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

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

**PREAMBLE**

**Title: Interventional Radiology Nurse Practitioner/Physician Assistant**

**I. Policy Statement**

- A. It is the policy of 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 Radiology Program Office (Room 1x55) 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

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

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

#### A. Setting

1. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center (SFGH ZSFG). Inpatient settings to include ICU and inpatient units. Outpatient settings to include the Radiology Department and Emergency Department.

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#### B. Supervision

1. Overall Accountability:  
The NP/PA is responsible and accountable to: Chief of Interventional Radiology.
2. A consulting physician, which may include attendings, and credentialed fellows, by phone, in person, or by other electronic means at all times.

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3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
- Acute decompensation of patient situation
  - Unexplained historical, physical, or laboratory findings.
  - Upon request of patient, affiliated staff, or physician.
  - Problem requiring hospital admission or potential hospital admission.
  - Acute, severe respiratory distress.
  - An adverse response to respiratory treatment, or a lack of therapeutic response.

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#### a-IV. Scope of Practice

Protocol #1	Health Care Management: Interventional Radiology Service
Protocol #2	Furnishing Medications/Drug Orders
Protocol #3	Discharge of Patients
Protocol #4	eReferral
Protocol #5	Procedure: Surface Trauma and Wound Care
Protocol #6	Procedure: Lumbar Puncture/Lumbar Drain Insertion
Protocol #7	Procedure: Chest Tube Removal
Protocol #8	Procedure: Abdominal Paracentesis
Protocol #9	Interventional Radiology Procedural Assistant
Protocol #10	Central Venous Catheter Placement
Protocol #11	Tunneled Central Venous Catheter Placement
Protocol #12	Tunneled Central Venous Catheter Removal
Protocol #13	Chest Port Central Venous Catheter Placement
Protocol #14	Chest Port Central Venous Catheter Removal
Protocol #15	Gastrostomy Catheter Exchange
Protocol #16	Chest Tube Placement
Protocol #17	Tunneled Pleural Catheter Placement
Protocol #18	Thoracentesis
Protocol #19	Procedural Sedation
Protocol #20	Lower Extremity Venous Sclerotherapy
Protocol #21	Hip Aspiration and Injection
Protocol #22	Shoulder Aspiration and Injection

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

##### A. Basic Training and Education

- Active California Registered Nurse/Physician Assistant license.

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**Commented [JK6R5]:** From CIDP meeting, Ryan preferred they are separated as the P&R numbers maybe attainable for hip more frequently than the shoulder

**Commented [UR7]:** The CIDP agreed to keeping two separate protocols.

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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. Must have certification of Advanced Cardiac Life Support (ACLS) training if requesting Procedural Sedation Protocol.
  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 and DEA Number if applicable.
  8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each practice site for each PA.
- B. Specialty Training
1. Specialty requirements
    - a. NP specialty certification as an ANP, FNP, ACNP.
    - b. Current ACLS certification if requesting Procedural Sedation protocol.
    - c. Pass National Certification as a Physician Assistant.
    - d. Specialty training will be provided by the Radiology/Interventional Radiology attendings as part of the orientation process.
    - e. For Minor Procedure Protocol training please refer to each Procedure Protocol.
  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, acute care or intensive care unit in an acute care hospital within 6 months of hire.
    - b. Two years experience as a PA in an emergency department, acute care or intensive care unit in an acute care hospital within 6 months of hire.

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- C. Evaluation of NP/PA Competence in performance of standardized procedures. For procedures please refer to specific Procedure Protocol.
1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and/or other supervisors, as applicable will assess the NP/PA's ability to practice.
    - a. Clinical Practice
      - Length of proctoring period will be three months. The term may be shortened or lengthened at the discretion of the supervising physician. This proctoring will also include 30 chart reviews (15 neuro IR and 15 body IR), which will include direct observation of NP/PA clinic encounters of 5 body IR and 5 neuro IR cases. The evaluator will be the Chief of Interventional Radiology or Clinical Supervising Physician Designee.
      - The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
        - a. Ten directly ~~observed~~ observed clinical encounters are presented to the evaluator
        - b. For directly observed clinical encounters evaluator reviews co-signs orders and progress notes
        - c. For directly observed clinical encounters, co-signatures by a licensed physician must be concurrent to patient care
        - d. For directly observed clinical encounters, 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
  2. Follow-up: areas requiring increased proficiency as determined by the initial or biennial evaluation will be re-evaluated by the Medical Director, and/or designated physician and/or 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.

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4. Biennial Reappointment: Medical Director, designated physician or designated same discipline peer must evaluate the NP/PA Clinical competence. Case numbers will be found in each procedure.
  5. Ongoing:
    - a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used.

These methods are:

1. Examination of the patient by Supervising Physician the same day as care is given by the PA.
2. Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter.
3. Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations.

Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review 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, 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

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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 – Interventional Radiology Services

##### A. DEFINITION

This protocol covers the procedure for 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. Settings to include; Emergency Department, Radiology Department, Outpatient Clinics, ICU and Inpatient Units.

##### B. DATA BASE

1. Subjective Data
  - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
  - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, treatments and review of systems.
  - c. Pain history to include onset, location and intensity.
2. Objective Data

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- 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.

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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.
- d. Patient consent obtained consistent with hospital policy before procedure is performed and according to Department of Radiology Guidelines.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation
- b. Unexplained historical, physical or laboratory findings
- c. Upon request of patient, NP, PA, or physician
- d. Initiation or change of medication other than those in the formularies.
- e. Any 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.

3. Education

- a. Patient education appropriate to diagnosis and should include treatment modalities and lifestyle counseling (e.g. diet and exercise).
- b. Discharge information and instructions.

4. Follow-up

As appropriate regarding patient health status and diagnosis.

E. RECORD KEEPING



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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: 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. 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/ies that will be used are: [Zuckerberg San Francisco General Hospital and Trauma Center/Community Health Network](#), Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

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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.

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- 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.

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C. DIAGNOSIS

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

D. PLAN

1. Treatment

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

2. Patient conditions requiring Consultation

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- a. Initiation or change of medication other than those in the formulary.
- b. Unexplained historical, physical or laboratory findings.
- 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 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 #3: Discharge of Patients

#### A. DEFINITION

This protocol covers the discharge of patients from San Francisco General Hospital and Trauma Center. The direction to discharge a patient will come from the attending physician. This protocol covers patients who are admitted by the Radiology/Interventional Radiology Service to the inpatient Wards, patients in the Radiology Department and those sent to PACU, 4C, Dialysis Unit 4B and Ward 17 to recover from interventional procedures and treatment.

#### 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, 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. Unexplained historical, physical or laboratory findings.
  - c. Upon request of patient, NP, PA or physician.

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- d. Initiation or change of medication other than those in the formulary.
- f. Referral to specialty services not provided by DPH.

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3. Education

- a. Review patient 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
  - whom to call if have symptoms of 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.

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#### PROTOCOL #4: eReferral Review

##### A. DEFINITION

eReferral review is defined as the review of outpatient imaging consultation requests via the online eReferral system. An imaging request is defined as a request for advanced imaging study, such as MRI, CT or Ultrasound, submitted by a health care provider to the radiology department. A review of imaging request is defined as determination of appropriateness and urgency (priority) of a requested imaging study, based on the provided subjective and objective data.

##### 1. Prerequisites:

- a. Providers reviewing eReferrals 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 they are allowed to review eReferrals independently.
  - b. Providers reviewing eReferrals will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
  - c. Providers reviewing eReferrals will consistently provide care to patients in the specialty clinic for which they are reviewing.
  - d. Providers reviewing eReferrals will have expertise in the specialty practice for which they are reviewing.
2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the eReferral system.
3. Proctoring: 15 reviews of the eReferral consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.

##### B. DATA BASE

##### 1. Subjective Data

- a. eReferral imaging request review will include the review of medical and surgical history, which is relevant to determination of appropriateness and priority of the imaging study. The scope of the review will be limited to the data provided by the referring provider on the electronic referral. 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.

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- b. The review will include the review of allergy history to anticipate contrast reactions.
- c. The review will include the review of special patient data that may affect the imaging study. This data may include, but is not limited to patient's language requirements, mobility issues, anxiety and need for sedation. Review of these special patient data will help anticipate problems during performance of the study, and thereby improve efficiency of the department.

## 2. Objective Data

- a. The review will include the review of physical exam findings, which are relevant to the determination of appropriateness and priority of the imaging study. The review will be limited in scope to the data provided by the referring provider.
- b. The record of prior radiological exams will be reviewed, to exclude (duplicate entries of the same study), and to help assess appropriateness of imaging. The record of prior radiological exams will be retrieved by the eReferral system automatically, however in some cases the reviewer may need to consult the electronic medical record.
- c. The record of laboratory findings, which are relevant to imaging, such as Creatinine and eGFR, will be automatically retrieved by the eReferral system. However, in some cases the reviewer may need to consult the electronic medical record to retrieve further information.

## C. DIAGNOSIS

Establishing the correct diagnosis is the goal of radiological imaging, therefore the eReferral review is not aimed at establishing the final diagnosis. However, it is essential to know the preliminary or provisional diagnosis in order to assess the appropriateness and priority of the imaging study. A correct ICD109 code of the preliminary diagnosis is also crucial to successful billing of the radiological procedures. eReferral review will include the preliminary diagnosis as provided by the referring provider through the eReferral system.

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## D. PLAN

### 1. Review of eReferral

~~b.a.~~ All data provided via the eReferral consultation request will be reviewed and assessed for appropriateness of the imaging request and priority (urgency) of the study. The review will be based on the published appropriateness guidelines of the American College of Radiology. The reviewer will also



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consider factors, which are local to ~~SFGH~~<sup>#7</sup>~~ZSFG~~, such as availability constraints and wait times in assigning priority to the imaging requests.

~~c.b.~~ 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 Radiologist Review
  - a. Upon request of the referring NP, PA or physician
  - b. Complex imaging questions, not clearly addressed by the American College of Radiology guidelines.
  - c. Problems requiring emergent imaging studies.
  - d. Problems requiring relatively counter-indicated imaging studies, when the benefits outweigh the risks.
  - e. Problems requiring emergent/urgent surgical intervention.
3. Education  
Provider education appropriate to the referring problem including usefulness, indications, counter-indications of imaging studies. The reviewer will also advise the referring clinicians regarding the limitations of availability of certain studies at ~~SFGH~~.
4. Scheduling of Appointments  
~~Dependent~~ upon the urgency of the referral, the eReferral will be forwarded to the scheduler for the next available imaging appointment.
5. Patient Notification
  - a. Notification of the patient will be done by the referring provider if the appointment is scheduled as next available. If the appointment is scheduled as an over book within two weeks of the eReferral, the consulting scheduler is responsible for notifying the patient.

#### E. RECORD KEEPING

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

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

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entered into the electronic medical record **LCR** and forwarded to the scheduler.

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## Procedure: Protocol #5: 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 protocol will be completed in the inpatient and outpatient unit(s) at Zuckerberg San Francisco General Hospital and Trauma Center.
2. Performance of procedure:
  - a. Indications  
Patient's presenting for assessment and treatment of lacerations, abrasions and avulsions.
  - b. Precautions (require attending physician consultation)  
Coagulopathy  
Potential for Foreign Bodies within wound  
Malnutrition  
Diabetes  
Immunocompromized State  
Peripheral Vascular Disease  
Unexplained historical, physical or laboratory findings.
3. Contraindications requiring attending physician consultation
  - 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 or fracture
  - d. Wounds with tendon, ligament, vessel or nerve involvement
  - e. Head laceration with galea disruption
  - f. Facial lacerations with cosmetic consideration (e.g. eyelids and vermillion borders)
  - g. Lacerations penetrating into joints
  - h. Children under the age of 10
  - i. Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
  - j. Wounds requiring repair of cartilage
  - k. Through and through lip lacerations
  - l. Unexplained historical, physical or laboratory findings that could compromise safety of the procedure.

### B. DATA BASE

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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 ~~SFGHMC~~ ~~ZSFG~~ POCT policy and procedure 16.20.

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C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained consistent with hospital policy before procedure is performed.
- b. Time out performed per hospital policy.
- c. Diagnostic tests for purposes of disease identification.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, 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
- 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

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- 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

Prerequisite:

- a. Specialty training will be provided by the Interventional Radiology attendings as part of the orientation process.
- b. Observe 2 wound care and surface trauma care procedures with MD.

Proctoring Period:

- a. New practitioner to procedure, a minimum of 3 successful observed demonstrations.
- b. Experience practitioner to procedure, a minimum of 2 successful observed demonstrations.
- c. Three medical record reviews/audits by the Chief of Interventional Radiology or Clinical Supervising Physician designee.
- d. Proctoring will be performed by the Chief of Interventional Radiology and/or his or her designee.

Evaluation of Reappointment Competency

- a. Evaluation will be performed by Supervising Physician and/or his or her designee.

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- b. Demonstration of 3 procedures completed every 2 years.
- c. Three chart reviews needed every 2 years

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Procedure: Protocol #6: Lumbar Puncture/Lumbar Drain Insertion

A. DEFINITION

Lumbar catheter insertion is defined as placement of a lumbar Cerebral Spinal Fluid (CSF) drainage catheter located within the subarachnoid space as decided upon by the Interventional Radiology team and in accordance with the Neuro-Interventional Radiology Attending Physician.

1. Locations to be performed: For purposes of this procedure, the protocol will be completed in the Radiology Department or inpatient units at [Zuckerberg San Francisco General Hospital](#) and Trauma Center.

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2. Performance of procedure:

a. Indications

1. 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).
2. A lumbar drain should be placed primarily for the purposes of CSF diversion. This procedure 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 (Requiring a physician consultation)

1. Mass effect, subarachnoid hemorrhage or obstructive hydrocephalus: will typically obtain a head CT to rule out these conditions.
2. Platelets should be greater than or equal to 100,000

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3. Patients on anticoagulants or who have bleeding tendencies (ex. Atrial fibrillation, Von Willebrand's, Hemophilia, Liver disease)
  4. ASA/NSAIDS/Cox II Inhibitors taken within past 5 days.
- c. Contraindications (Requiring a physician consultation)
    1. Infection in the tissues near the puncture site.
    2. Increased intracranial pressure, if suspected rule out with head CT
    3. Coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.

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#### B. DATA BASE

##### 1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
  1. Presence of motor or sensory deficits
  2. Presence of headache or meningitic symptoms
  3. 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 ~~SFGHMC~~ ZSFG POCT policy and procedure 16.20.

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#### 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.

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c. Referral to specialty clinic, supportive services for provider as needed.

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

Prerequisite:

- a. Specialty training will be provided by the Interventional Radiology attendings as part of the orientation process.
- c. Observe 2 lumbar punctures/drain insertions with MD.

Proctoring Period:

- a. New practitioner to procedure, a minimum of 5 successful observed demonstrations.

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- b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations.
- c. Proctoring will be performed by the Chief of Interventional Radiology and/or his or her designee.
- d. Successful completion of these requirements as determined by the Chief of Interventional Radiology or Clinical Supervising Physician designee is needed prior to independent practice.

Evaluation of Reappointment Competency:

- a. Evaluation will be performed by Supervising Physician and/or his or her designee.
- b. Demonstration of 3 procedures every 2 years.
- c. Three chart reviews every 2 years.

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## Procedure: Protocol #7: Drainage Catheter and Chest Tube Removal

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### A. DEFINITION

For the purposes of this protocol, a drainage catheter is defined as an indwelling catheter placed for therapeutic removal of fluid. A chest tube is defined as an indwelling catheter placed in the thoracic cavity for therapeutic removal of fluid or air.

1. Location to be performed: The removal of a chest tubes and drainage catheters will be performed on the inpatient units, Emergency Department, or Radiology Department.
2. Indications
  - a. Patient symptoms related to intrapleural air/fluid have diminished
  - b. Patients current chest radiograph/ laboratory studies support procedure
3. Precautions/Contraindications requiring attending consultation
  - a. Relevant diagnostic modalities indicate continued presence of air/fluid.

### B. DATA BASE

1. Subjective Data
  - a. Comfort, c/o shortness of breath, exercise tolerance.
  - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications
  - c. Relevant history and review of symptoms including but not limited to: results respiratory, allergies.
2. Objective Data
  - a. Appropriate physical exam including but not limited to: results of previous chest imaging, quantity and quality of output from the Chest Tube, evaluation for air leak, oxygen saturation, and breath sounds, to confirm appropriateness of procedure.
  - b. Evaluation of the chest tube insertion site for signs of infection including but not limited to purulence, erythema, induration, fluctuance, foul odor.
  - c. Review of current medication regiment including recent analgesia administration.
  - d. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
  - e. All Point of Care Testing (POCT) will be performed according to SFGHMC ZSFG POCT policy and procedure 16.20.

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#### C. DIAGNOSIS

Resolution of pneumothorax, hemothorax, effusion, suspected malfunction of the chest tube to function adequately (e.g. suspected clotted tube, proximal hole external to chest wall cavity). Prior to chest tube removal, the Interventional Radiology Service will complete an assessment of the subjective and objective data- see above.

#### D. PLAN

1. Therapeutic Treatment Plan
  - a. Explain procedure to the patient, if possible. If patient unable to understand, advise bedside nurse of procedure and plan.
  - b. Patient consent obtained before procedure is performed and obtained according to hospital policy.
  - c. Time out performed per hospital policy.
  - d. Diagnostic tests to confirm appropriateness of procedure.
  - e. This procedure is performed following standard medical technique according to the departmental guidelines/ standards.
  - f. Observe patient for signs of respiratory compromise immediately following procedure including (as indicated) respiratory rate, pattern, oxygen saturation. For ventilated patients, observe the measured airway pressures post removal.
2. Patient conditions requiring Attending Consultation
  - a. Acute decompensation of patient situation including but not limited to acute shortness of breath, persistent desaturation post removal.
  - b. Evidence of, or suspicion of air intra-thoracic air entrapment at the time of or immediately after removal (e.g. audible leaking from the chest wound site at the time of removal, increased intrathoracic pressures on ventilated patients).
  - c. Inability to remove the chest tube fractured or retained catheter.
  - d. Given evidence of increasing or unstable pneumothorax on post-pull imaging.
  - e. Upon request of patient, NP, PA, or physician
3. Education

Provide patient education related to the procedure. If patient is unable to comprehend instructions due to decreased mental status, provide nursing instruction prior to performance. If

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patient is on a ventilator or positive pressure ventilation advise  
respiratory therapist prior to performance.

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

E. RECORD KEEPING

1. A comprehensive procedural note and post procedure assessments will be documented in the medical record. Any sutures not removed at the time of the chest tube removal shall be described in this note.
2. For Physician Assistants, a minimum of five (5) percent of the patient chart entries will be reviewed, signed and dated by the Supervising Physician within thirty (30) days of the patient encounter.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

- a. Specialty training will be provided by Interventional Radiology attendings as part of the orientation process.
- b. Observe 2 chest tube removals with MD.

Proctoring Period:

- a. New practitioner to procedure, a minimum of 5 successful observed demonstrations.
- b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations.
- c. Proctoring will be performed by the Chief of Interventional Radiology and/or his or her designee.
- d. Successful completion of these requirements as determined by the Chief of Interventional Radiology or Clinical Supervising Physician designee is needed prior to independent practice.

Evaluation of Reappointment Competency:

- a. Evaluation will be performed by Supervising Physician and/or his or her designee.
- b. Demonstration of 3 procedures every 2 years.
- c. 3 chart reviews every 2 years.

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#### Procedure: Protocol #8: Abdominal Paracentesis

- A. Definition - Abdominal paracentesis entails inserting a needle through the abdominal wall into the peritoneal cavity under local anesthetic for aspiration of peritoneal fluid (ascites).
1. Locations to be performed: Emergency Department, inpatient units, Radiology Department.
  2. Performance of Procedure: (When possible paracentesis should be performed bedside with ultrasound guidance; an alternative is to have fluid localized and transport patient on same bed used for marking, i.e. patient is not moved).
    - i. Indications:
      - a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhotic).
      - b. Pt with ascites, fever, abdominal pain, i.e. to evaluate for spontaneous bacterial peritonitis.
      - c. Symptomatic treatment of tense ascites.
    - ii. Precautions (the following conditions necessitate attending physician consultation and ultrasound guided paracentesis):
      - a. Abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
      - b. Intra-abdominal adhesions or suspicion for loculated fluid.
      - c. Pregnancy
    - iii. Contraindications:
      - a. Fibrinolysis or DIC.
      - b. Cellulitis at puncture site.
- 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.

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- b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

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D. Plan

1. Therapeutic Treatment Plan.
  - a. Informed consent obtained prior to procedure and according to hospital policy.
  - b. Time out performed according to hospital policy.
  - c. Diagnostic tests for purpose of identifying disease etiology. Send for cytology as relevant.
  - d. Initiation or adjustment of medication per Furnishing/Drug Orders Protocol.
  - e. Referral to specialty clinic, supportive services for provider as needed.
2. Patient conditions requiring attending consultation
  - a. All patients with conditions listed in precaution section.
  - b. Acute decompensation of patient.
  - c. Upon the request of the patient, PA, NP or physician.
3. Education
  - a. Appropriate and relevant patient and family education in written and/or verbal format.
  - b. Contact information for follow up should needle puncture site result in leaking ascitic fluid.
4. Follow-up
  - a. As indicated and appropriate for procedure performed.

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, Care Vue, 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 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.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

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<div>#7</div> <div><div>a. Specialty training will be provided by Interventional Radiology attendings as part of the orientation process.</div><div>b. Observe 3 Abdominal Paracentesis procedures with MD.</div></div>
<div>Proctoring Period:</div> <div><div>a. New practitioner to procedure, a minimum of 5 successful observed demonstrations.</div><div>b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations.</div><div>c. Proctoring will be performed by the Chief of Interventional Radiology and/or his or her designee.</div></div>
<div>Evaluation of Reappointment Competency:</div> <div><div>a. Evaluation will be performed by Supervising Physician and/or his or her designee.</div><div>b. Demonstration of 3 procedures every 2 years.</div><div>c. Three chart reviews every 2 years.</div></div>

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## Protocol #9 Procedure: Interventional Radiology Procedural Assistant

### A. DEFINITION

This protocol covers the participation of the Nurse Practitioner who provides assistance to Interventional Radiology Attendings during interventional radiology procedures, where an Interventional Radiology Attending or Neuro-Interventional Radiology Attending is the primary operator and is present in the interventional radiology suite or at the patient bedside during procedures performed outside the IR suite. The assisted procedures are: angiography, venography, angioplasty, venoplasty, vascular embolization procedures, image guided biopsies, drainage procedures, drainage catheter placements, transjugular intrahepatic portosystemic shunts, inferior vena cava filter placements, gastrostomy tube placements, liver biopsies, chest tube placement, thoracentesis, chest port placements, chest port removals, tunneled central venous catheter removal, central venous catheter removal procedures and venous access procedures. Assistance refers to the process where under an attending's direct supervision and direction, the Nurse Practitioner assists the attending operator in the technical steps of the procedure but does not independently perform them. Technical steps of the procedure are the administration of medications, obtaining vascular access, suturing, preparation of instruments, tissue dilation, tissue dissection, tissue cutting, manipulation of intra-corporeal instruments, manipulation of intra-corporeal needles, manipulation of intra-corporeal catheters and drain insertions.

1. Location to be performed: Radiology Department, inpatient units, and Emergency Department.
2. Performance of procedure:
  - a. Indications  
This protocol addresses patients presenting to the Radiology Department, or patients undergoing interventional radiology procedures on the inpatient units, or in the Emergency Department.
  - b. Precautions  
None
  - c. Contraindications  
None.

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## B. DATA BASE

### 1. Subjective Data

- a. History of chief complaint and review of symptoms relevant to the suggested procedure, possible organ systems affected by the procedure, mechanism of injury and type of injury
- b. Pertinent past medical history including current medications, allergies, clotting disorders, previous wound history, previous vascular disease history, previous history of infection.

### 2. Objective Data

- a. Physical exam of the system prescribed for procedure, i.e. for neurovascular procedures performing neurologic exam, for vascular procedures providing an examination of associated tissues perfused.
- b. When a drain is implemented, data will include quantity and quality of drainage, level of set negative pressure, and assessment of the site.
- c. Appropriate motor, sensory and vascular exam of the involved area.
- d. The procedure is performed following standard procedural technique according to departmental guidelines.
- e. Laboratory and imaging evaluation, as indicated, relevant to history and exam. Appropriate laboratory values to be considered include (but are not limited to): complete blood count and coagulation studies, nutritional status and electrolytes.
- f. All Point of Care Testing (POCT) will be performed according to ~~SFGH~~ ZSFG POCT Policy and Procedure 16.2.

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## C. DIAGNOSIS

Assessment of subjective and objective data to identify disease process requiring intervention.

## D. PLAN

### 1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
- b. Explain procedure to the patient (if patient unable to receive information due to mental status, explain to

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surrogate and/or bedside RN) Explain the procedure to the family.

- c. Diagnostic tests for purposes of disease identification.
- d. Time out per hospital policy.
- e. Biopsy tissue is sent to pathology if specimen collected.
- f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- g. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending
  - a. All assisted interventional radiology procedures shall be performed in direct consultation with an Interventional Radiology Attending or Neuro-Interventional Radiology Attending, who will be in the IR suite during assisted procedures.
3. Education:  
Discharge information and instructions.
4. Follow-up:  
As appropriate for procedure performed.

E. RECORD KEEPING

1. Documentation of a detailed procedure note will be recorded in the medical record. Required follow up of the wound (e.g. suggested suture removal dates, ongoing care to be delivered by nursing/wound care orders, or future drain change) will be indicated in the procedure note and in daily progress notes.
2. All procedural dictations are reviewed and cosigned by an Attending Physician for quality assurance purposes.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

- a. Completion of 10 observed cases.
- b. Specialty Training Provided by Interventional Radiology Attendings.

Proctoring Period:

- a. All procedures will have direct supervision from a consulting Attending Interventional Radiologist or Neuro-Interventional Radiologist. Review will be done after each case.
- b. Proctoring period will be three months in length.

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Reappointment Competency Documentation:

- a. Minimum number of 10 procedures must be completed every two years.
- b. 10 chart reviews needed every two years.

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Procedure: Protocol #10: Central Venous Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of central venous catheters. A central venous catheter refers to a device used for central venous infusion or dialysis.

1. Location to be performed: Radiology Department, inpatient units, PACU, Emergency Department.
2. Performance of procedure:
  - a. Indications: Central venous access for delivery of medications, ~~nutritions~~, blood products, and frequent blood sampling. Dialysis for renal failure.
  - b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
  - c. Contraindications requiring attending physician consultation: Patients who have exhibited prior intolerance to the materials of construction.

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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. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

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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.
- f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained physical or laboratory findings
- c. Upon request of patient, NP, PA, or physician
- d. Initiation or adjustment of medication other than those in the formularies.
- e. Problem requiring hospital admission or potential hospital admission.)

3. Education

Instructions for clinical staff.

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

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

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Observe two CVC placements with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 10 CVC placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>b. Proctoring may be performed by experienced qualified provider MD/NP/PA.</li></ul>
Reappointment Competency: <ul style="list-style-type: none"><li>a. Successful placement of 5 CVCs every two years.</li><li>b. Direct observation of one CVC placement procedure will be performed every two years by a qualified provider.</li><li>c. 3 chart reviews will be performed every two years.</li><li>d. The Chief of the Interventional Radiology Department or qualified provider designee, will be the proctor/evaluator.</li></ul>

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## Procedure: Protocol #11: Tunneled Central Venous Catheter Placement

### A. DEFINITION

This procedure/protocol covers the placement of central venous catheters which are placed for the purposes of central venous infusion or hemodialysis. For the purposes of the protocol/procedure a central venous catheter refers to a venous access device, which is tunneled under the skin to the catheter exit site.

1. Location to be performed: Placement of tunneled central venous catheters will be conducted in the Radiology Department.
2. Performance of procedure:
  - a. Indications: Central venous access for delivery of medications, nutrition, blood products, and frequent blood sampling. Hemodialysis as indicated by presence of acute and/or chronic renal failure/insufficiency.
  - b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting.
  - c. Contraindications requiring attending consultation: Absolute contraindications to tunneled central venous catheter placement include bacteremia or sepsis, infection at the insertion site, and disseminated intravascular coagulopathy. Relative contraindications include neutropenia, recent but resolved sepsis, and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.

### 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.



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

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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.
  - f. **The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).**
2. Patient conditions requiring Attending Consultation
  - a. Acute decompensation of patient situation.
  - b. Unexplained physical or laboratory findings
  - c. Upon request of patient, NP, PA, or physician
  - d. Initiation or adjustment of medication other than those in the formularies.
  - e. Problem requiring hospital admission or potential hospital admission.
3. Education  
Discharge information and instructions.
4. Follow-up  
As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review

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

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Observe two tunneled hemodialysis catheter placements with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 10 tunneled hemodialysis catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>c. Proctoring may be performed by experienced qualified provider MD/NP/PA.</li></ul>
Reappointment Competency: <ul style="list-style-type: none"><li>a. Successful placement of 10 tunneled hemodialysis catheter placements every 2 years.</li><li>b. Direct observation of one hemodialysis access catheter placement procedure will be performed every 2 years by a qualified provider.</li><li>c. 3 chart reviews will be performed every 2 years.</li></ul>

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## Procedure: Protocol #12: **Tunneled Central Venous Catheter Removal**

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### A. DEFINITION

*This procedure/protocol covers removal of tunneled central venous catheters (CVC). For the purposes of the protocol/procedure a tunneled central venous catheter refers to venous access devices used for central venous infusion and/or hemodialysis, which is tunneled under the skin to the catheter exit site.*

- 1) Location to be performed: Removal of tunneled central venous catheters may occur in the Radiology Department, inpatient units, Emergency Department, PACU, and 4C.
- 2) Performance of procedure:
  - i. Indications: Discontinuation of catheters in patients with suspected CVC infections or for CVCs that are no longer medically needed.
  - ii. Precautions requiring attending physician consultation: patients with central venous obstruction or abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department...
  - iii. Contraindications: No absolute contraindications.

### 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~~ ZSFG POCT policy and procedure 16.20.**

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### 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.

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- 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.
- f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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.

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

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Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Observe one tunneled CVC removal with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 5 tunneled hemodialysis catheter removals without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>b. Proctoring may be performed by experienced qualified provider MD/NP/PA.</li></ul>
Reappointment Competency Documentation: <ul style="list-style-type: none"><li>a. Continued proficiency will be documented on annual evaluation or re-credentialing through the successful removal of 2 tunneled CVC annually and no unexpected complications.</li><li>b. 2 chart reviews will be performed annually.</li><li>c. The Chief of the Interventional Radiology Department or qualified provider designee, will be the proctor/evaluator.</li></ul>
Any additional comments:

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## Procedure: Protocol #13: Chest Port Central Venous Catheter Placement

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### A. DEFINITION

This procedure/protocol covers the placement of chest port central venous catheters. A chest port central venous catheter refers to a device used for central venous access with an infusion port which lies underneath the skin, typically at the upper anterior chest, and a catheter tip which lies in a central vein.

1. Location to be performed: Radiology Department.
2. Performance of procedure:
  - a. Indications: Central venous access for delivery of medications, nutrition, blood products, and frequent blood sampling.
  - b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department...
  - c. Contraindications requiring attending physician consultation: presence of known or suspected infections, septicemia, or peritonitis. Patients who have exhibited prior intolerance to the materials of construction, or patients whose body size or tissue is insufficient to accommodate the size of the port or catheter.

### 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~~ ZSFG POCT policy and procedure 16.20.

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### C. DIAGNOSIS

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Assessment of subjective and objective data to identify disease processes.

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#### 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.
  - f. **The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).**
2. Patient conditions requiring Attending Consultation
  - a. Acute decompensation of patient situation.
  - b. Unexplained physical or laboratory findings
  - c. Upon request of patient, NP, PA, or physician
  - d. Initiation or adjustment of medication other than those in the formularies.
  - e. Problem requiring hospital admission or potential hospital admission.)
3. Education  
Discharge information and instructions.
4. Follow-up  
As appropriate for procedure performed.

#### E. RECORD KEEPING

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



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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Observe two chest port placements with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 10 chest port placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>b. Proctoring may be performed by experienced qualified provider MD/NP/PA.</li></ul>
Reappointment Competency: <ul style="list-style-type: none"><li>a. Successful placement of 5 chest port central venous infusion catheter placements every two years.</li><li>b. Direct observation of one chest port placement procedure will be performed every two years by a qualified provider.</li><li>c. 3 chart reviews will be performed every two years.</li><li>d. The Chief of the Interventional Radiology Department or qualified provider designee, will be the proctor/evaluator.</li></ul>

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## Procedure: Protocol #14: Chest Port Central Venous Catheter Removal

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### A. DEFINITION

*This procedure/protocol covers removal of chest port central venous catheters (CVC). For the purposes of the protocol/procedure a chest port central venous catheter refers to venous access devices used for central venous infusion which is tunneled under the skin to a subcutaneous port.*

- 1) Location to be performed: Chest port CVCs will be removed in the Radiology Department.
- 2) Performance of procedure:
  - i. Indications: Discontinuation of catheters in patients with suspected CVC infections or for CVCs that are no longer medically needed.
  - ii. Precautions requiring attending physician consultation: patients with central venous obstruction, abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
  - iii. Contraindications: No absolute contraindications.

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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. **Laboratory and imaging evaluation, as indicated, relevant to history and exam.**
  - c. **All Point of Care Testing (POCT) will be performed according to ~~SFGH~~ ZSFG POCT policy and procedure 16.20.**

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### 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.

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- 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.
- f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

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.

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

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Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Observe removal of one chest port CVC with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 5 chest port removals without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>b. Proctoring may be performed by experienced qualified provider MD/NP/PA.</li></ul>
Reappointment Competency Documentation: <ul style="list-style-type: none"><li>a. Continued proficiency will be documented on annual evaluation or re-credentialing through the successful removal of 2 chest ports every two years and no unexpected complications.</li><li>b. 2 chart reviews will be performed every two years.</li><li>c. The Chief of the Interventional Radiology Department or qualified provider designee, will be the proctor/evaluator.</li></ul>
Any additional comments:

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## Procedure: Protocol #15: Gastrostomy Catheter Exchange

### A. DEFINITION

This protocol/procedure covers the exchange or removal of percutaneous gastrostomy and gastrojejunostomy catheters/tubes. For the purposes of this procedure a gastrostomy tube would be defined as catheter inserted percutaneously into the stomach, and with catheter end located in the stomach, duodenum or proximal jejunum.

1. Location to be performed: Gastrostomy catheter exchange will take place in Radiology Department, Emergency Department or inpatient units at San Francisco General Hospital.

Gastrojejunostomy exchange will take place in the Radiology department at San Francisco General Hospital.

2. Performance of procedure:

- a. Indications: malpositioned, malfunctioning catheter, or as part of routine exchange and catheter maintenance.
- b. Precautions requiring attending physician consultation: Gastrostomy tubes which have been in place less than 6 weeks and replacement of gastrostomy catheters that have completely fallen out of the body.
- c. Contraindications requiring attending physician consultation: immature gastrostomy tracts that may require fluoroscopic replacement.

### 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 ZSFG POCT policy and procedure 16.20.

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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 -
- e. Referral to physician, specialty clinics, and supportive services, as needed.
- f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained physical or laboratory findings
- c. Upon request of patient, NP, PA, or physician
- d. Initiation or adjustment of medication other than those in the formularies.
- e. Problem requiring hospital admission or potential hospital admission.

3. Education

Discharge information and instructions.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

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

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Observe one gastrostomy exchange with qualified provider.</li><li>c. Observe one gastrojejunostomy exchange with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 3 gastrostomy exchanges and 3 gastrojejunostomy exchanges with qualified provider without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>a. MD/NP/PA.</li></ul>
Reappointment Competency: <ul style="list-style-type: none"><li>a. Successful exchange of one gastrostomy tube and one gastrojejunostomy tube annually.</li><li>b. Direct observation of one gastrojejunostomy tube exchange every 2 years will be performed with qualified provider.</li><li>c. 2 chart reviews will be performed every 2 years, of one gastrostomy and one gastrojejunostomy.</li><li>d. The Chief of the Interventional Radiology Department or qualified provider designee, will be the evaluator.</li></ul>

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## Procedure: Protocol #16: Pleural Catheter Placement

### A. DEFINITION

This procedure/protocol covers the placement of a percutaneous pleural catheter. For the purposes of this protocol a pleural catheter or chest tube refers to a catheter placed using thoracentesis followed by dilation and catheter exchange over a wire method for obtaining access to the intra-pleural space for drainage of pleural fluid, in which the catheter may or may not have a locking cope loop.

1. Location to be performed: Radiology Department, inpatient units, PACU and emergency department.
2. Performance of procedure:
  - a. Indications: pleural effusions and pneumothorax.
  - b. Precautions requiring attending physician consultation, pulmonary bullae. Pleural adhesions and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines, which are posted in the Radiology Department.
  - c. Contraindications: need for emergent thoracotomy, skin infection over 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. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
  - c. All Point of Care Testing (POCT) will be performed according to ~~SFGH~~ ZSFG POCT policy and procedure 16.20.

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### C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.



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#### 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.
  - f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
2. Patient conditions requiring Attending Consultation
  - a. Acute decompensation of patient situation.
  - b. Unexplained physical or laboratory findings
  - c. Upon request of patient, NP, PA, or physician
  - d. Initiation or adjustment of medication other than those in the formularies.
  - e. Problem requiring hospital admission or potential hospital admission.
3. Education  
Discharge information and instructions.
4. Follow-up  
As appropriate for procedure performed.

#### E. RECORD KEEPING

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

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Qualification to perform thoracentesis.</li><li>c. Observe two pleural catheter placements with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 10 pleural catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>b. Proctoring may be performed by experienced qualified provider MD/NP/PA.</li></ul>
Reappointment Competency: <ul style="list-style-type: none"><li>a. Successful placement of 3 pleural catheters every 2 years.</li><li>b. Direct observation of two pleural catheter placement procedures will be performed every 2 years.</li><li>c. 3 chart reviews will be performed every 2 years.</li><li>d. The Chief of the Interventional Radiology Department or qualified provider designee, will be the proctor/evaluator.</li></ul>

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## Procedure: Protocol #17: Tunneled Pleural Catheter Placement

### A. DEFINITION

This procedure/protocol covers the placement of a tunneled percutaneous pleural catheter. For the purposes of this protocol a tunneled pleural catheter ~~and, -tunneled chest tube, or Pleurex Catheter~~ are used interchangeably and refer to a pleural catheter placed using thoracentesis followed by dilation and subcutaneous tunneling to an adjacent exit site for drainage of pleural fluid.

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1. Location to be performed: Radiology Department, inpatient units, PACU and emergency department.
2. Performance of procedure:
  - a. Indications: chronic pleural effusions.
  - b. Precautions requiring attending physician consultation, pulmonary bullae. Pleural adhesions and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines, which are posted in the Radiology Department.
  - c. Contraindications: active infection, parapneumonic effusions, skin infection over 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. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
  - c. All Point of Care Testing (POCT) will be performed according to ~~SFGH~~ ZSFG POCT policy and procedure 16.20.

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### C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

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#### 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.
  - f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
2. Patient conditions requiring Attending Consultation
  - a. Acute decompensation of patient situation.
  - b. Unexplained physical or laboratory findings
  - c. Upon request of patient, NP, PA, or physician
  - d. Initiation or adjustment of medication other than those in the formularies.
  - e. Problem requiring hospital admission or potential hospital admission.
3. Education  
Discharge information and instructions.
4. Follow-up  
As appropriate for procedure performed.

#### E. RECORD KEEPING

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

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: <ul style="list-style-type: none"><li>a. Completion of training on site.</li><li>b. Qualification to perform thoracentesis.</li><li>c. Observe two pleural catheter placements with qualified provider.</li></ul>
Proctoring Period: <ul style="list-style-type: none"><li>a. Under direct observation of a qualified provider, trainee will perform 10 tunneled pleural catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence.</li><li>b. Proctoring may be performed by experienced qualified provider MD/NP/PA.</li></ul>
Reappointment Competency: <ul style="list-style-type: none"><li>a. Successful placement of 3 tunneled pleural catheters every 2 years.</li><li>b. Direct observation of two pleural catheter placement procedures will be performed every 2 years.</li><li>c. 3 chart reviews will be performed every 2 years.</li><li>d. The Chief of the Interventional Radiology Department or qualified provider designee, will be the proctor/evaluator.</li></ul>

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#### Procedure: Protocol #18: Thoracentesis

- A. DEFINITION: Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid.
1. Location to be performed: Radiology Department, inpatient units, and emergency department.
  2. Performance of procedure  
Indications
    - a. For the purposes of this protocol, thoracentesis may be used to determine the cause of a pleural effusion or
    - b. To relieve the symptoms of respiratory distress  
Contraindications
    - a. Infection in the tissues near the puncture site.
    - b. Acute respiratory compromise
    - c. Abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
    - d. Significant pulmonary parenchymal disease
- 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~~ ZSFG POCT policy and procedure 16.20.
- C. DIAGNOSIS  
Assessment of subjective and objective data to identify disease processes.

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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.
  - f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- 2. Patient conditions requiring Attending Consultation
  - a. Acute decompensation of patient situation.
  - b. Unexplained physical or laboratory findings
  - c. Upon request of patient, NP, PA, or physician
  - d. Initiation or adjustment of medication other than those in the formularies.
  - e. Problem requiring hospital admission or potential hospital admission.
- 3. Education
  - Discharge information and instructions.
- 4. Follow-up
  - As appropriate for procedure performed.

- E. RECORD KEEPING
  - Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate.
- F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite
a. Onsite training by a qualified provider.
Proctoring Period
a.. Under direct observation of a qualified provider, trainee will perform 5 thoracentesis procedures without need for procedural intervention

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by training provider and such additional procedures as may be necessary to verify clinical competence.
b. Experienced provider to procedure, a minimum of 3 successful observed demonstrations
Reappointment Competency
a. The evaluator will be the Chief of Interventional Radiology or designated qualified provider.
b. Ongoing competency evaluation.
1. Perform a minimum of 3 procedures every 2 years.
2. Two chart reviews every 2 years.

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Procedure: Protocol #19: Procedural Sedation/Moderate Sedation (ACLS required)

#### A. DEFINITION

Procedural Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation (~~SFGH~~ZSFG policy number 19.8 titled, "Procedural Sedation: Moderate and Deep") by the Nurse Practitioner/Physician Assistant during procedures in adults within a monitored setting. For the purpose of this protocol, the setting is specifically in the Radiology Department. The Nurse Practitioner/Physician Assistant practices under the supervision of the Chief of Interventional Radiology or designee. Practitioners inducing a level of moderate sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes, and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedure may only be done in the designated areas for procedural sedation within the Radiology Department, which are equipped and staffed, according to departmental and hospital policy.

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Materials necessary for procedural sedation and rescue include:

- a. Appropriate monitoring equipment.
- b. Emergency medications and equipment for care and resuscitation, including cardiac defibrillator must be immediately available. Medications include, but are not limited to reversal agents (naloxone and flumazenil) and vasoactive medications (phenylephrine and dopamine).
- c. Supplemental oxygen and positive pressure ventilation equipment.
- d. Suction equipment/supplies.
- e. Intravenous access.

Indications:

- a. Procedural sedation may be indicated for procedures in which a need for moderate sedation is anticipated to manage procedural discomfort, including but not limited to chest tubes, and tunneled central venous catheters.

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Precautions/Contraindications requiring attending physician consultation:

- a. Inability to obtain informed patient consent.
- b. Anticipated difficult intubation.
- c. The patient's American Society of Anesthesiologists (ASA) physical status; consultation with Anesthesia Service should be considered for patients who have an ASA **score class** of 3 or above. A procedure requiring sedation would not be done on a patient with an ASA **score class** above a three (3) without anesthesia assistance.
- d. When the patient's cardiovascular status will not permit positioning in a recumbent position.

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## B. DATA BASE

### 1. Subjective Data

- a. Obtain a history within 24 hours of the procedure and sedation.
- b. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
- c. Pertinent past medical history, surgical history, hospitalizations, habits, anesthetic, allergy and drug history.

### 2. Objective Data

- a. Physical exam within 24 hours of procedure and sedation. The exam is to include airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight), and IV access.
- b. Diagnostic data, as appropriate.
- c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.
- d. Laboratory and imaging results, as indicated, relevant to the history and physical exam.

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## C. DIAGNOSIS/ASSESSMENT

1. A judgment as to the appropriateness of the procedure and safety of sedation for the particular patient, that includes consideration of the patient's age, medical condition, and the procedure and sedation side effects and risks.
2. Assignment of an ASA physical status. Patients with a Physical ASA class of IV or V will not undergo conscious sedation by the Nurse Practitioner/Physician Assistant in the Radiology Department.
3. Assignment of the pre-procedure Modified Aldrete Score.
4. Evidence of verification of compliance with the NPO status (adult: minimum 8 hours (solids) and 2 hours (liquids) before procedure to decrease risk of aspiration).

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5. Assess and document the benefits of sedation against the risk of possible aspiration.
6. A responsible adult is available to take the patient home after the procedure.

#### D. PLAN

1. Therapeutic Treatment Plan shall follow SFGH policy number 19.8 titled "Procedural Sedation: Moderate and Deep"
  - a. Informed consent for the procedure and sedation must be obtained and documented by the nurse practitioner/physician assistant prior to the delivery of sedation. The consent form must list the procedure to be performed as well as the sedation planned.
  - b. Pre-Procedure patient education shall be given and documented, to include, but not be limited to:
    1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
    2. Risks, benefits, and alternatives.
    3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
    4. Date/time of procedure.
    5. Necessity of an escort for discharge to home and/or an appropriate mode of transportation home.
  - c. Re-assessment immediately prior to the procedure to include:
    1. Indication for procedure.
    2. Two patient identifiers.
    3. A "time out" documented.
    4. Vital signs (blood pressure, cardiac rhythm, heart rate, oxygen saturation, and end-tidal carbon dioxide).
    5. An assessment of level of movement and consciousness, and responsiveness.
  - d. The Procedure:
    1. Verify pre-procedure assessment and monitoring guidelines.
    2. Administer appropriate medications as indicated.
    3. Continuously assess the patient's response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, ETCO<sub>2</sub>, rhythm, and pain level). Vital signs will be documented no less frequently than every 5 minutes beginning with the first administration of sedation.
    4. Cardiac monitoring if patient has any cardiac history.
    5. Reversal agents, if indicated.

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- e. Post-procedure
  - 1. Monitor level of consciousness, respiratory and cardiovascular parameters, and pain level.
- f. Termination of Treatment
  - 1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.
- 2. Patient conditions requiring Attending Consultation
  - a. Physical ASA status 3 or above.
  - b. Aspiration.
  - c. Acute decompensation of patient situation.
  - d. Unexplained historical, physical or laboratory findings.
  - e. Upon request of patient, NP, PA, or physician.
  - f. Problem requiring hospital admission or potential hospital admission.
- 3. Education

Patient will be instructed on signs and symptoms of complications. A 24 hour emergency advice number will be given to the patient for any post-procedural problems. Examination findings/pathology results will be provided to the patient by the primary care provider, telephone, or during an appointment in the Interventional Radiology Department.
- 4. Follow-up
  - A. If the patient is transferred to the recovering unit:
    - 1. The patient must be accompanied by trained and/or licensed personnel.
    - 2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:
      - a. Pertinent medical history.
      - b. The procedure performed.
      - c. The condition of the patient; including pain score.
      - d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
      - e. Any significant clinical events occurring during and post-procedure.
      - f. Any additional orders relating to the post-procedural/moderate sedation care.
  - B. Any patient receiving a reversal agent (~~narcan~~ naloxone or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re- sedation. In

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addition an Unusual Occurrence Report must be completed. See Hospital Policy 19.08 for other criteria requiring the submission of an unusual occurrence report.

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C. The outpatient is discharged "to home":

1. By a specific discharge order from a physician or nurse practitioner/physician assistant; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.
2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
3. Outpatients who are discharged to home must be accompanied by a responsible adult and have an appropriate mode of transportation.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the Medical record and LCR as appropriate. The patient status and compliance with discharge criteria must be documented in the patient's medical record by the physician, nurse practitioner, physician assistant, or registered nurse discharging the patient. Document all findings in the computerized procedure database, usually the PACS system.

F. Summary of prerequisites, proctoring & reappointment of competency

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

1. Indications for procedures.
2. Risks and benefits of procedures.
3. Related anatomy and physiology.
4. Bowel preparation procedures.
5. Informed consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.

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B. Training Program	
1. Read and sign SFGH ZSFG Hospital Policy 19.08 “Procedural Sedation – Moderate and Deep”	Formatted: Font: 18 pt
2. Completion of the SFGH ZSFG Procedural Sedation module and Test with a passing score of 90%.	Formatted: Right
3. Completion of Advanced Cardiac Life Support (ACLS) training.	Formatted: Font: 18 pt
4. Completion of the Registered Nursing Moderate Sedation Education Module.	Commented [NM54]: ZSFG
5. Furnishing License and/or DEA number.	Commented [NM55]: ZSFG
Proctoring	
A. Direct observation by IR attending staff credentialed in moderate sedation for a minimum of 30 procedures with moderate sedation, while an experienced practitioner to moderate sedation requires a minimum of 10 successful observed demonstrations.	
B. Review of 30 procedure notes by interventional radiology attendings.	
Reappointment Competency:	
A. Ongoing competency will include the successful completion of 15 procedures every 2 years.	
B. Direct observation of one observed moderate sedation case will be conducted by the Medical Director or other designated attending physicians every 2 years.	
C. Maintenance of ACLS and BLS Certification.	
D. Passing of Procedural Sedation test with a passing score of 90%	

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## Procedure: Protocol #20: Lower Extremity Venous Sclerotherapy

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### A. DEFINITION

For purposes of this protocol sclerotherapy refers to lower extremity venous sclerotherapy. Sclerotherapy is a medical procedure to eliminate varicose veins and spider veins. Sclerotherapy involves an injection of solution directly into the vein. The sclerosing agent irritates the lining of the blood vessel, causing to collapse and the blood to clot.

- 1) Location to be performed: Interventional Radiology- Building 5 and Building 25
- 2) Performance of procedure:
  - i. Indications Symptomatic superficial venous insufficiency with symptoms including edema, pain, restless legs, and/or ulceration.
  - ii. Precautions the following list of conditions necessitate attending physician consultation:
    - a. Current phlebitis
    - b. History of, or current DVT.
  - iii. Contraindications
    - a. Pregnancy
    - b. Any allergy to the sclerosing agent

### B. DATA BASE

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

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Assessment of subjective and objective data to identify disease processes.

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#### D. PLAN

##### 1. Therapeutic Treatment Plan

- Patient consent is obtained before the procedure is performed and filled according to hospital policy.
- Time out is performed before the procedure per hospital policy.
- Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
- Referral to physician, specialty clinics, and supportive services, as needed.

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##### 2. Patient conditions requiring Attending Consultation

- Acute decompensation of patient situation.
- Unexplained historical, physical or laboratory findings
- Uncommon, unfamiliar, unstable, and complex patient conditions
- Upon request of patient, NP, PA, or physician
- Initiation or adjustment of medication other than those in the formularies.
- 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 paper or electronic 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.

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## Procedure: Protocol #21: Hip Aspiration and Injection

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### A. DEFINITION

Hip aspiration and injection is a medical procedure which involves placing a needle percutaneously into hip joint, followed by aspiration and/or injection of liquid agents.

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- 1) Location to be performed: Interventional Radiology- Building 5 and Building 25
- 2) Performance of procedure:
  - i. Indications: Analysis of hip fluid in evaluation of infectious and non-infectious arthritis. Treatment of hip pain or inflammation.
  - ii. Precautions the following list of conditions necessitate attending physician consultation:
    - a. Patients with abnormal blood clotting reflected by anticoagulant usage or laboratory values outside of interventional radiology standard consensus guidelines.
  - iii. Contraindications
    - a. Pregnancy
    - b. Any allergy to procedural medications.
    - b-c. Injections are contraindicated for severe dermatitis, soft tissue swelling suspicious for infection.

### B. DATA BASE

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

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C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent is obtained before the procedure and filed is obtained before procedure is performed and obtained filed out according to hospital policy.
- b. Time out is performed before procedure per hospital policy.
- c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
- 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. Initiation or adjustment of medication other than those in the formularies.
- f. Problem requiring hospital admission or potential hospital admission.
- g. Severe dermatitis, soft tissue swelling suspicious for infection (see also contraindications).

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 paper or electronic medical 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,

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problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

<p>Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care</p> <p><u>Prerequisite:</u></p> <ul style="list-style-type: none"><li>a. Specialty training will be provided by Interventional Radiology attendings as part of the orientation process.</li><li>b. Observe 1 hip aspiration and/or injection procedure with MD.</li></ul>
<p><u>Proctoring Period:</u></p> <ul style="list-style-type: none"><li>a. New practitioner to procedure, a minimum of 5-35 successful observed demonstrations.</li><li>b. Experienced practitioner to procedure, a minimum of 3-34 successful observed demonstrations.</li><li>c. Proctoring will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.</li><li>d. Chart review of all observed cases.</li></ul>
<p><u>Reappointment Competency Documentation:</u></p> <ul style="list-style-type: none"><li>a. Demonstration of 3-2 procedures every 2 years.</li><li>b. Minimum 3-2 chart reviews-review needed to monitor ongoing competency every 2 years.</li><li>c. Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.</li></ul>
<p>Any additional comments:</p>

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**Commented [JK70]:** This is language from Ortho & Surgery SP: Training in above procedure will occur on site if NP/PA does not have previous experience, defined as active privileges for this procedure at another institution within the past six months.

**Commented [NM71]:** aspiration and/or injection

**Commented [JK72]:** Additions to coincide with Ortho Service SP minimum P&R evaluations 3 and 1; FCM, MED, CPC, ED use 2 for new and 1 for experienced

**Commented [RSS73]:** Discussed with committee keeping 5, as IR procedure is done with fluoroscopy guidance which takes a little more experience.

**Commented [JK74]:** Service review: 2 procedures and 2 chart reviews every 2 years

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## Procedure: Protocol #22: Shoulder Aspiration and/or Injection

### A. DEFINITION

Shoulder aspiration and injection is a medical procedure which involves placing a needle percutaneously into shoulder joint, followed by aspiration and/or injection of liquid agents.

- 1) Location to be performed: Interventional Radiology- Building 5 and Building 25
- 2) Performance of procedure:
  - i. Indications: Analysis of shoulder fluid in evaluation of infectious and non-infectious arthritis. Treatment of shoulder pain or inflammation.
  - ii. Precautions the following list of conditions necessitate attending physician consultation:
    - a. Patients with abnormal blood clotting reflected by anticoagulant usage or laboratory values outside of interventional radiology standard consensus guidelines.
  - iii. Contraindications
    - a. Pregnancy
    - b. Any allergy to procedural medications.
    - b-c. Injections are contraindicated for sSevere dermatitis or soft tissue swelling suspicious for infection.

### B. DATA BASE

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

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Commented [JK75]: Add medical terminology throughout? Athrosclerosis and intra-articular injection

Commented [UR76]: This protocol was approved by CIDP committee with "Shoulder Aspiration and/or Injection" as title.

Commented [NM77]: and/or

Commented [UR78]: procedure may involve one or other or both.

Commented [JK79]: Would severe dermatitis or soft tissue infection overlying the joint or acute trauma be a contradiction?

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

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C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent is obtained before the procedure and filed is obtained before procedure is performed and obtained filled out according to hospital policy.
- b. Time out is performed before the procedure per hospital policy.
- c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
- d. Referral to physician, specialty clinics, and supportive services, as needed.

Commented [NM80]: is obtained before the procedure and filed

Commented [NM81]: is performed before the procedure

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.
- g. Severe dermatitis, soft tissue swelling suspicious for infection (see also contraindications).

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3. Education

Discharge information and instructions.

Commented [JK83]: Consider adding specifics related to procedure? Perhaps instructed in signs and symptoms of infection and procedures to follow if they occur and if there are any instructions on pain and/or many need more than one injection for best possible outcome?

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 paper or electronic medical 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

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

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F. Summary of Prerequisites, Proctoring and Reappointment Competency

<u>Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care</u> <u>Prerequisite:</u>	
a.	Specialty training will be provided by Interventional Radiology attendings as part of the orientation process if NP/PA does not have previous experience, defined as active privileges for this procedure at another institution within the past six months.
b.	Observe 1 shoulder aspiration and/or injection procedure with MD.
<u>Proctoring Period:</u>	
a.	New practitioner to procedure, a minimum of 5-53 successful observed demonstrations.
b.	Experienced practitioner to procedure, a minimum of 3-34 successful observed demonstrations.
c.	Proctoring will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.
d.	Chart review of all observed cases
<u>Reappointment Competency Documentation:</u>	
a.	Demonstration of 3-2 procedures every 2 years.
b.	Minimum 3-2 chart reviews every 2 years.
c.	Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.
<u>Any additional comments:</u>	

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Commented [JK86]: Align with Ortho and Surgery SP language

Commented [NM87]: aspiration and/or injection

Commented [JK88]: Standardize across services: Ortho Service SP minimum P&R evaluations 3 and 1; FCM, MED, CPC, ED use 2 for new and 1 for experienced

Commented [RSS89]: Discussed with committee keeping 5, as IR procedure is done with fluoroscopy guidance which takes a little more experience.

Commented [JK90]: Ortho has minimum of 1 for experienced and other services have 2 and 2

Commented [JK91]: aspiration and/or injection

Commented [JK92]: Goal standardization across Services 2 procedures and 2 chart reviews in other Services