



Committee on Interdisciplinary Practice

San Francisco General Hospital and Trauma Center

Trauma Recovery/Rape Treatment Center/Child and Adolescent Sexual Abuse Center

Standardized Procedures Nurse Practitioners & Physician Assistants

Title: Trauma Recovery/Rape Treatment Center/Child and Adolescent Sexual Abuse Center (TRC/RTC/CASARC)

I. Policy Statement

- A. It is the policy of 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, Physician Assistants, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.
- B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the CASARC Exam Room (6E2) Rape Treatment Center, CASARC and on file in the Medical Staff Office.

II. Functions To Be Performed

The following standardized procedures are formulated as process protocols to explain the overlapping functions performed by the NP/PA in their practice. Each practice area will vary in the functions that will be performed, such as primary care in a clinical setting or inpatient care on a unit-based hospital setting.

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse

Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

A Physician Assistant (PA) is a health care provider licensed to practice medicine with physician supervision and who has 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. Beginning in 2014, certified physician assistants will transition to a 10 year certification maintenance cycle and will sit for recertification examination every ten years. Graduation from an accredited Physician Assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Delegation of Services Agreement (documents supervising agreement between supervising physician and PA)

The NP/PA conducts physical exams, diagnoses and treats illnesses, 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 Emergency Department, RTC/CASARC Exam Room (6E2), PES or inpatient setting, outpatient clinic at the Trauma Recovery/Rape Treatment Center, CASARC and the **San Francisco Children's Advocacy Center**.
2. Role in each setting may include primary care, inpatient and outpatient care.

B. Supervision

1. Overall Accountability:

The NP/PA is responsible and accountable to:

- ❖ The CASARC Supervising Physician for the management of patients <18 years;
- ❖ The Rape Treatment Center Supervising Physician for the management of patients \geq 18 years.

2. Overall Supervision:

The NP/PA will be clinically supervised by:

- ❖ The CASARC Supervising Physician for the management of patients <18 years;
- ❖ The Rape Treatment Center Supervising Physician for the management of patients \geq 18 years.

The RTC Supervising physician will:

- a. Provide consultation and supervision to Rape Treatment Center (RTC) nurse practitioner/physician assistant on non-emergent issues by phone, in person or by other electronic means.
- b. ~~Provide proctoring for~~ Assess competency and skills of newly hired Nurse Practitioner and Physician Assistants assigned to the RTC. ~~This includes~~ by performing a chart review of 5 proctored cases to assess medical triage, evaluation and treatment, medications prescribed, labs ordered and documentation/charting required. These 5 cases may be proctored by practicing RTC/CASARC NPs, PAs or physicians.
- c. Perform peer review via chart review of 2 cases on an annual basis for NP's and PA's.
- d. Attend RTC NP/PA quarterly meetings.

If the RTC NP/PA sees an adult patient in the ED or PES because they have other trauma and need to be treated in those settings, the RTC NP/PA will use the ED/PES staff for any urgent consultation. In addition, if the RTC NP/PA needs a more urgent consultation due to any of the situations described in B.3 of the SPs, then the RTC NP/PA will seek consultation from the ED/PES staff (attending, residents, fellows). ~~as will likely be signing the patient out to those services.~~

The RTC NP/PA is responsible and accountable to the CASARC Supervising physician for the management of patients <18 years. The RTC NP/PA will be clinically supervised by the CASARC supervising physician for cases where the patient is <18 years. Specifically the CASARC physician will:

- a. Provide consultation and supervision to Rape Treatment Center (RTC) nurse practitioners and physician assistants on non-urgent issues on an as needed basis.
- b. A CASARC pediatrician is also available 24/7 by phone or in person for acute consultation.

3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
 - a. Acute decompensation of patient situation
 - b. Unexplained historical, physical, or laboratory findings.
 - c. Upon request of patient, nurse practitioner, physician assistant, or physician.
 - d. Initiation or change of medication other than those in the formulary (ies).
 - e. Problem requiring hospital admission or potential hospital admission.
 - f. Any circumstances the NP/PA deems beyond her or his capabilities.

IV. Scope of Practice

The RTC/CASARC NP/PA scope of practice includes the performance of these standardized procedures/practice protocols for all patients.

~~Protocol #1 Sexual Assault Evaluation~~

Protocol #2 Evaluation of Pregnancy Risk and Treatment Options

Protocol #3 Evaluation of Exposure to Sexually Transmitted Diseases and Treatment Options

Protocol #4 Furnishing and Dispensing Drugs and Devices

Protocol #5 Follow-Up Care and Management

Protocol #6 Health Care Management: Acute/Urgent Care

Protocol #7 Waived Testing

V. Requirements for the Nurse Practitioner /Physician Assistant

A. Basic Training and Education

1. Active California Nurse Practitioner/Physician Assistant license.
2. Successful completion of a program, which conforms to

Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.

3. Maintenance of Board Certification as a Nurse Practitioner or Advanced Practice Nurse or Board Certification as a Physician Assistant by the National Commission on the Certification of Physician Assistants (NCPA).

Note:

- Pediatric Nurse Practitioners may treat all patients up to age 21 years.
- Women's Health Nurse Practitioners and Adult Nurse Practitioners may treat patients age 13 years and above. When a RTC Women's Health Nurse Practitioner and/or Adult Nurse Practitioner is caring for CASARC patients 12 years and younger, a CASARC pediatrician will provide onsite consultation and supervision.
- Family Nurse Practitioners and Physician Assistants may treat patients of all ages.

4. Maintenance of certification of Basic Life Support (BLS) from an American Heart Association Provider.
5. Possession of a Medicare/Medical billable provider identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file at the Medical Staff Office.
7. Furnishing Number.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA).

B. Specialty Training

Specialty requirements Successful completion of a 30 hour didactic training program in the specialty area of Sexual Assault of Adults and a 28 hour didactic training program in the specialty area of Pediatric Forensic Sexual Assault by EITHER the California Clinical Forensic Medical Training Center (CCFMTTC), OR the TRC/RTC/CASARC equivalent, as approved by the Medical Director and Nurse Manager of TRC/RTC/CASARC within 18 months of hire.

C. Evaluation of NP/PA Competence in performance of standardized procedures

1. Initial: Initial training will be on site with current RTC/CASARC examiners. Training will consist of direct observation of history and physical examinations, treatment

plans and required documentation. At the conclusion of the initial training, the new NP/PA will have 5 cases proctored (onsite observation) by a current RTC/CASARC examiner. These 5 cases will then be reviewed in a chart review process performed by the RTC/CASARC supervising physician(s). The chart review process will be used to evaluate the NP/PA's ability to practice and will consist of the RTC/CASARC supervising physician(s) reviewing a total of 5 charts to assess medical triage, evaluation and treatment, medications prescribed, labs ordered and documentation/charting. The RTC supervising physician will review and evaluate the NP/PA's management of patients ≥ 18 years. The CASARC supervising physician will review and evaluate the NP/PA's management of patients < 18 years.

2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the ~~TRC~~/RTC/CASARC ~~Medical Director or~~ supervising physician(s) 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.
3. Biennial Reappointment: ~~TRC~~/RTC/CASARC ~~Medical Director or~~ supervising physician will evaluate the NP/PA's competence through an annual performance appraisal and appropriate competency validation for the setting by reviewing 4 charts every 2 years.
5. Ongoing:
 - a. Physician Assistants: 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 the 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 thirty (30) days of the date of treatment under protocols

which shall be adopted by the Supervising Physician and PA, pursuant to section 1399.545 9e0 (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 physician, adopted from or referenced to, text or other sources. Supervising Physicians shall select for review those cases by diagnosis, problem, treatment or procedures represent in his/her judgment, the most significant risk to the patient.

VI. Development and Approval of Standardized Procedure

A. Method of Development

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

B. Approval

The CIDP, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to its implementation.

C. Review Schedule

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

D. Revisions

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

PROTOCOL # 1: ~~SEXUAL ASSAULT EVALUATION~~

1. ~~Definition: This protocol describes the management of child, adolescent and adult victims of sexual assault.~~

2. ~~Background: The Office of Criminal Justice Planning (OCJP) has established a protocol for the examination and treatment of sexual assault and child sexual abuse victims, and the collection and preservation of evidence. The protocol contains recommended methods for meeting the standards for evidentiary examinations. It is recommended that every health care professional who conducts an examination for evidence of sexual assault on victims, follow the *California Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims*. Prior to collecting any information, proceeding with an evidentiary examination, and gathering data, a request for sexual assault evidentiary examination on a patient must occur by one of the following: Patient, member of law enforcement, patient's family with patient's consent, patient's friend with patient's consent or patient's legal guardian. Clinic examiners should NEVER perform intrusive medical procedures for the purpose of forensic evidence collection on ANY non-consenting patient, whether or not an officer, family member, friend, or legal guardian requests the examination. In the event an unconscious patient requires forensic evidence collection and is unable to consent a court order for the exam must be obtained by law enforcement before any forensic evidence collection.~~

3. ~~Data Base:~~

a. ~~Subjective Data~~

- ~~• May include: History obtained from patient, family, guardian, or law enforcement history and/or suspicion of sexual assault.~~
- ~~• Must include patient declination of examination.~~

b. ~~Objective~~

- ~~• Must include: History and physical examination performed by the Examiner during the sexual assault evidentiary examination.~~

3. ~~Diagnosis~~

• ~~Must include:~~

~~Documentation of physical findings, OR
Documentation of NO physical findings, AND
Exam consistent with history, OR,
Exam inconsistent with history, OR
_____ Interpretation pending consultation.~~

4. Treatment Plan

- a. Perform sexual assault evidentiary examination. Refer to *“California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims.”*
- b. Evaluate the possibility of pregnancy resulting from sexual assault/abuse: Refer to the standardized procedure, *“Evaluation of Pregnancy Risk & Treatment Options.”*
- c. Evaluate the risk of transmission of sexually transmitted diseases resulting from sexual assault/abuse: Refer to the standardized procedure, *“Evaluation of Risk of Sexually Transmitted Disease Exposure & Treatment Options.”*
- d. Evaluate the necessity of Tetanus vaccine: Assess type and extent of injury(s), date of last Tetanus vaccine and administer per SFGH policy.

Prior Tetanus Toxoid Doses	Clean, Minor Wounds	All Other Wounds
Unknown, or < 3	YES	YES
3 or more, last < 5 yrs. ago	NO	NO
3 or more, last 5-10 yr. ago	NO	YES
3 or more, last > 10 yr. ago	YES	YES

5. Client conditions requiring consultation:

Physician consultation as per Preamble Section III, B. 3.

6. Education

- a. Aftercare Instructions that include the following, when applicable:
 - Instructions for taking all medications provided (as per Standardized Procedures, *“Evaluation of Pregnancy Risk & Preventative Treatment Options,”* and *“Evaluation of Risk of Sexually Transmitted Disease Exposure & Preventative Treatment Options”*).
 - Instructions for home care, including symptoms to watch for if injuries have been sustained, including common psychological and physical sequelae following sexual assault.
 - Recommendations for follow-up for any physical injuries, testing for pregnancy, and sexually transmitted diseases and/or other conditions if indicated. Refer to the Standardized Procedure, *“Follow-up Care and Management,”* for indications and

~~recommended schedule for follow-up care. Give referral names, addresses and telephone numbers where appropriate (See resource manual).~~

- ~~• Information regarding post-exam counseling at the TRC/RTC/CASARC, or other appropriate resources.~~

~~7. Follow-up:~~

~~Refer to the Standardized Procedure, "Follow Up Care & Management," for indications, recommendations and scheduling of follow-up appointments and examinations.~~

~~8. Record keeping:~~

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

~~PROTOCOL #2—Intimate Partner Violence Evaluation~~

- ~~1.—Definition: This protocol describes the screening & management of adult victims of intimate partner violence in the SFGH Emergency Department (ED), patients who have experienced violence by an intimate partner. This may include assisting with forensic photography, assisting with documentation, connecting clients to follow-up services at TRC/RTC, and answering questions concerning mandated reporting. This consultative service may be available only if the NP/PA is not currently working with a sexual assault client.~~
- ~~2.—Background: Intimate partner violence (IPV) is defined as a pattern of coercive and assaultive behaviors including physical, psychological, and sexual attacks used against an intimate partner as a means of intimidation and victimization. IPV is a problem of epidemic proportions with long lasting health implications. It is pervasive in multiple cultural, social, and economic communities, within married and unmarried relationships, and among gay, lesbian, and transgender communities. Patients often access the health care system for injuries and illnesses resulting from the physical and psychological trauma. In the absence of assessment and intervention, the violence may escalate in frequency and severity, often resulting in repeat visits within the healthcare system.~~

~~1.—Data Base:~~

~~a.—Subjective data:~~

~~May include: Disclosure by the patient (spontaneously or by use of the *Interpersonal Violence Screening/Assessment* tool) of ANY of the following within the past year:~~

- ~~● Being hit, punched, slapped, or kicked by a current or former intimate partner;~~
- ~~● Being threatened or intimidated by a current or former intimate partner;~~
- ~~● Being forced to perform any sexual acts against their will by a current or former intimate partner;~~
- ~~● Presenting to the ED as a result of injuries caused by a current or former intimate partner;~~
- ~~● Presenting to the ED because of illness or stress related to violent behavior, threats or fears from a current or former intimate partner.~~

~~b.—Objective data:~~

~~May include: Observation or assessment of ANY of the following presenting or historical components suggesting risk of IPV, in absence of~~

patient disclosure:

- ~~Traumatic, unexplained, multiple, old, or questionable injuries~~
- ~~Suicide attempt or ideation~~
- ~~Overdose~~
- ~~Pregnancy and/or problems or injuries during pregnancy~~
- ~~Vague, non-specific complaints~~
- ~~Physical symptoms related to stress~~
- ~~History inconsistent with injury~~
- ~~Delay in seeking medical care~~
- ~~Repeated visits to the ED~~
- ~~Reluctance to speak/evasiveness in front of partner~~
- ~~Overly protective and/or controlling partner~~
- ~~Exhibiting socially isolated lifestyle and/or internal blaming mechanisms~~

2. ~~Diagnosis:~~

~~Per client history of DV.~~

3. ~~Treatment Plan:~~

~~PLAN~~

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

4. ~~Follow-up:~~

~~Refer to the Standardized Procedure, "Follow Up Care & Management," for indications, recommendations and scheduling of follow-up appointments and examinations.~~

5. ~~Record Keeping:~~

~~As per Protocol #1 Section 9, Record Keeping~~

PROTOCOL # 2: Evaluation of Pregnancy Risk and Treatment Options

- A. Definition: This protocol describes the process for assessing the risk of pregnancy from sexual assault for female victims.

Background: The *California Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims* includes an assessment of the risk of pregnancy resulting from sexual assault for female victims. This assessment includes performance of a baseline pregnancy test, and discussing treatment options with clients. Options may include the use of emergency postcoital contraception. The probability of conception from a single, random unprotected act of intercourse depends on several factors, including the time in a woman's menstrual cycle the act occurs, the use of contraceptives, regularity of menstrual cycle, fertility of the patient, the fertility of the assailant, and whether or not the assailant ejaculated in or near the vagina.

B. Data Base

1. Subjective Data:
 - Includes Menstrual and Contraceptive history: LMP, LNMP; length of the patient's normal menstrual cycle; current or recent use of contraception by the patient.
 - Includes relevant Assault history/sexual assault that occurred within the past 72 hours; history or suspicion of sexual assault that included intravaginal ejaculation; history or suspicion of sexual assault that included ejaculation on the external genitalia.
2. Objective Data:
 - Result of baseline pregnancy test (sensitive urine or serum).

C. Diagnosis

1. Should include:
Determination of patient's risk of pregnant resulting from sexual assault.

D. Plan

1. Treatment
 - a. Discuss the probability of pregnancy, given the specific risk factors for the patient.
 - b. Discuss all medically appropriate options, including immediate and non-immediate treatments.
 - c. Administer post-coital emergency contraception as appropriate per formulary.
 - d. Offer preventative medication for nausea per formulary.

2. Client conditions requiring consultation:
Physician consultation per general policy.
 3. Education
 - a. If the patient chooses an option other than emergency contraception, provide appropriate referrals.
 - b. If the patient chooses to take emergency contraception, discuss mechanism of action, efficacy, instructions for use, common side effects, danger/warning signs and possible complications.
 - c. Inform patient that if she vomits within 2 hours of dose, she should repeat the dose. If she vomits more than 2 hours after taking dose, she does not need to repeat any doses.
 - d. Menstrual changes may occur as a result of taking emergency contraception. Patients' menses may come earlier than expected. If menses do not resume by 21 days after taking any of the approved regimens, the patient should have a sensitive pregnancy test performed.
 4. Follow-up
Refer to the Standardized Procedure, "*Follow Up Care & Management*," for indications, recommendations and scheduling of follow-up appointments and examinations.
- E. Record Keeping
All information from patient visits will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes). Documentation must include results of sensitive urine or serum urine pregnancy test. 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

Prerequisites:

Initial training will be on site with current RTC/CASARC examiners. Training will consist of direct observation of history and physical examination and required

documentation.

Initial Proctoring:

5 cases will be proctored (onsite observation) by a current RTC/CASARC examiner plus a chart review will be performed by the RTC/CASARC supervising physician(s) to assess medical triage, evaluation and treatment, medications prescribed, labs ordered and documentation.

Reappointment Competency:

4 charts will be reviewed by the RTC/CASARC supervising physician(s) to assess medical triage, evaluation and treatment, medications prescribed, labs ordered and documentation every 2 years.

PROTOCOL # 3: Evaluation of Exposure to Sexually Transmitted Diseases and Treatment Options

- A. Definition: This protocol describes the process for assessing the risk of exposure to sexually transmitted diseases from sexual assault and the various treatment options.

Background: The *California Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims* recommends evaluating the possibility of exposure to sexually transmitted diseases and offering prophylactic treatment options against those diseases. The probability of contracting a sexually transmitted disease from a sexual assault depends on various factors. These factors include penetration of body orifices of the sexual assault patient, number of assailants, and whether the assailant(s) are symptomatic or known to be infected. According to the Center for Disease Control and Prevention (1998), Gonorrhea, chlamydia, trichomoniasis, and bacterial vaginosis (BV), are the most frequently diagnosed infections among women who have been sexually assaulted. Additionally, *the 1998 Guidelines for Treatment of Sexually Transmitted Diseases* {January 23, 1998 / 47(RR-1); 1-118} recommends an initial evaluation for STD's at the time of the initial examination and at a follow-up exam 2 weeks later, as well as providing prophylaxis following a sexual assault.

B. Data Base:

1. Subjective Data:
 - May include history or suspicion of receptive and/or insertive anal or vaginal intercourse during assault, receptive oral contact with ejaculation, HIV or STD positive assailant(s), "high risk" assailant(s), including history of IVDU, sex industry workers, or men who have sex with men; multiple assailants, and/or, uncertain history for the previous factors, and patient desires assessment of exposure to and prophylaxis for sexually transmitted diseases.
2. Objective Data:
 - Should include assessment and documentation of patient's allergy status AND known pregnancy status of patient, if applicable.

C. Diagnosis:

- Should include assessment of patient's risk for exposure to STD's and patient's desire to receive testing and prophylaxis for such diseases.

D. Plan:

1. Treatment

a. Testing:

Indications for testing may include any of the following:

- The suspected offender is known to have a STD, be at high risk for having an STD, has a history of STD's, and/or has signs or symptoms of a STD.
- The victim has signs or symptoms of a STD.
- Patient request.

Standards for testing and collection of specimens:

- If collecting specimens for SCREENING and/or DIAGNOSTIC purposes, a first stream urine specimen may be utilized for LCR testing in lieu of a cervical culture for *N. gonorrhoea* and/or *C. trachomatis*.
- Obtain wet mount preparations of vaginal secretions for assessment of the presence of clue cells and trichomonads when clinically indicated.
- Inspect the genital, perianal and oral areas for genital warts, and ulcerative lesions. If lesions are present, obtain HSV cultures or other specimens as indicated.
- Collect a serum sample to be evaluated immediately and used as a baseline for comparison with follow-up serological tests. Serum ~~should~~ **may** be tested for *T. pallidum* (RPR), and HIV (Antibody), ~~Hepatitis B (HepB sAb), and Hepatitis C (titer),~~ when clinically indicated.

b. Prophylaxis for chlamydia, gonorrhea, incubating syphilis, BV, and trichomoniasis:

Per formulary

c. Hepatitis B:

Post exposure Hepatitis B vaccine (without HBIG) should adequately protect against chronic Hepatitis B infection. Client is questioned about known prior Hepatitis B vaccination. If previously vaccinated no Hepatitis B vaccine is offered. If client is unsure of prior Hepatitis B vaccination or acknowledges no previous vaccination against Hepatitis B, Hepatitis B initial vaccination is offered (serology baseline not necessary) using the following guidelines:

11-19 years	5 mcg Recombivax; OR 10 mcg Energix B
> 20 Years	10 mcg Recombivax;OR 20 mcg Energix B

- d. HIV Post-Exposure Prophylaxis (PEP):
Assess the risk of exposure to HIV using the following guidelines:

Client gives a history or suspicion of:

- Receptive or insertive anal or vaginal penetration (broken or no condom use).
- Receptive oral penetration with ejaculation.
- Known HIV positive assailant(s).
- Assailant(s) in “high risk” category for HIV, including history of IVDU, sex industry worker, or men who have sex with men.

1. Client desires PEP (with or without HIV Baseline testing :)

- HIV pre-test counseling
- Informed consent and specimen collection for HIV antibody test.
- PEP: Clinical indications, benefits, risks, common side-effects.
- PEP: Dispense per formulary.
- For all other clinical situations outside these protocols related to HIV PEP, contact medical consultant for HIV.

2. Client desires HIV test, no PEP:

- HIV pre-test counseling
- Informed consent and specimen collection for HIV antibody test.

3. Client DOES NOT want HIV testing OR PEP:

Provide referral information, via the ED Referral Center, about Community Health Network (CHN) sites and/or other community sites where HIV testing is performed. See Education section below for recommended counseling about follow-up HIV testing in absence of PEP.

2. Client conditions requiring consultation

- As per general policy

3. Education

HIV and PEP printed information and materials

4. Follow-up

Refer to the Standardized Procedure, “*Follow Up Care & Management*,” for indications, recommendations and scheduling of follow-up appointments and examinations.

E. Record Keeping:

- Documentation of allergy status of client.
- Results of sensitive urine or serum pregnancy test.
- Types and sites of collection of STD baseline tests submitted to the hospital laboratory.
- Any declination of prophylaxis regimens offered to client.
- Physician consultation related to treatment regimens.

- All information from patient visits will be recorded in the medical record(e.g.: admission notes, progress notes and procedure notes. For physician assistants, using protocols for supervision, the supervising physician shall review , countersign and date a minimum 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

<p>Prerequisites: Initial training will be on site with current RTC/CASARC examiners. Training will consist of direct observation of history and physical examination, and required documentation.</p>
<p>Initial Proctoring: 5 cases will be proctored (onsite observation) by a current RTC/CASARC examiner plus a chart review will be performed by the RTC/CASARC supervising physician(s) to assess medical triage, evaluation and treatment, medications prescribed, labs ordered and documentation.</p>
<p>Reappointment Competency: 4 charts will be reviewed by the RTC/CASARC supervising physician(s) to assess medical triage, evaluation and treatment, medications prescribed, labs ordered and documentation every 2 years.</p>

Protocol #4: Furnishing and Dispensing Drugs and Devices

A. DEFINITION

“Furnishing “of drugs and devices by Nurse Practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A “drug order” is a medication order issued and signed by a Physician Assistant. Physician Assistants may issue drug orders for controlled substances Schedule II -V with possession of a DEA number and prior approval by supervising physician for a particular patient. Nurse Practitioners may order Schedule II - V controlled substances when in possession of a DEA number. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies (e.g.: San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, Medi-Cal and AIDS Drug Assistance Program). This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

1. Subjective Data

- a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
- b. Pain history to include onset, location, and intensity.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Describe physical findings that support use for CSII-III medications.
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

- C. **DIAGNOSIS**
Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.
- D. **PLAN**
1. Treatment
 - a. Initiate, adjust, discontinue, and/or renew drugs and devices.
 - b. Schedule II - V controlled substances may be ordered 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:
 - i. location of practice
 - ii. diagnoses, illnesses, or conditions for which medication is ordered
 - iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
 - c. To facilitate patient receiving medications from a pharmacist provide the following:
 - i. name of medication
 - ii. strength
 - iii. directions for use
 - iv. name of patient
 - v. name of prescriber and title
 - vi. date of issue
 - vii. quantity to be dispensed
 - viii. license no., furnishing no., and DEA no. if applicable
 2. Patient conditions requiring Consultation
 - a. Problem which is not resolved after reasonable trial of therapies.
 - b. Initiation or change of medication other than those in the formulary.
 - c. Unexplained historical, physical or laboratory findings.
 - d. Upon request of patient, NP, PA, or physician.
 - e. 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. When a Physician Assistant writes a drug order for a schedule II medication, the supervising physician must sign and date the chart containing such a drug order within seven (7) days.

Protocol # 5: Follow Up Care and Management

- A. Definition: This protocol will describe the policies and procedures related to ~~medical and psychological and/or forensic~~ follow up of child, adolescent and adult victims of sexual assault and intimate partner violence.

Introduction: Evaluation in the acute aftermath of a violent event may not reveal a client's entire symptomatology, or the extent of their injuries at the time of the initial examination. Visible injuries, areas of potential injury, and psychological sequelae may not be fully developed until 1-10 days after a traumatic event. Additionally, follow-up of laboratory tests performed at the initial examination, as well as assessment of therapeutic regimens should be performed during a follow-up examination, and can be a mechanism to promote follow-up psychological care.

B. Data Base:

1. Medical Indications for follow-up by a TRC/RTC/CASARC Nurse Practitioner or Physician Assistant (NP/PA) may include:
 - Evaluation of trauma or minor injuries needing medical attention.
 - Review of pertinent laboratory test results with patient, family, and/or significant other.
 - Follow-up testing for sexually transmitted diseases, if indicated.
 - Follow-up inquiry about patient's, patient's family and/or significant other's desire for counseling and/or other psychological services.
 - Hepatitis B Vaccine #2, #3 ~~and/or Syphilis serology.~~
 - ~~Repeat HIV antibody testing.~~
2. ~~Forensic Indications for follow-up by RTC/CASARC NP/PA:~~
 - ~~Re-examination and documentation of the development of visible findings, such as genital injuries, bruises, bite marks.~~
 - ~~Re-examination and documentation of areas of potential injury, such as areas of tenderness, or early bruising at the initial exam.~~
 - ~~Documentation of the resolution of findings and/or healing of injuries.~~
3. ALL eligible patients will be offered psychological follow-up and the RTC/CASARC NP/PA will facilitate a referral to TRC/RTC/CASARC mental health staff. Additionally, any patient who verbalizes a need, interest or desire for follow-up should be offered an acute follow-up visit. High risk criteria include:
 - Suicidality/homicidality/history of violent behavior.
 - Substance use/abuse.
 - Previous traumatic event in lifetime.
 - Acute Stress Disorder symptoms, currently (See below, under Education)

- Minimal or absent support system or resources: Housing, food, shelter.

C. Diagnosis:

Follow-up of client indicated based on medical, forensic, and/or psychological indicators.

D. Plan:

1. Treatment

- a. Determine the type(s) of follow-up indicated for the patient.
- b. Discuss the type and extent of any physical injuries sustained and the expected time frame for healing of injuries, if applicable.
- c. Discuss the necessity to document evolution, resolution and/or progression of physical injuries.
- d. Discuss the possibility of specific reactions to the assault (See below, under Education).

2. Client conditions requiring consultation:

- Acute suicidal/homicidal ideation, plan and risk.
- Acute inability to provide for basic needs.
- Severely traumatized patient.

3. Education:

May include any of the following issues related to Traumatic Stress Responses:

- Address the nature of the traumatic event: May involve threat and/or fear of death, possible serious injury, threat to physical integrity, or safety of significant other.
- Immediate reactions may include dissociative symptoms such as: numbness, detachment, depersonalization, derealization, reduced awareness of surroundings, flat affect, dissociative amnesia, and/or outward calmness; Preoccupation with the assault and persistent re-experiencing of the trauma, such as flashbacks, intrusive thoughts, and images associated with specifics of the assault, and/or distress or avoidance upon exposure to reminders of the assault; and symptoms of anxiety such as irritability, problems concentrating, exaggerated startle response, and/or hyper vigilance.
- Reactions that may have onset 1-3 days after the event may include: disruption to personal, social, occupational, and other areas of functioning; shock and disbelief; hysterical reactions; confusion and non-sequential recollection of events; fears about personal safety; concerns about consequences of disclosing the assault to law enforcement and/or the reactions of others.
- Longer-term reactions may involve persistent re-experiencing of the trauma, persistent avoidance of people, situations or stimuli associated with the trauma, reduced responsiveness and/or

numbing, diminished interest or participation in significant activities, inability to recall an important aspect of the trauma, feeling detached or estranged from others, restricted range of affect, and/or sense of a foreshortened future; Persistent symptoms of anxiety or increased arousal, such as sleep disturbances, irritability, mood swings, difficulty with concentration, hyper vigilance, and an exaggerated startle response.

- Other additional symptoms that may occur include: Depression, self-blame, guilt, shame, humiliation, loss of personal dignity, anger, sexual dysfunction, somatic symptoms such as headaches, GI distress, pelvic pain, loss of self confidence, devaluation with regard to personal identity and self-esteem, alteration in world view and assumptions.

4. Follow-up:

a. Medical follow-up:

- Within (10) days after initial exam for review of pertinent laboratory results, follow-up examination, **evaluation of possible medication side effects and ~~which may include re-testing for STD's and/or pregnancy, and/or~~ dispensing of remainder of HIV PEP, if clinically appropriate.**
- 1-2 months after initial exam for Hepatitis B Vaccine #2 **and repeat HIV testing when appropriate.**
- 4-6 months after initial exam for Hepatitis B Vaccine #3 **and repeat HIV testing when appropriate.**
- ~~1 year for repeat HIV testing when appropriate.~~

~~b. Forensic follow-up:~~

- ~~1-10 days after initial exam for re-examination and documentation of the development of visible physical findings, AND/OR to document areas of potential injury, AND/OR to document resolution of physical findings and healing of injuries when appropriate~~

c. Psychological follow-up (NP/PA will refer this follow-up to TRC/CASARC mental health staff):

- Within 10 days, at 1st medical follow-up visit to assess eligibility, symptomology and desire for psychological services.

5. Record Keeping:

Should include patient Aftercare Instructions and Education provided regarding follow-up care and management. 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 percent of medical records of patients treated. The physician shall select for review cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

Protocol #6: Health Care Management : Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions. (ED, PES, Inpatient units, TRC/RTC/CASARC outpatient)

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Therapeutic Treatment Plan

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

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation
- b. Problem that is not resolved after reasonable trial of therapies
- c. Unexplained historical, physical or laboratory findings
- d. Uncommon, unfamiliar, unstable, and complex patient conditions
- e. Upon request of patient, NP, PA, or physician
- f. Initiation or change of medication other than those in the

formularies.

- g. Problem requiring hospital admission or potential hospital admission.
- h. When ordering complex imaging studies or procedures.

3. Education

Patient education including treatment modalities.
Discharge information and instructions.

4. Follow-up

As indicated and appropriate to patient health status, and diagnosis.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record, admission notes, progress notes and procedure notes. For physician assistants, a minimum of five (5) per cent of the patient chart entries will be reviewed, signed and dated by the supervising physician within thirty (30) days of the patient encounter.

Procedure # 7: Waived Testing

A. DEFINITION

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

1. Location where waived testing is to be performed: Emergency Department, 6E2 examination room, RTC, CASARC or other site patient may be located.
2. The following non-instrument based waived tests are currently performed by RTC/CASARC:
 - a. SP® Brand Urine Pregnancy
Indication: Assist with the diagnosis of pregnancy.

B. DATA BASE

1. Subjective Data
Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed
2. Objective Data
Each waived test is performed in accordance with approved SFGH policies and procedures specific for each test as well as site-specific protocols and instructions for:
 - a. Indications for testing
 - b. Documentation of test results in the medical record or LCR
 - c. Actions to be taken (follow-up or confirmatory testing, Attending consultation, referrals) based on defined test results.
 - d. Documentation or logging of tests performed

C. DIAGNOSIS

Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.

D. PLAN

1. Testing
 - a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
 - b. Use gloves and other personal protective equipment, as appropriate.

- c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.

Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.

- d. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?
- 2. Test Results requiring Attending Consultation
 - a. Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.
 - 3. Education
 - a. Inform patient of test results and need of additional tests, as necessary
 - 4. Follow-up
 - a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics, Psychiatry Forensics-RTC.
Proctoring: Successful completion of Healthstream quizzes for each of the waived

tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module.

Reappointment Competency Documentation:

Renewal required every two years with documentation of successful completion of the required Healthstream quizzes. Provider must have passed each required module with a score of 80%.

Any additional comments: N/A