



—Zuckerberg San Francisco General Hospital and Trauma Center

Committee on Interdisciplinary Practice

## STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

### PREAMBLE

Title: Urology Department

#### I. Policy Statement

- A. It is the policy of 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 Title 16, 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 Urology and in the 3M Urology Clinic 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 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 conduct(s) physical exams, diagnoses and treats illness, order(s) and interpret(s) tests, counsel(s) on preventative health care, assist(s) in surgery, perform(s) invasive procedures and furnish(es) medications/issue(s) drug orders as established by state law.

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

#### A. Setting

- 1) Location of practice is outpatient clinics, inpatient units, operating room, ICU, and emergency department.

#### B. Supervision

1. Overall Accountability:  
The NP/PA is responsible and accountable to: Chief of Urology specific unit Medical Director, Chief of Service, or other designated supervising physicians or attending and other supervisors as applicable.
2. A consulting physician, who may include attending's and fellows, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
  - a. Acute decompensation of patient situation
  - b. Problem that is not resolved after reasonable trial of therapies.
  - c. Unexplained historical, physical, or laboratory findings.

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

#### IV. Scope of Practice – Protocols

- 1. Protocol #1: Health Care Management: Acute/Urgent Care
- 2. Protocol #2: Furnishing Medications and Drug Orders
- 3. Protocol #3: Discharge of Inpatients
- 4. Protocol #4: [eReferrals/Consult](#)-Review
- 5. Protocol #5: Procedure: Suprapubic Catheter Change
- 6. Protocol #6: Procedure: Coude Catheter Placement
- 7. Protocol #7: Procedure: Intravesical instillation of BCG
- 8. Protocol #8: Procedure: Ordering Blood Transfusions
- 9. Protocol #9: Procedure: Waived Testing

#### 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) that must be from an American Heart Association provider.
  - 5. Possession of a National Provider Identifier or must have submitted an application.
  - 6. Copies of licensure and certificates must be on file in the Medical Staff Office.
  - 7. Furnishing Number and DEA Number if applicable.
  - 8. Physician Assistants are required to sign and adhere to the [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. No previous specialty area experience expected for this position.

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 as appropriate. Please note numbers as noted in each protocol.
    - The evaluator will be Medical Director, Chief of Service, and/or designated supervising physicians or peer as applicable.
    - The methods of evaluation in clinical practice will be those needed to demonstrate clinical competence as noted in each protocol.
    - Number of observations and chart reviews needed to cover core protocols: (#1-3) is 3. One case may be representative of multiple core protocols.
2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician at appropriate intervals.
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, designated physician must evaluate the NP /PA's clinical competence as noted in each protocol including one chart review for each core protocol (1-3), one case may be representative of multiple core protocols
5. Physician Assistants:
  - a. Physician Assistants have 3 (three) 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 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 its implementation.

##### C. Review Schedule

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

##### D. Revisions

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

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

- A. DEFINITION  
This protocol covers the procedure for patient visits for urgent urologic problems, which include but are not limited to common acute urologic problems, uncommon, unstable, or complex conditions within outpatient clinics, inpatient units, and the emergency department.
  
- B. DATA BASE
  - 1. Subjective Data
    - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
    - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
  
  - 2. Objective Data
    - a. Physical exam appropriate to presenting symptoms.
    - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
    - c. All Point of Care Testing (POCT) will be performed according to the [SFGH-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.
  
- 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

**Commented [AT1]:** Should this mirror the list of the conditions listed in the Preamble?

**Commented [JK2R1]:** CIDP meeting notice that this list in the HCM – Acute/Urgent Care is from the template. Suggesting to either list the same as the PreAble section or state “see preamble section...” and list in this section any additional conditions specific to the Service or SP

f. Any 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 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: 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 and midwives 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. Midwives may prescribe Schedule II controlled substances in a hospital setting with patient specific protocols. The practice site (clinic or inpatient), 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 to be used are [Zuckerberg](#), San Francisco General Hospital and Trauma Center/Community Health Network. This protocol follows [CHN-ZSFG Administrative](#) policy on Furnishing Medications [and Devices for NPs and CNMs](#) (policy no. 13.2) and the writing of Drug Orders [and Medical Devices issued by Physician Assistants \(PA\)](#)-(Policy no. 13.5).

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### 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 ~~SFGH~~-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 [LCRelectronic medical 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. 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** 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.

**Commented [AT4]:** Should we just say electronic medical record

### Protocol #3: Discharge of Inpatients

#### A. DEFINITION

This protocol covers the discharge of inpatients from [Zuckerberg](#) 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: health history and current health status

##### 2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Review medical record: in-hospital progress notes, consultations to assure follow-through.
- c. Review recent laboratory and imaging studies and other diagnostic tests noting any abnormalities requiring follow-up.
- d. Review current medication regimen, as noted in the 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 #4: [eReferraleConsult](#) Review

A. DEFINITION

[eReferraleConsult](#) review is defined as the review of new outpatient consultation requests via the online [eReferraleConsult](#) 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 eReferraleConsults 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 do eReferraleConsults independently.~~

b.a. Providers reviewing [eReferraleConsults](#) will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.

c.b. Providers reviewing [eReferraleConsults](#) will consistently provide care to patients in the specialty clinic for which they are reviewing.

d.c. Providers reviewing [eReferraleConsults](#) 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 [eReferraleConsult](#) system.

3. Proctoring: A review of [at least -20 5% of the eReferraleConsult](#) consultation decisions will be performed by the Chief of Service or designee concurrently for the first ~~three~~ six months. ~~Before performing eConsults independently, providers will have 1) six months experience with patients in the specific specialty area provided at ZSFG or elsewhere and 2) successfully complete proctoring.~~

4. [Ongoing reappointment: Review of 5 consultations every 2 years](#)

B. DATA BASE

1. Subjective Data

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Commented [JK5]: Substitute number instead of %. Suggested "Concurrent review of first 20 consultations"

Commented [BB6R5]: Agree with 20 consultations

Commented [JK7]: Standardized reappoint numbers with other Services all

Commented [BB8R7]: agree

- 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. [eReferraleConsult](#) review will be confined to data found in the submitted [eReferraleConsult](#) form. Data contained in the paper or electronic medical record, but not in the [eReferraleConsult](#), is specifically excluded from the [eReferraleConsult](#) 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 [eReferraleConsult](#) 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 [eReferraleConsult](#)
  - 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 [eReferraleConsult](#) system.
  - b. All data provided via the [eReferraleConsult](#) 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. 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. Dependent upon the urgency of the referral, the [eReferraleConsult](#) 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 [eReferraleConsult](#), the consulting scheduler is responsible for notifying the patient.

E. RECORD KEEPING

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

During the proctoring period, the [eReferraleConsult](#) 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 [AT9]:** Is there a certain number or does this mean all econsults done during the proctoring period?

**Commented [JK10R9]:** 20

**Commented [JK11]:** Sara, is this the current process?

Protocol #5: Procedure: Suprapubic Catheter Change

A. DEFINITION

Changing of an existing suprapubic catheter

- 1) Location to be performed: inpatient wards, outpatient clinics, Emergency Department.
- 2) Performance of procedure:
  - i. Indications: Patient with an existing suprapubic catheter needing change (e.g. regular scheduled change, catheter is not draining well, catheter fell out, active urinary tract infection)
  - ii. Precautions: none
  - iii. Contraindications: patient is acutely ill (febrile within 24 hours and/or hemodynamically unstable); patient had the initial suprapubic catheter placed within 2 weeks.

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 [SFGH-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.)
  - f. Difficulty removing or replacing the suprapubic tube

- 3. Education
  - Discharge information and instructions.

- 4. Follow-up
  - As appropriate for the next suprapubic catheter change or for the ongoing management of active urologic conditions.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and [LCR electronic medical record](#) 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 Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care:

- a. Completion of training on site
- b. State the number of procedures provider must observe being done by a qualified provider: 5

Proctoring Period:

- a. Actual number of performances needed to be directly observed: 3
- b. State who can do the proctoring: any urology attending

Reappointment Competency Documentation:

- a. Minimum number of procedures that must be completed in two years: 2
- b. Is direct observation of procedure needed? no
- c. Who will be the evaluator? Any urology attending
- d. Chart reviews needed: 2

Protocol #6: Procedure: Coude Catheter Placement

A. DEFINITION

Placement of a Coude-tip catheter

1. Location to be performed: inpatient wards, outpatient clinics, operating room, emergency department.
2. Performance of procedure:
  - i. Indications: male patient requiring a catheter placement with known prostatic hypertrophy, or inability to place a regular Foley catheter
  - ii. Precautions: tip of coude catheter should be pointed upwards on insertion
  - iii. Contraindications: none

B. DATA BASE

1. Subjective Data
  - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
  - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
  - a. Physical exam appropriate to the procedure to be performed.
  - b. 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 [SFGHZSFG](#) 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.)
  - f. No urine drainage and/or unable to irrigate the coude catheter after placement
- 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

<p><u>Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care</u>Prerequisite:</p> <ul style="list-style-type: none"> <li>a. Completion of training on site</li> <li>b. State the number of procedures provider must observe being done by a qualified provider: 2</li> </ul>
<p>Proctoring Period:</p> <ul style="list-style-type: none"> <li>a. Actual number of performances needed to be directly observed: 2</li> <li>b. State who can do the proctoring: any urology attending</li> </ul>
<p>Reappointment Competency Documentation:</p> <ul style="list-style-type: none"> <li>a. Minimum number of procedures that must be completed in two</li> </ul>

years: 2

- b. Is direct observation of procedure needed? no
- c. Who will be the evaluator? Any urology attending
- d. Chart reviews needed: 2

Protocol #7: Procedure: Intravesical instillation of Bacillus Calmette–Guérin (BCG)

A. DEFINITION

Placement of a foley catheter, instillation of BCG (standard dose) into the bladder through the foley catheter, foley catheter removal

1. Location to be performed: outpatient clinic
2. Performance of procedure:
  - i. Indications: patient with certain types of bladder cancer who meet criteria for and agree to have intravesical BCG treatment based on the established algorithm. Patient needs to have a negative urinalysis done in clinic (POCT) prior to each instillation
  - ii. Precautions: person administering the medication should use droplet contact precautions
  - iii. Contraindications: immunosuppressed individuals, active tuberculosis, hematuria, urinary tract infection, traumatic foley catheter insertion, febrile illness, hemodynamic instability, prior BCG sepsis

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 [SFGH-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.
  - f. Difficulty placing foley catheter
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 [LGR electronic medical record](#) 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

<p><u>Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care</u> Prerequisite:</p> <ul style="list-style-type: none"><li>a. Completion of training on site</li><li>b. State the number of procedures provider must observe being done by a qualified provider: 5</li></ul>
<p>Proctoring Period:</p> <ul style="list-style-type: none"><li>a. Actual number of performances needed to be directly observed: 3</li><li>b. State who can do the proctoring: any urology attending</li></ul>
<p>Reappointment Competency Documentation:</p> <ul style="list-style-type: none"><li>a. Minimum number of procedures that must be completed in two years or state number of procedures annually: 2</li><li>b. Is direct observation of procedure needed? no</li><li>c. Who will be the evaluator? Any urology attending</li><li>d. Chart reviews needed: 2</li></ul>



## Protocol #8: ORDERING TRANSFUSIONS

### A. DEFINITION

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

NOTE: Transfusion orders generally consist of at least two parts: the blood component order directed to Blood Bank staff, e.g. "Type and cross 2 units of RBC", and the order to administer the ordered components usually intended for nursing staff, e.g. "transfuse 2 RBC units at the patient's next outpatient visit on (date). These orders may be written at the same time or sequentially.

1. Location to be performed: Inpatient, outpatient setting.
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 [SFGH-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  
Absolute: none  
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 evaluation.
  - c. All Point of Care Testing (POCT) will be performed according to [SFGH-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. ([SFGH-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
  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 including completed transfusion report form 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

<p>Prerequisite:</p> <ol style="list-style-type: none"><li>Successful completion of the San Francisco General Hospital Transfusion Training course.</li><li>Successful completion of Transfusion Training course test on blood ordering and informed consent.</li><li>Must have an 80% test score on both examinations.</li></ol>
<p>Proctoring Period:</p> <ol style="list-style-type: none"><li>Read and Sign the <a href="#">SFGH-ZSFG</a> Administrative Policy and Procedure 2.3 "Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options".</li><li>Read <a href="#">SFGH-ZSFG</a> Transfusion Guidelines in Laboratory manual.</li><li>Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.</li></ol>
<p>Reappointment Competency Documentation:</p> <ol style="list-style-type: none"><li>Completion of the two education modules and completion of the two examinations with a passing score of 80%.</li><li>Performance of 2 transfusion every 2 years and review of 2 medical records every 2 years.</li><li>Review of any report from the Transfusion Committee.</li><li>Evaluator will be the medical director or other designated physician.</li></ol>

## Protocol #9: 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: outpatient clinics
- 2) The following non-instrument based waived tests are currently performed at [SFGH ZSFG](#):
  - a. SP® Brand Urine Pregnancy  
Indication: Assist with the diagnosis of pregnancy.
  - b. Chemstrip® Urine Dipstick  
Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

### B. DATA BASE

- 1) Subjective Data  
Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed
- 2) Objective Data  
Each waived test is performed in accordance with approved [SFGH-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 of additional tests, as necessary

## 4. Follow-up

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

## E. RECORD KEEPING

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Prerequisites:</p> <p>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,</p>
<p>Proctoring:</p> <p>Successful completion of Halogen quizzes for each of the waived tests the practitioner is performing at <a href="#">SFGH ZSFG</a>, i.e., achievement of passing scores of at least 80% on each module.</p>
<p>Reappointment Competency Documentation:</p> <p>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%.</p>