SUBJECT: PATIENT CARE STANDARDS – BEFORE, DURING AND AFTER ENDOSCOPIC PROCEDURES

Policy Statement: Upper endoscopy is the direct visualization of the esophagus, stomach and proximal duodenum for diagnosis and/or therapeutic treatment. The procedure may be performed with or without moderate sedation. A pre-procedure nursing and physician assessment will be completed and documented on the appropriate flow sheets and progress notes. To reduce patient anxiety, pre-procedure teaching will include what to expect during and after the procedure. Patients will be monitored according to hospital policy throughout and after the endoscopy examination.

Physician's Order Required: Yes

Performed By: RN

Equipment:

Refer to Standard Equipment and Safety Procedures
Endoscope of choice
Light source/video system
Two suction sources
Water bottle, sterile water
Electrosurgery/coagulation devices (monopolar, bipolar, heater probe, argon plasma, coagulator)
Oxygen with nasal cannula
ECG monitor available
Pulse oximeter
Blood pressure cuff or monitor
Mouthpiece/bite block
Oral suction

Accessory Supplies:

Biopsy forceps, hot biopsy forceps
Snares
Retrieval forceps
Cytology brushes
Glass slides
Cytology containers w/preservatives
Histology / pathology containers with preservative
Labels for specimen labeling
Sterile containers, non-bacteriostatic saline
Fixative spray
Sterile suction trap container
Laboratory specimen slips

Miscellaneous Supplies:

Syringes and needles
Personal protective equipment
Gauze sponges
Lubricant (water soluble)
Silicone
Local anesthetics
Medications for sedation w/reversal agents
Camera, film, videotape
Suction tubing and catheters / oral suction
IV solutions and IV setup, IV pole
Irrigation setup
Medications as per physician order
Crash cart

Signature(s) on File.

Pre-Procedure Assessment/Care (Documentation will exist on Moderate Sedation flow sheet):

1. Verify informed consent.
2. Verify that outpatient who will require sedation has a person responsible for his/her transportation.
3. Obtain baseline temperature, heart rate respirations, blood pressure and oxygen saturation.
4. Obtain patient's medical history including allergies, current medications and information pertinent to current complaint.
   KEY POINT: Complete the outpatient admission nursing assessment on all outpatients. *(See attached.)*
5. Verify length of NPO status.
6. Remove dental appliances.
7. Inspect airway for neck and jaw mobility.
8. Assess gag reflex.
9. Ensure patent venous access.
10. Administer medications as ordered.

Patient Teaching:

1. Explain the purpose of the procedure, positioning, relaxation methods, techniques to be used, estimated length of the procedure and sensations the patient is likely to experience during and after the exam.
2. Explain the use of the bite block and oral suction.
3. Reassure the patient that the endoscope will not interfere with breathing.
4. Explain the effects of the sedative medication to be used.
5. Review discharge instructions with patient/family prior to sedation and at discharge. *(See attached post-procedure discharge instructions.)*

Responsibilities During Procedure (Document on Moderate Sedation flow sheet):

1. Anesthetize throat as ordered.
2. Position patient on left side.
3. Place bite block and oral suction.
4. Administer medication as directed by the physician and as permitted by institutional policy. Refer to policy B815.
5. Assist physician during procedure.
6. Monitor vital signs (heart rate, respirations, blood pressure) and oxygen saturation if undergoing sedation and analgesia.
   a) Affix a pre, intra and post procedure cardiac monitor strip to flowsheet.
7. Assess level of consciousness/mental status (Aldrete score).
8. Assess level of comfort/response.
9. Provide emotional support to the patient.
10. Maintain oral airway and manage oral secretions.
11. Properly handle, preserve and label all specimens obtained. Refer to Specimen Collection procedure.

Post-Procedure Assessment/Care:

1. Monitor vital signs (heart rate, respirations, blood pressure) and oxygen saturation if patient received sedation and analgesia.
   KEY POINT: Patients with neurologic disability are at risk for airway obstruction when they are sedated: maintain proper head position to ensure airway patency.
2. Monitor level of consciousness/mental status (Aldrete score).

3. Monitor level of comfort/response.
4. Observe patient for:
   a) Hemorrhage
   b) Vomiting
   c) Abdominal distention
   d) Pain
5. Maintain NPO status until gag reflex returns.
6. Remove venous access device prior to patient's discharge, if applicable.
7. Provide discharge instructions to outpatient and/or accompanying adult, who demonstrates understanding and signs form. *(See attached.)*
8. Provide report to subsequent caregiver.
9. Discharge outpatients who have received sedation to a person responsible for his/her transportation according to hospital policy B815.
10. Inpatients who receive sedation will be escorted back to their units, accompanied by licensed staff and give report to appropriate licensed staff on unit.
11. If reversal agent is given, patient will be kept in recovery area for an additional hour prior to discharge.

References: RLANRC Administrative Policy Manual; policy B815

Society of Gastroenterology Nurses and Associates, Inc. (2000)

JCAHO 2002 TX.2.1-.2.4.1
TX.5-.5.4
PF.3&.3.9
RI.1.2.1

08/99 – Revised
05/02 – Revised
09/02 – Revised

Attachment(s) - 3

SPL25.02