ENDOSCOPY PATIENT

OBJECTIVES

To provide baseline data regarding patient's condition prior to endoscopic procedure.
To maintain patient safety during endoscopic procedures.
To identify changes occurring to patient intra and post procedure.
To promote patient/significant other understanding of pre-procedure preparations, the procedure to be done and discharge instructions post-procedure.
To reduce anxiety and provide emotional support.

PROCESS STANDARDS

1. The patient's growth and development needs will be considered in planning/implementing nursing care.
2. All patients requiring home care preparation prior to an endoscopic procedure (including EGD, Colonoscopy, Esophageal dilatation, PEG placement, Sclerotherapy) will receive written instructions prior to scheduled procedure.
3. All patients undergoing an endoscopic procedure with conscious sedation will have a nursing assessment performed (including BP, P,R, T and O2 saturation) and documented according to the Pre & Post Endoscopy Nursing protocol in the Electronic Health Record (EHR). Vital signs and weight are obtained on all flexible sigmoidoscopy proctoscopy and clinic visit patients. This information is recorded in the EHR.
4. All patients's valuables will be given to the person accompanying the patient.
5. All patients undergoing endoscopic procedures, except proctoscopies, will be given a gown to wear during the procedure. Patients receiving any endoscopic procedures will be covered with a sheet.
6. All routine proctoscopy or flexible sigmoidoscopy patients will receive adequate preparation including flex enemas prior to their exam.
7. All patients' IV push medication will be administered according to:
   Hospital Policy 5.26, Management of Patients Receiving Conscious Sedation
   Patient Care Services Nursing, Policy I-40-1, IV Push Medications Administering
8. Prior to the patient undergoing any endoscopy procedure including proctoscopes, the physician will explain the procedure and the risk involved as indicated by the signed consent. The nurse will provide reinforcement information as needed.
9. All patients receiving conscious sedation will be monitored via vital signs monitor with pulse oximeter.
10. All patients shall remain in the clinic 30 minutes after the procedure is completed for a post procedure assessment as documented in the EHR.
11. All patients whose post procedure assessment indicated need for further action will be referred to the physician as documented in the EHR.
12. All patients post procedure will receive verbal and written discharge instructions. All patients who have undergone an endoscopy procedure will receive printed home care instructions as documented in the EHR. Patients/family understanding of home care instructions shall be documented in the EHR as well as all patient education.

13. All patients requiring a return to clinic visit or further diagnostic testing will receive an appointment as indicated in the EHR.

14. All patients requiring preparatory instructions for diagnostic testing will receive verbal and printed instructions as documented in the EHR. Documentation of the patient's understanding of instructions shall be documented in the EHR. If prep medications are required, the patient will be given those medications with documentation in the EHR.

15. All patients/family will be given the opportunity to verbalize their feelings regarding satisfaction with services provided.

OUTCOME STANDARDS

1. The patient/significant other will understand procedure done and any preparatory instructions to be done for further testing.

2. The patient will have undergone the procedure with minimal complications.

3. The patient/significant other will have received post procedure home care instructions.

4. The patient/significant other will know when to return to clinic or other scheduled appointments.

5. The patient will be discharged from clinic in a stable condition or admitted to hospital for further care, if indicated.