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Owner:	*Shelley Goldstein: Mgr Unit*
Policy Area:	*Patient Care Services*
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Assessment Standards: Outpatient Procedures, 699.47.00

Document Type: Policy, Procedure

SUPERSEDES: 3/13, 3/07, 06/06, 9/05

POLICY:

All patients will be assessed by a Registered Nurse for their admission to Outpatient Procedures.

PROCEDURE:

Admission of GI Endoscopy/Bronchoscopy and Pain Management Procedures

The admission process will include a pre-procedure evaluation with documentation which includes:

1. Admission date/time with reason for admission and type of procedure to be performed.
2. Patient/procedure verification:
    - Identify the correct patient by confirming the name and birth date as stated by the patient and compared to the patient's identification band.
    - Check the medical record documentation and compare information with the consent form and as applicable to the following: H & P/Physician's Orders/Procedure schedule
    - Verbally identify with the patient the correct procedure, site and side. If the patient is a minor or not capable of confirming the information, a parent or legal guardian is permitted to confirm this information.
    - Ensure that patient has the correct patient identification band; allergy and blood bank band as applicable.
3. Pre-Operative Checklist:
    - Patient Identification
    - Fasting Status
    - Conditions of Admission/Operative Consent
    - History & Physical
    - Laboratory tests, EKG, CXR as applicable

- Removal of clothing, jewelry, hairpins, glasses, dentures
- Documentation of person who received the items/location of items
- Location of loose teeth i.e., upper/lower
- Presence of hearing aid
- Presence of patient identification band; allergy band and blood bank if applicable
- Pre-procedure medication
- Pre-procedure teaching
- Void prior to procedure

4. Medication/Food Allergies
5. Medication History: Includes prescription, over the counter and herbal medications.
6. Safe Transport Home: For outpatient procedures, confirm the availability of safe transport home with accompanying responsible adult.
7. Discharge Planning: Contact Social Services for concerns with discharge planning.
8. Admit History:
   - The admit history will be completed in the electronic medical record.
   - Smoking Cessation: Assess and document intervention in medical record.
   - Bloodless Medicine: Document assessment/intervention in medical record.
   - Personal Safety addressed with documentation of intervention in medical record.
   - Confirm Advanced Directive.
9. Physical Assessment

   The initial assessment of the patient must be completed before the patient is transported to the procedure room or to the department where the procedure is being performed. Documentation of this assessment will be completed within 2 hours of admission. The physical assessment will include but is not limited to:

Vital Signs:	Blood pressure, pulse, respiratory rate, temperature, oxygen saturation, Pain rating to include, description and location of pain. Height/Weight
Neurological:	Assess for orientation/level of consciousness; motor movement, sensation. Check reaction of pupils, movement and strength of all extremities Glascow coma scale as indicated (for neurological surgery patients)
Cardiovascular:	Auscultation of heart sounds rate and regularity. Palpation of radial, posterior tibial and dorsalis pedis pulses as applicable Assess for presence of edema, chest pain, dizziness Capillary refill
Respiratory:	Color of skin, lips, nail bed. Lung sounds, respiratory rate, depth, rhythm and effort.
Gastrointestinal:	Assessment of abdomen, bowel sounds Presence of nausea/vomiting
Renal Urinary:	Deferred unless able to assess during admission process. Color and clarity of urine. Presence of odor.

Musculoskeletal:	Assess ambulation and movement of all extremities Assess color, motion, sensitivity of extremities
Skin:	Assess for general integrity of skin, color, temperature, bruises, rash. Assess condition of incisions, if applicable.
EENT:	Assess for redness, drainage or pain in eyes, ears, nose or throat.
Psychosocial:	Observed behavior. Patient interaction with family/staff.

ADDITIONAL ASSESSMENTS/INTERVENTIONS:

- Confirm pre-procedure physician orders for medications and treatments.
- Perform Fall/Skin Risk assessment.
- Initiate care plan.
- Provide patient education for the procedure with identification of learner's goals, obstacles to learning, willingness to learn and learning methods.
- Intravenous Therapy: Document size, type, location of intravenous placement and rate of infusion.
- Pre-Sedation Assessment: This assessment will be performed by the monitor nurse prior to the procedure. This includes:
- Previous reaction to sedatives/anesthetic agents
- Level of consciousness/emotional status

INTRA-PROCEDURE DOCUMENTATION:

- Intra-procedure documentation will include but not limited to:
- Type of procedure
- Endoscope identification
- Personnel present
- Monitoring devices
- Oxygen flow rate and type of delivery system/capnography
- Medications
- Time out
- Start and end time of procedure
- Insertion and removal time of endoscope
- Instrumentation
- Location of specimens obtained
- Untoward reactions
- Location of recovery

Monitoring of the patient receiving sedation analgesia will include the following data with documentation every 5 minutes: blood pressure, pulse rate, respirations, pulse oximetry/ cardiac monitoring. Capnography monitoring as indicated.

Level of consciousness monitoring will be continually assessed with documentation every 15 minutes or with any changes in the assessed level of consciousness.

PHASE II INITIAL ASSESSMENT:

The initial post-procedure assessment and documentation for patients will include, but are not limited to:

- Time of arrival and from what location

- Mode of transport
- Level of consciousness
- Condition and color of skin (integumentary assessment)
- Condition of surgical site dressings/drains, as applicable
- Assessment of post-procedure pain and interventions utilizing the 0-10 pain scale
- Vital signs including blood pressure, pulse, respiratory rate, temperature, pulse oximetry
- Location and condition of intravenous lines
- Presence of nausea/vomiting
- Auscultation of lung sounds as applicable
- Evaluation of patient by discharge criteria to include:
  Respirations
  Blood pressure
  Level of consciousness
  Movement
  Oxygen concentration
  Nausea and vomiting/ability to swallow
  Pain
  Procedure site

Vital signs will be monitored and documented every 15 minutes x 4, every 30 minutes x 2 and every 1 hour x 2 and at discharge. The discharge criteria evaluation will be completed and documented with each vital sign until discharge criteria score is met and with change of patient condition.

(Reference unit specific policies for requirements for vital sign monitoring for special procedures.)

DISCHARGE:

1. Patients may be discharged to home when the final discharge criteria assessment is 12 or greater. This includes:
   - Vital signs stable and consistent with the patient's age and pre-procedure status
   - Temperature 96.8
   - No signs of respiratory distress
   - Alert and oriented or returned to pre-procedural condition
   - Minimal nausea/vomiting
   - Minimal dizziness
   - Able to ambulate, consistent with pre-procedure ability and/or limitations as a result of surgical/ invasive procedure
   - Able to swallow, consistent with pre-procedure ability
   - Adequate pain control (general guidelines: level 5 or less)
   - No excessive bleeding from surgical site as applicable
2. Written discharge instructions will be given to the patient and the accompanying responsible adult with verbalization of understanding. A copy of these instructions will be included in the medical record.
3. Provide additional resource for the patient to contact should post-procedure problems arise.
4. Verify arrangements for safe transport home and responsible caregiver available for the day. Refer to

Policy 21.58/22.07

5. Document intake and output.
6. Document discontinuation of intravenous access and condition of site.
7. Document vital signs including T, BP, P, R, oxygen saturation and discharge criteria assessment.

PROCEDURE:

Admission of Infusion Therapy/Minor Nursing and Drug Pump Procedures

The initial admission process with documentation will include:

1. Admission date/time with reason for admission and type of procedure to be performed.
2. Patient/procedure verification:
    - Identify the correct patient by confirming the name and date of birth as stated by the patient and compared to the patient's identification band.
    - Verbally identify with the patient the correct procedure/therapy as compared to the physician orders.
3. Document changes in health, falls risk assessment, patient safety concerns/suicide risk and medication/ food allergies
4. Medication List: Including prescription, over the counter and herbal medications.
5. Vital Signs: Blood pressure, pulse, respiratory rate, temperature, oxygen saturation(Vital signs for minor nursing procedures done dependent on patient condition,) Pain rating to include description and location of pain. Height/Weight

Additional Assessments/Interventions:

1. Provide patient education for the procedure with identification of learner's goals, obstacles to learning, willingness to learn and learning methods.
2. Document size, type, location of intravenous placement and rate of infusion.
3. If central vascular access device present, document location, intervention and condition of site.
4. Patients will be provided education/discharge instructions upon completion of initial infusion.

Subsequent admissions during the month for the prescribed therapy:

1. Admission date/time with reason for admission and type of procedure to be performed.
2. Patient/procedure verification:
    - Identify the correct patient by confirming the name and date of birth as stated by the patient and compared to the patient's identification band.
    - Verbally identify with the patient the correct procedure/therapy as compared to the physician orders
3. Documentation of changes in health, modified falls risk assessment, patient safety concerns, suicide risk, vital signs, weight (as applicable) and pain
4. Intravenous therapy: Document type, size, location of intravenous access and rate of infusion If central vascular access device present, document location, interventions and condition of site.
5. Documentation of medication given or treatment performed.

Attachments

No Attachments

Approval Signatures

Approver	Date
Kirk Harper: VP, Nursing & CNO	03/2019
Heather Shipman: Executive Assistant	03/2019

Applicability

WA - Kadlec Regional Medical Center