



*Ambulatory Clinic Policy and Procedure*

Title: <b>PROCEDURE MANAGEMENT AND DOCUMENTATION</b>	Policy Number: <b>EP 3.10</b>
Regulation: Joint Commission, NPSG Reference:	Effective Date: <b>7/2021</b>

**Policy Statement:**

It is the policy of the Texas Tech Physicians of El Paso (TTP-EP) to provide safe and accurate patient care to those patients who are to have procedures in the clinics.

**Scope and Distribution:**

This policy applies and will be distributed to all Texas Tech Physicians of El Paso clinics.

**Procedure:**

Departments shall identify procedures performed in their clinic that expose the patient to more than minimal risk of harm, require site marking, or are of such complexity that a consent is required and universal protocol applies.

1. **Informed consent** must be obtained from patients prior to performing these procedure.
  - a. Consents may be obtained no more than 30 days prior to the procedure.
  - b. Consents should not contain any abbreviations. All verbiage should be spelled out completely.
  - c. Consents must be filled out completely and accurately for every procedure.
2. A basic **pre-procedure clinic visit note** should be on record in the patient’s medical record no more than 30-days prior to a procedure being done. Any elements in addition to the basic elements of a clinic visit note will be left to the judgement of each practitioner prior to the procedure being done.
3. A pre-procedure **process (time out)** by the procedure team must be conducted immediately prior to beginning the procedure to verify the following:
  - a. Correct patient using two identifiers (name and date of birth)
  - b. Correct procedure
  - c. Correct site (the patient is involved in the verification process when possible)
  - d. Relevant documentation is available
  - e. Diagnostic and radiology test results are displayed
  - f. All required equipment is available
  - g. This process must be documented in the medical record.
4. Procedure **site must be marked**. (Sites require marking when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.)
  - a. The site is marked with indelible ink using initials by the practitioner performing the procedure with the patient involved, when possible. Adhesive stickers are not acceptable means of marking the site.
  - b. If a patient refuses the site marking, further education will be provided to the patient including the importance and possible implications of refusing the marking. If the patient continues to refuse the marking, the procedure team will verbalize the site of the procedure and document the refusal in the patient’s medical record.



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5. A **procedure note** must be documented in the patient’s medical record using procedure designated forms to include the following:
  - a. The name of the procedure performed.
  - b. A description of the procedure performed.
  - c. Any findings of the procedure.
  - d. Any estimated blood loss.
  - e. Any specimens removed.
  - f. The post-operative diagnosis (even if the same as the pre-operative diagnosis).
  - g. Any unanticipated events or complications. If no unanticipated events or complications, this should be documented as well.
  
6. The following post-operative information must be documented in the patient’s medical record:
  - a. The patient’s vital signs.
  - b. Any medications administered prior, during, or after the procedure, including IV fluids.

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Signatory approval on file by: Juan Figueroa Director of Clinical Operations Clinic Medical Directors Committee, Chair Texas Tech Physicians of El Paso	
	