode of diversion is achieved i.e. EVD or VP shunt.~~

~~b. Precautions (Requires a physician consultation)~~

~~i. Obtain a CT head to rule out mass effect, subarachnoid hemorrhage or obstructive hydrocephalus~~

~~ii. Aseptic technique / avoid chemical meningitis, abscess~~

~~iii. Platelets should be greater than or equal to 100,000~~

~~iv. Patients on anticoagulants or who have bleeding tendencies (F.F., Von Willebrand's, Hemophilia, Liver disease)~~

~~v. ASA/NSAIDS/Cox II Inhibitors~~

~~vi. Withdraw CSF slowly and only the amount that is needed (1 ml/tube)~~

c. Contraindications
i. Infection in the tissues near the puncture site.
ii. Increased intracranial pressure, if suspected rule out with head CT
iii. Coagulopathy

B. DATA BASE
1. Subjective Data
a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
i. Presence of motor or sensory deficits
ii. Presence of headache or meningitic symptoms
iii. Presence of continued or new CSF leak.

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

2. Patient conditions requiring Attending Consultation
a. Acute decompensation of patient situation.
b. Resistance met on drain insertion.

c. Patient complaint of nerve root pain.
d. Failure to obtain CSF drainage or flow.
e. Upon request of patient, NP, PA, or physician
f. Initiation or adjustment of medication other than those in the formularies.

3. Education
Discharge information and instructions.

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

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Protocol #78: Procedure: Lumbar Catheter Discontinuation

A. DEFINITION
Lumbar catheter discontinuation is defined as removal of a lumbar CSF drainage catheter located within the subarachnoid space.

1. Location to be performed
For purposes of this procedure, the protocol will be completed in the inpatient units at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of procedure:
   a. Indications
      i. Lumbar catheter removal will be determined by the Neurosurgical team and in accordance with the Attending Neurosurgical Surgeon.
      ii. Resolution of cerebral spinal fluid leak.
      iii. Completion of antibiotic therapy for meningitis
      iv. Resolution or alternative treatments instituted for hydrocephalus.
      v. Definitive CSF samples obtained for laboratory testing.

   b. Precautions
      i. Platelets should be greater than or equal to 100,000
      ii. Patients on anticoagulants or who have bleeding tendencies (F.F., Von Willebrand's, Hemophilia, Liver disease)
      iii. ASA/NSAIDS/Cox II Inhibitors

   c. Contraindications
      i. Coagulopathy
      ii. Evidence of CSF leak including ottorhea, rhinorrhea, leak at the insertion site

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA, or physician
   c. Initiation or adjustment of medication other than those in the formularies.
   d. Continued leakage of cerebral spinal fluid (CSF) following discontinuation
   e. Inability to remove catheter
   f. Broken catheter
   g. Symptoms of Meningitis
   h. Evidence of infection at the lumbar drain insertion site
   i. Change in neurological status following drain discontinuation

3. Education
   a. Instruct patient to reports symptoms of severe headache, fever, chills, numbness, tingling or weakness of extremities, impaired balance, incoordination, neck pain
   b. Pain or stiffness, redness swelling or discharge from insertion site, nasal or ear drainage
   c. Instruct the patient to lie flat for approximately 1-3 hours post drain removal, after which time he/she may resume normal activities

4. Follow-up
   As appropriate for procedure performed.
   a. Leave original dressing in place for 48 hours
   b. Change dressing daily and check for CSF leak until healed
   c. Assess for rhinorrhea or otorrhea
   d. Assess for signs of site infection
   e. Assess for symptoms of meningitis
   f. Follow-up laboratory results on CSF samples and if appropriate catheter tip cultures
   g. Assess for changes in neurological status

E. RECORD KEEPING
   a. 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.
   b. The amount of CSF drainage before device removal will be documented in the above note and communicated with nursing
   c. Any cultures or CSF samples submitted to lab will be noted in the medical record

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 #~~89~~: Procedure: Removal of CSF from EVD/Administration of ~~Intrathecal Antibiotics~~ Intracranial Medications.~~Intrathecal Antibiotics.~~

A. DEFINITION

CSF Sampling from an EVD (external ventricular drain) is defined as removal of CSF for the purpose of culture, gram stain, cell count, and/or chemistry from a catheter located within the intraventricular space. Administration of ~~intrathecal antibiotics~~ intracranial medications is defined as injection of a specific ~~antibiotic~~ medication and dosage as determined by the Infectious Disease Service (for antibiotics) or Neurosurgical team (for Tissue Plasminogen Activator (tPA) and/or Normal Saline) into the intracranial space via an appropriate catheter.
~~antibiotic and dosage as defined by the Infectious Disease Service into the intraventricular space for a patient with a known or presumptive diagnosis of meningitis or ventriculitis.~~

1. Location to be performed:
   For purposes of this procedure, the protocol will be completed in the inpatient units at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of procedure:
   a. Indications

   Removal of CSF from an EVD will be determined by the Neurosurgical team and in accordance with the Attending Neuros~~urgical S~~urgeon. A~~s well a~~dministration of intrathecal antibiotics for the purpose of treatment of meningitis or ventriculitis will be determined in accordance with the Neurosurgical team/Attending and the Infectious Disease Service. Administration of intracranial tPA for the purpose of blood clot disruption will be determined in accordance with the Neurosurgical team/Attending. It may be indicated for a patient with a diagnosis of intracerebral hemorrhage, in whom a clot is causing hydrocephalus or increased intracranial pressure. NS may be administered with either of these, or by itself for the purpose of unclogging the catheter.

   a. Precautions
      Increased Intracranial Pressures
      Medication ~~Antibiotic~~ ~~Antibiotic~~ Allergies
      Immunocompromised State
      Coagulopathic state
   b. Contraindications

Resistance met upon injection
Absent waveform or Intracranial Pressure Measurement

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.
      i. Review of medication dosages
      ii. Laboratory review of microbiology results and white count if applicable, coagulation factors if applicable
      iii. Assessment for febrile (≤ 38.5) state
      iv. Evaluation of the EVD insertion site for evidence of infection
      v. Performance of a neurological examination
      vi. Patient evaluation for signs of meningitis; including but not limited to; severe frontal/occipital headache, neck stiffness, light sensitivity, fever, rash
   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 ~~SFGHMC~~ 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. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient conditions requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Upon request of patient, NP, PA, or physician
    c. Initiation or adjustment of medication other than those in the formularies.
    d. Resistance met upon withdraw of CSF and/or administration of sterile preservative free normal saline or antibiotics
    e. Noted leakage of fluid from the EVD catheter/tubing
    f. Presence of air noted within the EVD catheter/tubing
    g. Evidence of infection at the EVD insertion site
    h. Change in neurological status following CSF withdraw or antibiotic administration
    i. Development of rash, hives, fever, tachycardia or change in respiratory status following antibiotic administration
    j. Loss of waveform following drain manipulation

3. Education
   Instruct patient to report~~s~~ symptoms of severe headache, fever, chills, numbness, tingling or weakness of extremities, impaired balance, incoordination, development of rash, hives, or shortness of breath

4. Follow-up
    a. Assess EVD for evidence of effective functioning; presence of ICP waveform, active CSF drainage
    b. Assess EVD and tubing for signs of loss of integrity including; leakage, breakage, presence of air
    c. Assess for signs of site infection
    d. Assess for symptoms of meningitis
    e. Follow-up laboratory results on CSF samples and if appropriate catheter tip cultures and toxicology values
    f. Assess for changes in neurological status

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 #~~9~~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: Emergency Department, Inpatient Units, and Outpatient Clinics~~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 ~~SFGH~~ 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 ~~SFGH~~ 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 ~~SFGH~~ 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.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Successful completion of the Zuckerberg 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 ~~SFGH~~ ZSFG Administrative Policy and Procedure 2.3 “Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options”. b. Read ~~SFGH~~ 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 #101: eConsultReferral Review

A. DEFINITION

eConsultReferral review is defined as the review of new outpatient consultation requests via the online eConsultReferral 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 eConsultReferrals will have six months experience with patients in the specific specialty area provided at Zuckerberg San Francisco General Hospital and Trauma Center or elsewhere before allowed to review eConsultReferrals independently.
   b. Providers reviewing eReferrals will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
   c. Providers reviewing eConsultReferrals will consistently provide care to patients in the specialty clinic for which they are reviewing.
   d. Providers reviewing eConsultReferrals 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 eConsultReferral system.
3. Proctoring: A concurrent review of 5%the first 20 of the eConsultReferral consultation decisions will be performed by the Chief of Service or designee concurrently for in the first three months.
4. Reappointment: 5 chart reviews will be needed for reappointment every 2 years.

Commented [JK4]: CIDP/CC prefer concrete numbers standardized across Services. Ortho and Surgery specify the first 20 eReferral/now eConsults

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. eConsultReferral review will be confined to data found in the submitted eConsultReferral form. Data

contained in the paper or electronic medical record, but not in the eConsult~~Referral~~, is specifically excluded from the eConsult~~Referral~~ 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 eConsult~~Referral~~ 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 eConsult~~Referral~~
   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 eConsult~~Referral~~ system.
   b. All data provided via the eConsult~~Referral~~ 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 eConsult~~Referral~~ 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 eConsult~~Referral~~, 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)~~medical record upon scheduling or after a period of six months.

~~During the proctoring period, the eConsultReferral 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.~~

Commented [JK5]: CIDP noted that this specific process specifying how the review to be done is not needed in this level of detail. Recommended to remove this paragraph from all future Service eConsult SP reviews.