

# 4. Pre- and post-procedure guidelines and checklists for endoscopy facilities

## INTENDED USE OF THIS RESOURCE

This resource includes two components:

- ▶ Guidelines outlining the minimum requirements for patient information that should be collected, and, activities that should be completed prior to and after a colonoscopy procedure
- ▶ Three sample checklists including a *Day-of Procedure Pre-Procedural Checklist*, *Procedure Room Pre-Procedural Checklists* and *Post-Procedural Checklist*

The Partnership suggests that:

- ▶ Facilities use the pre- and post-procedure guidelines to compare their current processes to those outlined in the guidelines to identify existing gaps and to ensure that the minimum requirements outlined in these guidelines are integrated into the facility's provision of colonoscopy services.
- ▶ Where facilities are completing the activities recommended in the guidelines **but may not be adequately documenting the completion of important pre- and post-procedure activities, the three checklists provided may be used to efficiently document the completion of these activities.**

*The intent of providing these sample checklists is not to duplicate existing processes for documentation. If the completion of the activities outlined on the checklists are documented using existing clinical documentation processes, the Partnership does not prescribe the use of the checklists provided.*

For a full list of evidence consulted in creating this resource, please see the accompanying document titled *Background and Resource Summary – The Early Quality Initiatives (EQIs) – Quality Improvement Resource Package for Endoscopy/Colonoscopy*.

## BACKGROUND

The following resource, including pre- and post-guidelines and the three accompanying checklists aim to:

- ▶ ensure that all important activities are completed prior to and after a colonoscopy is performed
- ▶ improve communication within the care team and between the care team and the patient
- ▶ standardize pre- and post-procedural activities across Ontario facilities

Note: The *Out-of-Hospital Premises Inspection Program (OHPIP) Program Standards* (2013) published by the College of Physicians and Surgeons of Ontario (CPSO) were reviewed during the development of this tool and its content generally aligns with these standards. One area of distinction is the requirement for a “surgical pause”. The *OHPIP Program Standards* companion document (*Guide to Applying the Out-of-Hospital Standards in Endoscopy/Colonoscopy OHPs/IHFs, 2014*) indicates that a “surgical pause” is not required for endoscopy/colonoscopy premises and that it is sufficient to conduct a two-stage verification process where the patient and the intended procedure is verified and documented by two different premises staff. However, the following guideline does include components to be verified by the care team immediately prior to endoscope insertion because this will enhance communication within the care team and prepare them adequately for the procedure.

# GUIDELINES

## Minimum requirements for the collection of patient information and completion of pre- and post-procedure activities for colonoscopies

### Pre-procedural guidelines

- ▶ **BEFORE OR ON THE DAY OF THE PROCEDURE**, patients presenting for sedation and/or analgesia must undergo a pre-procedure assessment and interview, which may include, but is not limited to, the following:
  - o History and physical examination that includes findings that confirm the indication for the proposed procedure as well as patient age and significant medical issues and comorbidities (including sleep apnea)
  - o ASA Physical Status Classification
  - o Weight, height, body mass index (BMI)
  - o Vital sign measurement (i.e., blood pressure and pulse rate)
  - o Auscultation of heart and lungs and evaluation of the airway
  - o Medications (including prescription, non-prescription, non-traditional medications (e.g., herbal remedies), and type of bowel preparation)
  - o Allergies
  - o History of tobacco, alcohol, or substance use or abuse
  - o ECG, laboratory tests, pre-procedure consultation, and investigations
  - o Adequate explanation of the risks of bowel preparation and the procedure, including anticipated outcomes, risks of sedation and/or analgesia, and assessment of previous adverse experience with sedation and/or analgesia
  - o Adequate explanation of discharge processes, including policies regarding requirements for adult accompaniment at discharge
- ▶ **ON THE DAY OF THE PROCEDURE**, patients presenting for sedation and/or analgesia must undergo an admission assessment, including but not limited to, the following:
  - o Confirmation of baseline pre-procedure assessments and interview (if the baseline pre-procedure assessments and interview were not completed on the day of the procedure)
  - o Assess for changes in medical history since last assessment. This is particularly important if more than 14 days have passed since the patient was last assessed.
  - o Measurement of vital signs (blood pressure, pulse rate, respiration rate, oxygen saturation, temperature). A glucometer reading may be appropriate for diabetic patients
  - o Documentation of time and nature of last oral intake
- ▶ **ON THE DAY OF PROCEDURE**, the care team must:
  - o Complete a two stage patient verification process: the patient's full name and date of birth must be confirmed with the patient/ substitute decision maker/ legal guardian. The identifiers may be verified against the patient's arm-band and any other documentation in the room. For the first verification, the patient must be awake and aware. The second verification must be completed by a different member of the care team than the member who completed the first verification. If possible, the complete care team should be present during the second verification.
  - o Complete a two stage verification of correct procedure and indication: the correct procedure and indication must be confirmed with the patient/ substitute decision maker/ legal guardian. For the first verification, the patient must be awake and aware. The second verification must be completed by a different member of the care team than the member who completed the first verification. If possible, the complete care team should be present during the second verification.
  - o Patients must be assessed for anticoagulation/ antiplatelet use. Relevant findings must be communicated to all members of the care team.
  - o Complete care team introductions. Each member of the care team must introduce him/herself by name and role to ensure that the patient/substitute decision-maker/legal guardian is aware of the names of the care team and to ensure that all team members know each other by name
  - o Confirm that the patient is appropriately monitored prior to administration of sedation or analgesia (if applicable)
  - o Assess functionality of equipment and confirm that all required equipment is available, including equipment and kits that would be required in the event of complication or adverse event

## Post-procedural guidelines

- ▶ **AFTER THE PROCEDURE**, the care team must:
  - o Verify that the specimens are correctly labelled and that the accompanying documentation matches the labelling (if samples were collected)
  - o Confirm the accuracy of the anesthetic/nursing procedural report **before** the patient is transferred to the recovery area, including verification that the report accurately reflects the procedure performed, medications administered, patient status, and any special instructions regarding recovery
  - o An anesthesiologist or physician is responsible for writing the discharge order for a patient following the colonoscopy procedure.
- ▶ Important considerations for post-procedural assessments:
  - o Elderly patients (70+); patients with oxygen desaturation, hypotension, or bradycardia; and those needing reversal agents require longer recovery times
  - o Half-life of reversal agents tends to be shorter than half-life of sedatives; therefore, reversal agent effects may wane before those of sedatives
- ▶ Policies for discharge of patients should encompass:
  - o A clear and specific discharge process that accommodates differences in patients' responses, particularly to sedation and/or analgesia
  - o An objective scoring system to assess readiness for discharge based on assessments of respiration, oxygen saturation, consciousness, circulation, and activity levels (e.g., Modified Aldrete score, PADSS)
  - o Documentation of the discharge tool result in the patient record
- ▶ General guidance for recovery and discharge criteria for discharge after sedation/analgesia:
  - o Patients should be alert, oriented, and should have returned to their baseline status
  - o Vital signs should be stable and within acceptable limits
  - o Sufficient time (up to 2 hours) should have elapsed after the last administration of reversal agents (e.g., naloxone, flumazenil) to ensure that patients do not become re-sedated after reversal effects have worn off
  - o Outpatients should be discharged in the presence of a responsible adult who will accompany them home and be able to report any post-procedure complications
- ▶ Additional important considerations for discharge:
  - o Outpatients and their accompanying adult should be provided with verbal and written instructions including, but not limited to, a summary of the procedure, key findings, the management plan, possible complications and side-effects of the procedure, instructions regarding activity 24 hour activity restrictions as well as diet and medication modifications, and a phone number to be called in case of emergency
  - o Patient satisfaction with the discharge process should be regularly monitored

# CHECKLIST 1: DAY OF PROCEDURE PRE-PROCEDURAL CHECKLIST

**COMPLETE WITH PATIENT/SUBSTITUTE  
DECISION-MAKER/LEGAL GUARDIAN ON  
DAY OF THE PROCEDURE**

Affix patient ID label here

Activity	Please check and sign at the time of completion
1. COMPLETE FIRST VERIFICATION OF PATIENT IDENTIFICATION	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
2. COMPLETE FIRST VERIFICATION OF CORRECT PROCEDURE AND INDICATION	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
<b><u>PATIENT ALLERGIES:</u></b> COMPLETE ONLY IF PATIENT HAS ALLERGIES	<input type="checkbox"/> Not Applicable
3. VERBALIZE PATIENT ALLERGIES WITH CARE TEAM	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
<b><u>ANTICOAGULANT AND/OR ANTIPLATELET MEDICATIONS:</u></b> MARK NOT APPLICABLE IF THE PATIENT IS NOT ON ANTICOAGULANT AND/OR ANTIPLATELET MEDICATIONS	Not Applicable
4. CONFIRM THE PATIENT HAS/HAS NOT STOPPED TAKING ANTICOAGULANT AND/OR ANTIPLATELET MEDICATIONS	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
5. CONFIRM THE PATIENT HAS/HAS NOT RECEIVED BRIDGING ANTICOAGULATION	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
<b><u>DIABETIC PATIENTS:</u></b> MARK NOT APPLICABLE IF THE PATIENT IS NOT DIABETIC:	<input type="checkbox"/> Not Applicable
6. CONFIRM THERE IS A PLAN TO ASSESS GLUCOSE LEVELS	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
<b><u>PATIENTS WITH A PACEMAKER OR IMPLANTABLE CARDIOVERTER DEFIBRILLATOR:</u></b> MARK NOT APPLICABLE IF THE PATIENT DOES NOT HAVE A PACEMAKER OR ICD	<input type="checkbox"/> Not Applicable
7. IF THE PATIENT HAS A PACEMAKER OR ICD, CONFIRM THIS HAS BEEN VERBALIZED WITH THE CARE TEAM	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
8. CONFIRM SEDATION/ANALGESIA PLAN WITH CARE TEAM	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
9. CONFIRM SEDATION/ ANALGESIA PLAN WITH PATIENT	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
10. CONFIRM INFORMED CONSENT	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>

Provider Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Disclaimer: We encourage you to use and benefit from these documents. However, please be aware that this document has been prepared for informational purposes only. The recommendations included in this document are not intended to take the place of the professional skill and judgment of health care providers.



# CHECKLIST 2: PROCEDURE ROOM PRE-PROCEDURAL CHECKLIST

**COMPLETE WITH THE CARE  
TEAM BEFORE SCOPE INSERTION**

Affix patient ID label here

Activity	Please check and sign at the time of completion
1. COMPLETE SECOND VERIFICATION OF PATIENT IDENTIFICATION	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
2. COMPLETE SECOND VERIFICATION OF CORRECT PROCEDURE & INDICATION	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
3. VERBALIZE ANY RELEVANT ALLERGIES, COMORBIDITIES, MEDICATIONS & SIGNIFICANT MEDICAL ISSUES WITH THE CARE TEAM	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>

Provider Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# CHECKLIST 3: RECOVERY AREA POST-PROCEDURAL CHECKLIST

**COMPLETE WITH THE PATIENT/  
SUBSTITUTE DECISION-MAKER/LEGAL  
GUARDIAN IN THE RECOVERY AREA**

Affix patient ID label here

Activity	Please check and sign at the time of completion
1. COMMUNICATE MANAGEMENT PLAN TO PATIENT/SUBSTITUTE DECISION-MAKER/LEGAL GUARDIAN	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>
2. CONFIRM THERE IS A PLAN FOR RESUMING ANTICOAGULATION and/or ANTIPLATELET MEDICATIONS (If applicable)	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/> <input type="checkbox"/> Not Applicable
3. ASSESS DISCHARGE READINESS USING AN OBJECTIVE SCORING SYSTEM (E.G. MODIFIED ALDRETE SCORE OR PADD5)  IF APPLICABLE...PLEASE NOTE BELOW THE REASON(S) FOR NOT ASSESSING DISCHARGE READINESS (e.g., NO SEDATION):	<input type="checkbox"/> <input style="width: 80px; height: 20px;" type="text"/>

Provider Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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# APPENDIX

## APPENDIX 1 ASA Physical Status Classification System

<b><i>Purpose</i></b>	To assess the fitness of patient before selecting the anesthetic or prior to performing surgery
<b><i>ASA Physical Status 1</i></b>	A normal healthy patient
<b><i>ASA Physical Status 2</i></b>	A patient with mild systemic disease
<b><i>ASA Physical Status 3</i></b>	A patient with severe systemic disease
<b><i>ASA Physical Status 4</i></b>	A patient with severe systemic disease that is a constant threat to life
<b><i>ASA Physical Status 5</i></b>	A moribund patient who is not expected to survive without the operation
<b><i>ASA Physical Status 6</i></b>	A declared brain dead patient whose organs are being removed for donor purposes

Source: American Society of Anesthesiologists. Available online: <https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system>.