



**Community Health Network of San Francisco
Committee on Interdisciplinary Practice**

**STANDARDIZED PROCEDURE
NURSE PRACTITIONER/ PHYSICIAN ASSISTANT**

PREAMBLE

Title: Dermatology Department

I. Policy Statement

- A. It is the policy of the Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in 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 Dermatology Ward 92 at ZSFG 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

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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 ten years (6 year recertification cycle prior to 2014, 10 year recertification cycle starting in 2014 and thereafter). 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 San Francisco Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Delegation of Services Agreement (documents supervising agreement between supervising physician and PA).

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

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

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

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to: specific unit Medical Director, Chief of Service, designated supervising physician or attending and other supervisors as applicable.
2. A consulting physician, who may include attending, or credentialed fellows will be available to the NP/PA, by phone, in person, or by other electronic means at all times. There is one to one supervision.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:

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- a. Acute decompensation of patient situation or instability as defined by an extreme deviation from normal parameters of standard physiologic variables.
- b. Problem that is not resolved after reasonable trial of therapies.
- c. Unexplained historical, physical, or laboratory findings.
- d. Upon request of patient, affiliated staff, or physician.
- e. Problem requiring hospital admission or potential hospital admission.
- f. Acute, severe respiratory distress.
- g. An adverse response to treatment, or a lack of therapeutic response.
- h. When consultants from any other service are used.

IV. Scope of Practice

1. Protocol #1: Health Care Management: Acute/Urgent Care
2. Protocol #2: Health Care Management: Primary Care/Specialty Clinics
3. Protocol #3: Furnishing Medications and Drug Orders
4. Protocol #4: Procedure: Skin Biopsy
5. Protocol #5: Procedure: Destruction of Skin Lesion
6. Protocol #6: Procedure: KOH Scraping
7. Protocol #7: Procedure: Intralesional Steroid Injection

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 Board of Registered Nurses(BRN)/Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) standards.
 3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
 4. Maintenance of certification of American Heart Association Basic Life Support for Healthcare Providers (BLS-HCP)
 5. Possession of a Medicare/Medi-Cal Billable Provider Identifier, or must have submitted an application.
 6. Copies of licensure and certificates on file in the Medical Staff Office.
 7. Furnishing Number and DEA Number
 8. Physician Assistants are required to sign and adhere to the

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San Francisco General Hospital and Trauma Center
Delegation of Service Agreement (DSA).

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 ability to practice.
 - a. Clinical Practice
 - Length of proctoring period will be: three months which can be shortened or lengthened. (Please note numbers as noted in each protocol.)
 - b. Format
 - All cases presented to proctor
 - Proctor reviews co-signed orders and progress notes.
 - Co-signatures must be concurrent to patient care.
 - Chart review is conducted for inpatient medication ordering and outpatient discharge medications.
 - Proctored cases as noted for procedures and ~~20 cases for Core~~ Protocols 1-73, with a minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures.
 - c. The evaluator will be: Medical Director, Chief of Service and/or designated supervising physicians as applicable.
 - d. The method of evaluation in clinical practice will be that needed to demonstrate clinical competence as noted in each protocol.
 2. Follow-up: areas requiring increased proficiency as determined by the initial evaluation will be re-evaluated by the Medical Director, and/or designated same discipline proctors as applicable.
 3. Ongoing Professional Performance Evaluation (OPPE) Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and report sent to the Medical Staff Office.
 4. Biennial Reappointment: Medical Director, designated physician or designated same discipline peer must evaluate the NP's clinical competence as noted in each protocol. For

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reappointment will need 5 chart reviews every 2 years.
Charts can include reviews completed for special
procedure reviews.

VII. Development and Approval of Standardized Procedure

- A. Method of Development
 - 1. Standardized procedures are developed collaboratively by the Nurse Practitioners, Physician Assistants, Nurse Midwives, Pharmacists, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.
- B. Approval
 - 1. The CIDP, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to their implementation.
- C. Review Schedule
 - 1. The standardized procedure will be reviewed every three years by the NP/PA and the Medical Director and as practice changes.
- D. Revisions
 - 1. All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.



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

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

- B. **DATA BASE**
 - 1. **Subjective Data**
 - a. Screening: age appropriate history that includes but is not limited to: past medical history, pre-hospital incident history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments and review of systems.
 - b. Ongoing continuity: review of symptoms and history relevant to the disease/injury process or presenting complaint.
 - c. Pain history to include onset, location and intensity.
 - d. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

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

- C. **DIAGNOSIS**
Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of disease (e.g. stable, unstable and uncontrolled)

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

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2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation
 - b. Problem that is not resolved after reasonable trial of therapies
 - c. Unexplained historical, physical or laboratory findings
 - d. Uncommon, unfamiliar, unstable, and complex patient conditions
 - e. Upon request of patient, NP, PA, or physician
 - f. Any Problem requiring hospital admission or potential hospital admission.
 3. Education
 - a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
 - b. Anticipatory guidance and safety education that is age and risk factor appropriate.
 - c. Discharge information and instructions.
 4. Follow-up
As indicated and appropriate regarding patient health status and diagnosis.
- E. **RECORD KEEPING**
All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)
For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.



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

A. DEFINITION

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

B. DATA BASE

1. Subjective Data

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

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g. stable, unstable, and uncontrolled).

D. PLAN

1. Treatment

- a. Age appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- c. Immunization update.
- d. Referral to specialty clinics and supportive services, as needed.



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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. Initiation or change of medication other than those listed in or approved by the formulary/ies.
 - f. Upon request of patient, NP, PA, or physician.
 - g. Problem requiring hospital admission or potential hospital admission.
 3. Education
 - a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
 - b. Anticipatory guidance and safety education that is age and risk factor appropriate.
 - c. Discharge information and instructions.
 4. Follow-up
As indicated and appropriate to patient health status and diagnosis.
- E. **RECORD KEEPING**
All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.



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Protocol #3: Furnishing Medications/Drug Orders

A. A. DEFINITION

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

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

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

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

This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE
1. Subjective Data

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- a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
 - b. Pain history to include onset, location, and intensity.
2. Objective Data
- a. Physical exam appropriate to presenting symptoms.
 - b. Describe physical findings that support use for CSII-III medications.
 - c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - d. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.
- C. DIAGNOSIS
Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.
- D. PLAN
1. Treatment
 - a. Initiate, adjust, discontinue, and/or renew drugs and devices.
 - b. 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 electronic medical record. 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.
 - c. To facilitate patient receiving medications from a pharmacist the following information must be provided:
 - 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

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viii. license no., furnishing no., and DEA no.

- d. Limitations
 - i. A prescription for a Schedule II or III controlled substance shall be limited to the number of tablets needed until the next scheduled follow-up clinic appointment.
 - ii. No refills will be allowed for lost or stolen narcotic prescriptions.
 - iii. Attending consultation.
2. Patient conditions requiring Attending Consultation
 - a. Problem which is not resolved after reasonable trial of therapies.
 - b. Unexplained historical, physical or laboratory findings.
 - c. Upon request of patient, NP, PA, or physician.
 - d. Failure to improve pain and symptom management.
 - e. Acute, severe respiratory distress
3. Education
 - a. Instruction on directions regarding the taking of the medications in patient's own language.
 - b. Education on why medication was chosen, expected outcomes, side effects, and precautions.
4. Follow-up
 - a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. RECORD KEEPING

All medications furnished by NPs will be recorded in the medical record\electronic medical record (~~LCR\MAR\oCW, EPIC and Medweb~~) 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.

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Protocol #4: Procedure: Skin biopsy

A. DEFINITION

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

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

1. Location to be performed: ~~Ward 92 Dermatology Department~~
ZSFG Campus

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2. Performance of procedure:

- i. Indications
 - a. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.
- ii. Precautions
 - a. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
 - b. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
 - c. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.
- iii. Contraindications: None

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20

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- C. **DIAGNOSIS**
Assessment of subjective and objective data to identify disease processes. Attending will decide if skin biopsy is indicated.
- D. **PLAN**
1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
 - d. Diagnostic tests for purposes of disease identification.
 - e. Biopsy tissue is sent to pathology *as appropriate*.
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician and supportive services, as needed.
 2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation.
 - b. Unexplained historical, physical or laboratory findings
 - c. Uncommon, unfamiliar, unstable, and complex patient conditions
 - d. Upon request of patient, NP, PA, or physician
 - e. Initiation or adjustment of medication other than those listed in or approved by the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
 3. Education
Pre-procedure and post procedure education as appropriate and relevant in verbal or written format.
 4. Follow-up
As appropriate for procedure performed.
- E. **RECORD KEEPING**
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and

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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> Prerequisites </p> <ol style="list-style-type: none"> a. 2 direct observations of a qualified provider doing each procedure b. Review of aseptic technique c. Review of departmental policy and procedure
<p> Proctoring Period </p> <ol style="list-style-type: none"> a. New practitioner to procedure, a minimum of 2 successful observed demonstrations of each procedure b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations of each procedure c. Chart review of all observed cases.
<p> Reappointment Competency </p> <ol style="list-style-type: none"> a. Evaluator will be the Medical Director or other qualified provider b. Competency <ol style="list-style-type: none"> 1. Perform 1 of each procedure every 2 years. 2. 1 chart review of each procedure every 2 years.

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Protocol #5: Procedure: Destruction of skin lesion

A. DEFINITION

Destruction of skin lesion by cryotherapy (liquid nitrogen)

- 1) Location to be performed: ~~Ward 92 Dermatology Department~~
ZSFG Campus
- 2) Performance of procedure:
 - i. Indications: Removal of skin lesions like actinic keratosis, seborrheic keratosis, and warts.
 - ii. Precautions: Scarring, infection, pigment change
 - iii. Contraindications: None

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B. DATA BASE

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed

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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. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
- 3. Education
Discharge information and instructions.
- 4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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

- a. Review of aseptic technique.
- b. Review of departmental policy and procedure



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Proctoring Period

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

Reappointment Competency

- a. Evaluator will be the Medical Director or other qualified provider
- b. Competency
 1. Perform 1 of each procedure every 2 years.
 2. 1 chart review of each procedure every 2 years.



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Protocol #6: Procedure: KOH (potassium hydroxide) scrapings

A. DEFINITION

Collection of skin scrapings for KOH preparation. Apply KOH and heat specimen appropriately. Exam for hyphae and record in lab book and report in EMR.

- 1) Location to be performed: ~~Ward 92 Dermatology Department~~
ZSFG Campus

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- 2) Performance of procedure:
 - i. Indications: Suspected fungal infection
 - ii. Precautions: Bleeding
 - 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 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.



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- 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. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.)

- 3. Education
Discharge information and instructions.

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

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

- F. **Summary of Prerequisites, Proctoring and Reappointment Competency**

[Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care Prerequisites](#)

- a. Review of aseptic technique
- b. Review of departmental policy and procedure

Proctoring Period



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NURSE PRACTITIONER/ PHYSICIAN ASSISTANT**

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

Reappointment Competency

- a. Evaluator will be the Medical Director or other qualified provider
- b. Competency
 - 1. Perform 1 of each procedure every 2 years.
 - 2. 1 chart review of each procedure every 2 years.

STANDARDIZED PROCEDURE
NURSE PRACTITIONER/ PHYSICIAN ASSISTANT

Protocol #7: Procedure: Intralesional Steroid injections

A. DEFINITION

Injection of steroid into skin.

- 1) Location to be performed: ~~Ward 92 Dermatology Department~~
ZSFG Campus

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Commented [SP12]: change location to campuswide

- 2) Performance of procedure:

- i. Indications: Treatment of keloids and alopecia areata.
- ii. Precautions: Bleeding, skin atrophy
- iii. Contraindications: Skin atrophy

B. DATA BASE

1. Subjective Data

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

2. Objective Data

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

Commented [SP13]: Does the decision to do ILS injections fall on shoulders of attending or NP? Dr. Mauer, please clarify

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.

Commented [SP14R13]: Per Dr. Mauer, NP can decide if indicated (after precepting 5 cases, which is stipulated below in procting)

**STANDARDIZED PROCEDURE
NURSE PRACTITIONER/ PHYSICIAN ASSISTANT**

- 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. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
 3. Education
Discharge information and instructions.
 4. Follow-up
As appropriate for procedure performed.
- E. **RECORD KEEPING**
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record ~~and LCR~~ as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
- F. **Summary of Prerequisites, Proctoring and Reappointment Competency**

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

- a. ~~2 direct observations of a qualified provider doing each procedure~~
 - a. ~~b.~~ Review of aseptic technique
 - a. ~~_____~~
 - b. ~~c.~~ Review of departmental policy and procedure

**STANDARDIZED PROCEDURE
NURSE PRACTITIONER/ PHYSICIAN ASSISTANT**

Proctoring Period

- a. New practitioner to procedure, a minimum of ~~2~~
5 successful observed demonstrations of each procedure
- b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations of each procedure
- c. Chart review of all observed cases.

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Commented [SP15]: Per dr. mauer, requesting proctoring of 5 cases prior to independent practice

Reappointment Competency

- a. Evaluator will be the Medical Director or other qualified provider
- b. Competency
 1. Perform 1 of each procedure every 2 years.
 2. 1 chart review of each procedure every 2 years.