

# **Guidelines for Nursing Documentation in Gastrointestinal Endoscopy**



Society of Gastroenterology Nurses and Associates, Inc.

## **Acknowledgments**

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## **Preface**

Documentation development is guided by the use of the nursing process (assessment, planning, intervention, and evaluation) and helps establish consistent yet individualized plan of care for patients during endoscopy.

This guideline is intended to provide direction for healthcare providers in establishing consistent patient care documentation for endoscopy. Healthcare team members are encouraged to keep current on changes in documentation.

Documentation should clearly and uniformly record details that accurately describe situations or events occurring to patients undergoing endoscopy or related procedures. This guideline incorporates Centers for Medicare and Medicaid Services (CMS) requirements, as well as recommendations from The Joint Commission and Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). Various members of the health care team may be responsible for documenting specific items in the patient record.

In order to provide information that is easily adaptable to each patient care environment, the guideline is divided into three major components: *Pre-Procedure*, *Intra-Procedure*, and *Post-Procedure*. The intent is to provide information and criteria that can be selected in formulating an individualized document that meets the needs and requirements that conform to institutional policy.

Each institution must comply with applicable regulations and guidelines. These include but are not limited to state regulations, The Joint Commission guidelines, CMS requirements, and the institution's standards for the monitoring of patients.

## **Definition of Terms**

For the purpose of this document, the following terms are defined:

**Hand off** refers to an up-to-date exchange of information between caregivers regarding the patient's condition, care, treatment, medication, services, and any recent or anticipated changes (Runy, 2008; The Joint Commission, 2012).

**Intra-Procedure Phase** begins with the time-out and at the beginning of sedation until the completion of the diagnostic or therapeutic procedure.

**Medication Reconciliation** refers to the accurate and complete reconciliation of medications across the continuum of care and includes name, dose, route, frequency, and purpose (The Joint Commission, 2012).

**Post-Procedure Phase** refers to the period of time from the completion of diagnostic or therapeutic procedure until the patient is discharged.

**Pre-Procedure Phase** refers to the period of time prior to the patient entering the procedure room.

**Procedural team** refers to the individual performing the procedure, a registered nurse, and a technician. It may also include anesthesia providers and other active participants who will be participating in the procedure.

**Time-out** refers to a verification process done immediately before starting the procedure where procedural team members agree, at a minimum, to the correct patient, correct procedural site, and correct procedure (The Joint Commission, 2013).

**Universal Protocol** refers to a process designed to avoid wrong patient, wrong site surgery and includes three components: a pre-procedure verification, site marking, and a time out (The Joint Commission, 2012).

**Vital signs** refer to a patient's temperature, heart rate, respiratory rate, blood pressure, pain, oxygen saturation assessment, and may also include capnography. Components used may vary depending on procedural phase and institutional requirements.

### **A. Pre-Procedure Phase**

During this phase, an age-specific patient assessment is performed by a registered nurse in order to determine appropriate nursing care, treatment, and services that meet individualized patient requirements.

Patients should be reassessed as determined by the institution and state protocols but at a minimum as determined by the care, treatment, and services sought, the patient's presenting condition(s), and whether the patient agrees to care, treatment, and services (The Joint Commission, 2012).

The following data are recommended to be included during this phase:

1. Patient identification using a minimum of two patient identifiers (The Joint Commission, 2012)
2. Physical assessment, individual needs, and procedure(s) to be performed (Burden, DiFazio, O' Brien, & Dawes, 2000). Assessment to include, but not limited to:
  - a. Date/time
  - b. Baseline vital signs, including pain assessment. When applicable, may include:
    - i. Cardiac monitoring
    - ii. Capnography
  - c. Warmth, dryness, and color of skin (Potter, Perry, Stockert, & Hall, 2012)
  - d. NPO status (Afelbaum et al., 2011)
  - e. Results and type of bowel prep (if applicable) (Bjorkman & Popp, 2006)
  - f. Fall risk assessment
  - g. Pregnancy status (American Society for Gastrointestinal Endoscopy [ASGE], 2012)
  - h. Nutritional status
  - i. Abdominal assessment
  - j. Height and weight
  - k. Activities of daily living: independent, requires assistance, total dependence (Burden et al., 2000)
  - l. Emotional and psychological needs; spiritual and cultural beliefs (Burden et al., 2000)
  - m. Possible abuse, neglect, or exploitation (The Joint Commission, 2012)
3. Allergies and reactions to include prescribed and over-the-counter medications, herbals, food, environmental sensitivities, contrast media, and latex

4. Signed/Witnessed informed consent
5. Sedation scoring system to include but not limited to (Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy, 2008):
  - a. Level of consciousness/mental status
  - b. Airway/respiratory status/oxygen saturation
  - c. Circulation
  - d. Activity
6. Disposition of patient valuables (e.g., glasses, jewelry, etc.) (Potter et al., 2012)
7. Presence of removable dental appliances, loose teeth, glasses/contact lenses, hearing aids, piercings (Potter et al., 2012)
8. Presence of prosthetic devices (e.g., hip replacement, valves), pacemakers, mechanical assist devices, internal defibrillators, and implantable devices (e.g., insulin pump)
9. Medication reconciliation
10. Labs or previous procedures results (if applicable)
11. Intravenous line to include type, site, inserted by, rate of IV solution or presence of venous access device (O'Grady et al., 2011)
12. Known significant medical diagnoses and conditions (e.g., gag reflex, current status of infectious disease/exposure, oncology treatments, physical disabilities, and conditions) (Burden et al., 2000)
13. Past medical/surgical history and invasive procedures, history of complications, or reactions to previous sedation, analgesia, or general anesthesia (Burden et al., 2000)
14. Physician required documentation
  - a. History and physical
  - b. American Society of Anesthesiologists (ASA) Classification
  - c. Airway assessment (i.e., jaw and neck mobility) (American Association for the Study of Liver Diseases et al., 2012; Gross et al., 2002)
15. Educational needs assessment to include (The Joint Commission, 2012):
  - a. identification of barriers to learning
  - b. learning style preference
  - c. ability to comprehend information provided (Burden, et al, 2000)
  - d. pre-procedure education
  - e. post procedure instructions/patient or responsible person's signature of receipt
    - i. availability and name/access number of responsible adult
    - ii. availability of safe transport home
16. For pediatric patients: all items listed also to pertain to pediatric patients (Connors, Cravero, Lowrie, Scherrer, & Werner, 2013)
17. Advance Directives, as applicable
18. Hand-off communication to receiving caregiver
19. Registered nurse signature, date, and time

### **B. Intra-Procedure Phase**

Every patient undergoing a diagnostic, therapeutic, or invasive procedure requires monitoring by a registered nurse or other qualified personnel (Society of Gastroenterology Nurses and Associates, Inc. [SGNA], 2012). Documentation should include the event, intervention (if necessary) and outcome.

The following data are recommended to be included during this phase (The Joint Commission, 2012):

1. Time-out

2. Procedural team
3. Equipment and alarms reviewed and set
4. Ongoing patient assessment
  - a. Vital signs (American Association for the Study of Liver Diseases et al., 2012).  
When applicable, may include:
    - i. Cardiac monitoring
    - ii. Capnography
  - b. Pain assessment
  - c. Abdominal assessment
  - d. Level of consciousness
  - e. Warmth, dryness, and color of skin
  - f. IV maintenance
    - i. Site
    - ii. Type and amount of all fluids administered (including blood and blood products) (The Joint Commission, 2012).
5. Patient positioning
6. Name and dosage of all drugs and agents used (including oxygen and contrast media), time, route of administration, by whom, and patient response (The Joint Commission, 2012)
7. Abdominal pressure if applicable
8. Fluoroscopy exposure time, if applicable (SGNA, 2008)
9. Equipment/accessories relevant to the procedure
10. Grounding pad location and skin condition pre and post procedure
11. Endoscopic therapies utilized during procedure (e.g., clips, stents, drains, bands, tubes)
12. Adverse events
13. Specimen collection
14. Procedure performed/findings
15. Start and end time. May include:
  - a. endoscope insertion
  - b. endoscope removal
16. Disposition of patient; discharge criteria met
17. Hand-off communication to receiving caregiver
18. Signature(s), date, and time

### **C. Post-Procedure Phase**

The frequency of the assessment is determined by institutional/departmental policy, the physician and/or the registered nurse. The following data are recommended to be included during this phase (The Joint Commission, 2012):

1. Start time of post-procedure phase
2. Ongoing patient assessment appropriate to patient's age, needs, and procedure performed (American Association for the Study of Liver Diseases et al., 2012);
  - a. Vital signs, including pain assessment. When applicable, may include
    - i. Cardiac monitoring
    - ii. Capnography
  - b. Sedation scoring system to include but not limited to:
    - i. Level of consciousness/mental status
    - ii. Airway/respiratory status/oxygen saturation

- iii. Circulation
- iv. Activity
- c. Gag reflex if applicable
- d. Abdominal assessment
- e. IV maintenance
  - i. Site
  - ii. Type and amount of all fluids administered (including blood and blood products) (The Joint Commission, 2012).
  - iii. IV disposition (i.e., maintain, lock, discontinue)
- 3. Name and dosage of all drugs used (including oxygen), time, route of administration, by whom, and patient's response (The Joint Commission, 2012)
- 4. Intake and output
- 5. Adverse events, interventions, and outcomes (The Joint Commission, 2012)
- 6. Age specific, individualized discharge instructions reviewed and provided to patient and/or accompanying adult per institutional policy (The Joint Commission, 2012).  
May include, but not limited to:
  - a. Follow-up and specific patient orders written by the physician
    - i. Medication reconciliation
    - ii. Diet and activity
    - iii. Signs/symptoms of possible complications
    - iv. Follow up appointments
  - b. Emergency contact numbers
  - c. Community resources available (if applicable)
  - d. Educational materials (The Joint Commission, 2012)
- 7. Disposition of patient
  - a. Location (e.g., hospital room, home, x-ray)
  - b. Patient's belongings returned (Potter et al., 2012)
  - c. Accompany responsible adult/transporter (Gross et al., 2002)
  - d. Mode of transportation out of the department (e.g., ambulatory, stretcher, wheelchair)
- 8. Hand-off given to subsequent healthcare provider, if applicable (The Joint Commission, 2012)
- 9. Time of discharge and signature of discharge nurse

### **Summary**

This document has been compiled using current guidelines on documentation along with published data. SGNA anticipates that these recommendations will help healthcare providers establish a comprehensive institutional documentation policy.

As an additional resource, the Minimum Data Set is included as Appendix 1. The Minimum Data set is defined as the basic essential elements necessary to document delivery of patient care in the gastrointestinal endoscopic setting. The Minimum Data set complements the Guidelines for Nursing Documentation by providing more detailed data sets.

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### **Recommended Reading**

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**APPENDIX 1: SGNA Minimum Data Set**

**PRE-PROCEDURE**

Date

Time of arrival  AM/PM

**History obtained from:**

- Patient
- Spouse
- Parent
- Child
- Sibling
- Friend
- Significant other
- Other

**Arrival mode**

- Ambulatory
- Wheelchair
- Stretcher

**Transportation**

- Private
- Public

**Arrived with:**

- Alone
- Spouse
- Parent
- Child
- Sibling
- Friend
- Significant other

**Discharge arrangements**

- Driver
- In Lobby
- Need to call

Signed generic post-op instructions

- Yes  No

Date:

Time:

**Reason for Procedure**

*(use ICD9 codes if automated)*

- Abdominal pain
- Colorectal Cancer Screening
- Constipation
- Bleeding
- Dysphasia
- GERD/heartburn
- IBS
- Pain
- Other

**Scheduled procedure**

*(pick multiple choices)*

*(link this to post procedure to link with actual procedure performed)*

- EGD
  - Scheduled
  - Repeated
  - Unscheduled
- Endoscopic Ultrasound (EUS)
- Fine Needle Aspiration (FNA)
  - Scheduled
  - Repeated
- Flexible Sigmoidoscopy
  - Scheduled
  - Repeated
  - Unscheduled
- Colonoscopy
  - Scheduled
  - Repeated
  - Unscheduled
- ERCP
  - Scheduled
  - Repeated
  - Unscheduled
- Dilatation
  - Scheduled
  - Repeated
  - Emergency

Manometry & Motility

- Biliary
- Esophageal
- Rectal
- Scheduled
- Repeated

- 24-hour pH
- Scheduled
  - Repeated

Capsule Endoscopy

- Scheduled
- Repeated

**Pre-op contact**

Date:

Time:

Person contacted

Relationship

Person who initiated contact

No

Reason

**Procedure and patient verified**

Yes  No

Reason:

Patient

Physician

Family/significant other

**Patient issued:**

ID band

Allergy ID band

Mastectomy band

Not indicated

Shunt band

Not indicated

Comments:

**Pre-op teaching**

Date:

Time:

Method

Verbal

Written

Video

Reason for procedure

Verbalizes understanding

**Individuals present for teaching**

Patient

Spouse

Parent

Child

Sibling

Friend

Significant other

**Verbalized understanding of teaching content:**

Patient

Spouse

Parent

Child

Sibling

Friend

Significant other

**Potential barriers to learning**

Anxiety level

Cognitive ability

Hearing

Language

Sight

**Primary language**

English

Spanish

Other

Translator utilized

**People present for teaching** (write in names)


Comments:

**Review of medical history**

**Previous sedation analgesia problems**

- Fainted
- Hyperexcitability
- Hypotension
- Persistent nausea
- Persistent vomiting
- Prolonged sedation
- Tachycardia
- Unstable blood pressure
- None

**Patient allergies**

- Latex
  - Meds
- |  |
|--|
|  |
|  |
|  |
|  |
- Food
  - Dye (radiology)
  - Other
- |  |
|--|
|  |
|  |
|  |
|  |

**Previous medical procedures**

- Mastectomy
  - Right
  - Left
- Shunt
  - Right
  - Left

- Heart
  - Automatic internal cardiac defibrillator
  - Hypertension
  - Pacemaker
  - Valve replacement
  - Other 

--
- Lung
  - Asthma
  - Chronic obstructive pulmonary disease
  - Ostomy
- Liver/GI
  - Yes (Comments: free text field)
- Kidney/ GU
  - Yes (Comments: free text field)
- Airway (Mallampati classification per MD)
  - 1-4
- Mouth opens adequately
  - Airway patent
- Neuro/seizures
  - Sleep apnea

**Orthopedic**

*(flag intraprocedure grounding pad/pad placement)*

- Appliance
  - Neck
  - Back
  - Upper extremity
    - Left
    - Right
  - Lower extremity
    - Left
    - Right

**Significant family history**

- Colorectal cancer
- Gardner syndrome
- Peutz-Jaegers Disease

**Medications**

- Anticoagulants
  - Aspirin
  - Coumadin
  - Plavix
  - Heparin
    - Date last taken
    - Time last taken
- Herbals
  - Date last taken
  - Time last taken
- MAO inhibitors
  - Date last taken
  - Time last taken
- Nonsteroidal anti-inflammatories
  - Date last taken
  - Time last taken

**Exposure to:**

- HIV
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Sexually Transmitted Disease
- TB
- Other (free text)

**Endocrine**

- Insulin dependent/non-insulin dependent
- Last blood glucose  
  - Date
  - Time

**Substance use**

- Alcohol
  - Amount (free text)
  - None
- Caffeine
  - Amount (free text)
  - None

- Drugs
  - Yes
    - History of (free text)
  - None
- Tobacco
  - Amount (free text)
  - Years
  - None

**History of:**

- Glaucoma
- Previous endoscopic procedures (list)
- Previous surgeries (list)

Comments:

**Condition upon arrival**

- American Society of Anesthetists (ASA) Scoring** (per physician)
  - 1
  - 2
  - 3
  - 4
  - 5

**Aldrete scoring per facility choice**

- Activity
  - Able to move 4 extremities (2)
  - Able to move 2 extremities (1)
  - Able to move 0 extremities (0)
- Respiration
  - Deeply breaths, coughs freely (2)
  - Dyspnea or limited breathing (1)
  - Apneic (0)
- Circulation
  - Systolic BP +/- 20 mmHg pre-procedure level (2)
  - Systolic BP +/- 20 mmHg to 50 mmHg pre-procedure level (1)
  - Systolic BP +/- 50 mmHg or more of pre-procedure level (0)

- Consciousness
  - Fully awake (2)
  - Arises on calling (1)
  - Unresponsive (0)
- Color
  - Pink (2)
  - Pale, dusky, blotchy, jaundiced (1)
  - Cyanotic (0)

- Arrived in unit with oxygen at \_\_\_\_\_ liters
  - How administered
    - Cannula
    - Mask
    - Tracheostomy
    - ET tube

**Pain**

- No
- Yes
  - Location
  - Duration
    - 0-10
    - What 0-10 would be acceptable for patient?
  - Frequency
  - Symptoms relieved by
  - Symptoms worsened by
  - Description
    - Free text

**Vital sign base line readings**

- Blood pressure
- Pulse
- Respiratory rate
- O2 SAT
- Capnography (CO2)
- Temperature

**Sedation plan**

- Moderate
- Deep
- General
- Local
- Topical

**General Assessment**

**Skin temperature**

- Warm
- Cool

**Skin status**

- Dry
- Moist
- Intact
  - Yes
  - No
  - Body piercing  
*(free text to note location)*
- Other

**Follows command**

- Yes
- No

**Psychological state**

- Agitated
- Anxious
- Cooperative
- Oriented
- Restless
- Tranquil

**Weight**

- Stated
- Actual

**Height**

- Stated
- Actual

**Pregnant**

- No
- Yes
  - Physician notified
- Date of last menstrual period

**Respiratory Assessment**

- Clear
- Congested

**Abdominal assessment**

- Distended
- Firm
- Flat
- Nontender
- Round
- Soft
- Tender

**Intravenous (IV) access**

- Extremity restriction
  - Left
  - Right
- New insertion
  - Time
- Name of person inserting/credentials
- Type of IV  
*(need option for more than 1 IV)*
  - Size
  - Number of attempts
  - Patency
  - Peripheral
    - Angiocath
    - Butterfly
    - Other
  - Central
    - Triple lumen
    - Port

- Site
  - L Hand
  - R Hand
  - L posterior forearm
  - R posterior forearm
  - L anterior forearm
  - R anterior of forearm
  - L antecubital space
  - R antecubital space
  - Other
- Solution
  - D5/W
  - Normal saline
  - Lactated ringers
  - D5 1/2 NS
  - D5 1/4 NS
  - Packed red blood cells
  - Platelets
  - Fresh frozen plasma (FFP)
    - Amount remaining
    - Rate ordered
  - Other

- Arrived with IV access in place
  - Type of IV (need option for more than 1 IV)
    - Size
    - Number of attempts
    - Patency
    - Peripheral
      - Angiocath
      - Butterfly
      - Other
    - Central
      - Triple lumen
      - Port

Site

- L Hand
- R Hand
- L posterior forearm
- R posterior forearm
- L anterior forearm
- R anterior of forearm
- L antecubital space
- R antecubital space
- Other

Solution

- D5/W
- Normal saline
- Lactated ringers
- D5 1/2 NS
- D5 1/4 NS
- Packed red blood cells
- Platelets
- Fresh frozen plasma (FFP)
  - Amount remaining
  - Rate ordered
- Other

**Oral Assessment**

- Dentures
  - Yes
    - Removed
      - Upper
      - Lower
- Loose teeth
  - Yes
    - Location
- Tongue pierced

**Risk/screen**

- Abuse
  - Physical
  - Emotional
  - Mental
  - Verbal
  - Sexual
- Fall risk
- Nutrition
- Psychosocial

Comments:

**Preparation for procedure**

- NPO
  - Last solid food
    - Date
    - Time
  - Last liquids ingested
    - Date
    - Time
- Bowel prep
  - Type
    - PEG solution
    - Biscodyl tablets
    - Biscodyl suppositories
    - Fleets enema
    - Fleets oral
    - Citrate of Magnesia
    - Tap water enemas
    - Soap suds enemas
    - Visical
    - Other
  - Taken as instructed
    - Yes
    - No
      - Reason
  - Description of last stool
    - Consistency
      - Liquid
      - Semi-solid
      - Solid

- Color
  - Clear
  - Yellow
  - Brown
  - Other

**Review of lab results**

- None ordered
- Within normal limits
- Physician notified of abnormality
- Not available

**Advance directives**

- Living will
  - Yes
  - No
- Additional information provided for patient
- Patient does not wish more information
- Durable power of attorney for medical affairs

**Belongings removed**

- Dentures
- Glasses
- Hearing aids
- Other

**Disposition**

- With patient
- With significant other
- Other
- Who completed assessment

*(track staff with number system- unique identifier per facility policy)*

Comments:

## INTRA-PROCEDURE

### Procedure and Patient re-verified

- Yes
  - Patient
  - Physician
  - Family/significant other

### Verify allergies with patient

- yes

### Verify sedation planned

- yes

### Verify consent forms signed

- Procedure
- Sedation
- Observation (people in the room)
- Permission to discuss findings with
- Procedure Room number
- Time entered room

### Personnel

- Nurse (*drop down menu, free text*)
- GI Tech (*drop down menu, free text*)
- Radiology Tech (*drop down menu, free text*)
- Attending physician (*drop down menu, free text*)
- Fellow (*drop down menu, free text*)
- Pathologist (*drop down menu, free text*)
- Resident (*free text*)
- Student (*free text*)
- Observer (*free text*)

## Procedural information

### Scopes

- Scope utilized (drop down box with all available scopes)
  - Not applicable
  - Scope ID number
- Time scope inserted in patient
- Time endoscopist reached cecum (*only for colonoscopy*)
- Time scope removed from patient

### Events/Occurrences

- None
- Abdominal pressure applied (*link to colonoscopy/flex sigmoidoscopy procedures*)
- Allergic reaction
- Anatomical variances
- Compromised airway
  - Required airway support
    - ET tube
    - Jaw lift
    - Oral airway
    - Nasal trumpet
    - AMBU bag
- Dental injury
- Equipment malfunctioning
- Equipment not available
- Failed sedation
  - Anesthesia called
  - Procedure terminated
- Incomplete bowel prep
- Incomplete procedure
- Nausea
- O2 at 10% < baseline for 2 minutes or more and/or 85%
- Required cardiopulmonary resuscitation (airway and circulation)
- Required cardiovascular medication administration (*list of meds comes up when drug given*)

- Required reversal agent administration  
(comes up when drug given)
- Suspected aspiration
- Suspected perforation
- Unanticipated bleeding
- Uncooperative patient
- Vomiting

**Vital signs**

- Blood pressure
- Heart rate
- Heart rhythm
- Respiratory rate
- O2 saturation
- Capnography (CO2)
- Oxygen at \_\_\_\_\_liters
  - Time initiated
  - Time discontinued
  - How administered
    - Cannula
    - Mask
    - Tracheostomy
    - ET tube

*In some situations, ICU nurse will be asked to stay to monitor patients in this condition; provision for linking to ICU documentation forms would be helpful.*

Comments:

**Specimens**

*(need option for multiple site selections with number of specimens and cm level 0-60)*

**Organ**

- Esophagus
  - Mid \_\_\_\_\_cm
  - Proximal \_\_\_\_\_cm
  - Distal \_\_\_\_\_cm
  - Random
- or
  - \_\_\_\_\_ specimens at \_\_\_\_\_cm

- Stomach
  - Esophagogastric junction
  - Cardia
  - Body
  - Fundus
  - Antrum
  - Pylorus
  - Random
  - H Pylori
- Duodenum
  - Duodenal bulb
- Jejunum
- Biliary tract
  - Ampulla
  - Common bile duct
  - Common hepatic duct
  - Pancreatic duct
- Colon
  - Ileocecal valve
  - Ascending
  - Splenic flexure
  - Transverse
  - Hepatic flexure
  - Sigmoid
- Rectum
- Anus

Number of specimens from each site  
*(minimum 0, maximum 60)*

- Location (text)

**Sent to laboratory for:**

- Cytology
- Pathology
- Microbiology

Specimens labeled and documented  
*(Labels to be generated by above information)*

**Media**

Documentation video of

- #
- Disposition
- To patient
- To archives
- Documentation photo of

- #
- Disposition
  - To patient
  - To archives
  - To chart

Comments:

**Therapeutic devices**

- Argon plasma coagulator**
  - Serial #/ Unit ID
  - Manufacturer
  - Site (*pull from specimen list*)
  - Gas Flow (check?)
  - Watts
  - Seconds
  - Pulses #
  - Watt seconds (multiplication of watts x seconds)
- Balloons
  - Manufacturer
  - Serial #
  - Size(s)
    - French
    - Length
  - PSI (Pounds per square inch)
  - Time (minutes, seconds)

- Bicap hemostasis/heater probe
  - Manufacturer
  - Serial #
  - Probe size
  - Coagulation power (0-10)
  - Watts
- Biopsy forceps
  - Hot
    - upper
    - lower
  - Cold
    - upper
    - lower
  - Both
- Manufacturer
- Identification code
- Number used
- Type  
(*drop down menu per institution*)

- Capsule
  - Signal verified
  - Lot #
  - Time ingested

**Cautery**

- Manufacturer
- Serial # / Unit ID
- Settings
- Watts
  - Monopolar
    - Cut (0-10 or range)
    - Coag (0-10 or range)
    - Blend (0-10 or range)
  - Bipolar
    - Cut (0-10 or range)
    - Coag (0-10 or range)
    - Blend (0-10 or range)

- Grounding Pad
  - Placement
    - Thigh
      - L
      - R
    - Other
  - Skin preparation
    - Yes
    - No
    - Not applicable
  - Skin condition at pad removal
    - Same as preprocedure
    - Erythematous
    - Abrasion
    - Other
- Cytology brush
  - Manufacturer
  - Identification code
  - Number used
  - Type (*drop down per institution*)
- Drain/stent
  - Type
    - Biliary
    - Colonic
    - Esophageal
    - Nasal Biliary
    - Pancreatic
    - Rectal
  - Manufacturer
  - Serial #
  - French (*customize - pull from inventory*)
    - \_\_\_\_\_cm
  - Length
- Dilatation
  - Balloons
    - Manufacturer
    - Serial #
    - Size(s)
      - French
      - Length
    - PSI (Pounds per square inch)
    - Time (minutes, seconds)
  - Bougie
    - Maloney
      - French  
*(multiple choice per institution, free text)*
    - Hurst
      - French  
*(multiple choice per institution, free text)*
  - Savary
    - Millimeters
- EMR Kit
  - Manufacturer
  - Serial # / Unit ID
  - Site
- Endocut
  - Type of probe
  - Filter change
  - Medications
    - Epinephrine
    - Normal saline
- ERCP
  - Basket
    - Serial #
    - French
  - Cannulas
    - Serial #
    - French
  - Dilation catheter
    - Serial #
    - French
  - Papillotome
    - Serial #
    - French

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- Stone retrieval
  - Balloon
  - Serial #
  - French
- Foreign body retrieval
  - Basket
  - Biopsy forceps
  - Magnet
  - Net
  - Rat tooth
  - Snare
  - Tripod
  - Other (*free text*)
- Fine needle aspiration needle
  - Manufacturer
  - Serial # / Unit ID
  - Size
- Guide wires
  - Manufacturer
  - Serial #
  - Size(s)
  - Number
  - Type
- Injection therapy
  - Site (from specimen list)
  - Needle serial #
  - Size
  - Medications/solutions
    - Epinephrine
      - Ethanolamine
      - India ink
      - Normal saline
      - Sodium morruate
      - Sodium tetradecyl
        - Dilution
        - Total amount
        - Increments
        - Number of injections
- Laser
  - Serial # / Unit ID
  - Manufacturer
  - Site
  - Gas Flow (check  )
  - Joules
  - Seconds
  - Pulses (#)
  - Joules Seconds (multiplication of watts times seconds)
- Motility/manometry catheter
  - Type
    - Water perfused
    - Solid state
  - Placement
    - Esophageal
      - Location
        - R Nares
        - L Nares
        - Oral
    - \_\_\_\_\_ cm
  - Rectal
    - \_\_\_\_\_ cm
  - Biliary
  - Pancreatic
- Percutaneous endoscopic gastrostomy/jejunostomy
  - Manufacturer
  - Serial #
  - French (range)
- pH Probe
  - Manufacturer
  - Serial #
  - Unit ID
  - Placement
    - Location
      - R Nares
      - L Nares

- Oral
    - \_\_\_\_\_ cm
  - On medications
    - Yes
    - No
  - Time probe inserted
  - Date probe inserted
  - Time probe removed
  - Date probe removed
  - Snares
    - Manufacturer
    - Serial #
    - Size(s)
    - Number
    - Type
  - Spray catheter
    - Acetylcysteline
    - Lugols solution
    - Methylene Blue
  - Variceal ligation
    - Banding
      - number of bands
      - site
  - Standard equipment in room (*optional to list*)
- Comments:

### Sedation monitoring

- Aldrete scoring
  - Activity
    - Able to move 4 extremities (2)
    - Able to move 2 extremities (1)
    - Able to move 0 extremities (0)
  - Respiration
    - Deeply breaths, coughs freely (2)
    - Dyspnea or limited breathing (1)
    - Apneic (0)

- Circulation
  - Systolic BP +/- 20 mmHg pre-procedure level (2)
  - Systolic BP +/- 20 mmHg to 50 mmHg pre-procedure level (1)
  - Systolic BP +/- 50 mmHg or more of pre-procedure level (0)
- Consciousness
  - Fully awake (2)
  - Arises on Calling (1)
  - Unresponsive (0)
- Color
  - Pink (2)
  - Pale, dusky, blotchy, jaundiced (1)
  - Cyanotic (0)

### Patient position(s)

- Decubitus
- Fowlers
- Lateral
  - Left
  - Right
- Prone
- Semi-fowlers
- Supine
- Trendelenburg

### Oral suction

- Yes
- No

### Transportation to recovery room

- Ambulatory
- Wheel chair
- Via stretcher with side rails up

### Intravenous fluids

(*have system do the math to give total at end*) (*match pre-procedure list*)

- Solution
  - D5/W

- Normal saline
- Lactated ringers
- D5 1/2 NS
- D5 1/4 NS
- Packed red blood cells
- Fresh frozen plasma
- Platelets
  - Total amount infused
  - Site
- Other
- Discontinued time
  - Catheter tip intact
    - Yes
    - No
  - Site with edema
    - Yes
    - No
  - Site with erythema
    - Yes
    - No
- Meperidine IV
- Midazolam IV
- Naxolone IV
- Promethazine IV
- Propofol
- Romazicon IV
- Other (free text)
- Topical anesthetics
  - Benzocaine Spray PO
  - Lidocaine viscous
  - 2% Lidocaine jelly
- Other medications
  - Acetylcysteline
  - Atropine
  - Epinepherine IV
  - Lugols solution
  - Lidocaine injectable
    - 2%
    - 4%
  - Methylene Blue
  - Sincalide IV
  - Free text

**Medications**

*(computer enter name of administrator/time of administration)*

- Antibiotics  
*(list most common used per institution)*
- Bowel prep
  - Fleets enema
  - PEG solution
- Interventional medications
  - Cholecystokinen
  - Glucagon
  - Metaclopramide
  - Simethicone

Sedation

- Diphanhydramine
- Droperidol IV
- Fentanyl IV

**Radiation (Fluoroscopy)**

- Patient shielded
  - Yes
  - No
  - Not applicable
- Fluoroscopy settings
- Contrast media
  - Amount
  - Type
    - Ionic
      - Full
      - Half
    - Non-ionic
      - Full
      - Half
    - Gastrograffin
- Total fluoroscopy time
- Time out of room

Comments:

## POST-PROCEDURE

- Time admitted to recovery

### Procedure(s) performed

*(link to procedure(s) scheduled)*

- Capsule Endoscopy
  - Scheduled
  - Repeated
- Colonoscopy
  - Scheduled
  - Repeated
  - Emergency
- Dilation
  - Scheduled
  - Repeated
  - Emergency
- EGD
  - Scheduled
  - Repeated
  - Emergency
- ERCP
  - Scheduled
  - Repeated
  - Emergency
- EUS
  - FNA
  - Scheduled
  - Repeated
- Flexible sigmoidoscopy
  - Scheduled
  - Repeated
  - Emergency
- Manometry and Motility
  - Biliary
  - Esophageal
  - Rectal
  - Scheduled
  - Repeated

- 24 hour pH
  - Scheduled
  - Repeated

### Vital signs

- Blood pressure
- Heart rate
- Heart rhythm
- Respiratory rate
- O2 saturation
- Capnography (CO2)
- Oxygen at \_\_\_\_\_liters  
*(link from pre-procedure)*
  - Time initiated
  - Time discontinued
  - How administered
    - Cannula
    - Mask
    - Tracheostomy
    - ET tube
- Skin temperature
  - Warm
  - Cool
- Skin status
  - Dry
  - Moist
  - Intact
    - Yes
    - No
  - Body piercing  
*(free text to indicate location)*
  - Other

### Additional Tests

- EKG
- Glucometer
  - Blood glucose level
  - Time
  - Other
- Lab *(drop menu with list)*
- Radiology *(drop menu with list)*

**Discharge instructions**

*(be sure JCAHO requirements are covered here)*

**Diet** *(can choose more than one)*

- As tolerated
- Clear liquid
- Full liquid
- Gluten free
- High fiber
- Low fiber
- Low fat
- Return to normal
- Small frequent meals
- Soft
- Other *(free text)*

**Limitations** *(These are examples – customize for individual institution)*

- Do not drive any vehicle, drink alcohol, operate any dangerous equipment - such as power tools, lawn mowers, etc., or make any major decisions for at least 12 hours.
- Do not eat any solid food for one hour following the completion of the procedure.
- Do not take any aspirin, Advil, Nuprin, Alleve, BC powder, or ibuprofen for 7 days. Tylenol is acceptable.
- Fluids – encourage to drink
- Medication instructions
- Prescriptions provided
- Rest at home for the next 12 hours
  
- Questions invited and answered
  - Yes
  - No
  - Narrative (text)

**Follow up appointment**

- Office
- Procedure

**Emergency follow up indicated for:**  
*(examples – customize for individual facility)*

- Any gastrointestinal bleeding > 1 tablespoon
- Any pain or red streaks near your IV site
- Nausea or vomiting lasting over 2 hours
- Referred pain to shoulder/neck area
- Severe or unusual abdominal discomfort or pain
- Temperature over 101 degrees F
- Call Dr.  immediately at phone #

**Post procedure teaching**

- Date
- Time
- Method
  - Verbal
  - Video
  - Written
- Verbalizes understanding
- Individuals present for teaching
  - Patient
  - Spouse
  - Parent
  - Child
  - Sibling
  - Friend
  - Significant other
- Teaching content verbalized as understood by:
  - Patient
  - Spouse
  - Parent
  - Child
  - Sibling
  - Friend
  - Significant other

- Potential barriers to learning
  - Anxiety level
  - Cognitive ability
  - Hearing
  - Language
    - Primary language
    - Translator utilized
  - Sight
- Teaching content  
*(drop-down menu with common discharge instruction worksheets to identify which one(s) were given to the patient/family/etc.)*
- People present for teaching  
*(write in names)*

**Post procedure devices in place**

*(those inserted during procedure)*

- ET tube
- PEG/PEJ
- Rectal tube
- Stent (link to intraprocedure entry)

**Post procedure devices retrieved**

- Discharged with devices in place
- Retrieved prior to discharge
- ET tube
- PEG/PEJ
- Rectal tube
- Stent (link to intraprocedure entry)

**Occurrences**

- Admitted to hospital
- Allergic reaction
- Anesthesia
- Aspiration
- Bleeding
- Code
- Flumazemil administration
- Intubation
- IV infiltration
- Naloxone administration
- Nausea
- Perforation

- Readiness for discharge greater than 2 hours

- Vomiting

Comments:

**Discharge**

- Inpatient
  - Returned to room
  - Admitted to ICU
  - Transferred to another facility
  - Transported by
    - RN
    - LVN
    - Tech
    - Other
- Outpatient
  - Home
  - Admitted to room
  - Admitted to ICU
  - Returned to ER
  - Transferred to another facility
  - Accompanied by (specify name)
    - Family
    - Significant other
    - Ambulance staff
- Transportation
  - Public
  - Private
- Mode
  - Ambulatory
  - Wheel chair
  - Stretcher
- Report
  - Called
  - Given to
  - Given by
  - Not applicable

**Assessment**

- Abdominal assessment
  - Soft
  - Firm
  - Round
  - Flat
  - Distended
  - Tender
  - Nontender
  - Ascites
  - Passing flatus
- Gag reflex present
- Tolerating PO fluids

**Intravenous access**

- Site(s)
- Solution
  - D5/W
  - Normal saline
  - Lactated ringers
  - D5 1/2 NS
  - D5 1/4 NS
  - Packed red blood cells
  - Fresh frozen plasma (FFP)
  - Other
- Total amount infused
- Total amount remaining (*system should calculate from amt. hung and amt. infused.*)
- Discontinued time
- Type of dressing applied
- Catheter tip intact
  - Yes
  - No
- Site with edema
  - Yes
    - Site care instructions offered
  - No
- Site with erythema
  - Yes
    - Site care instructions offered

**Aldrete scoring**

- Activity
  - Able to move 4 extremities (2)
  - Able to move 2 extremities (1)
  - Able to move 0 extremities (0)
- Respiration
  - Deeply breaths, coughs freely (2)
  - Dyspnea or limited breathing (1)
  - Apneic (0)
- Circulation
  - Systolic BP +/- 20 mmHg pre-procedure level (2)
  - Systolic BP +/- 20 mmHg to 50 mmHg pre-procedure level (1)
  - Systolic BP +/- 50 mmHg or more of pre-procedure level (0)
- Consciousness
  - Fully awake (2)
  - Arises on Calling (1)
  - Unresponsive (0)
- Color
  - Pink (2)
  - Pale, dusky, blotchy, jaundiced (1)
  - Cyanotic (0)

**Pain**

- No
- Yes
  - Location
  - Duration
    - 0-10
    - What 0-10 would be acceptable?
  - Frequency
  - Symptoms relieved by
  - Symptoms worsened by
  - Description
    - Free text

**Belongings returned**

- Dentures
- Glasses
- Hearing aids
- Other

*Guidelines for Nursing Documentation in Gastrointestinal Endoscopy*

**Discharged by:** *(drop down menu with list of staff)* :

Comments