UC San Diego Health

Policy Name and or Number:	**Interventional Radiology Intra-Procedural Documentation Guidelines**
Department/Unit:	Interventional Radiology
Effective Date:	2/2025
Revision Date(s):	

POLICY STATEMENT/SCOPE:

Documentation in Electronic Medical Record (EMR) will be initiated on all patients in the intra-procedural areas.

I. RESPONSIBLE PARTY

Interventional Radiology (IR) Intra-procedure Staff

II. PROCEDURES

a. Documentation will be completed in the electronic medical record (EMR).

b. A licensed procedural nurse initiates the documentation.

III. GUIDELINES

a. Patient Identification (ID): Patients will be properly identified using 2-item identification and ID band will be applied. Allergy, limb alert, and fall risk identification(s) will be included with arm band. Patient ID confirmed with pre-procedure nurse.

b. Verify consent: Correct procedure, laterality if applicable, and all signatures present.

c. Verification: Document availability of implants, equipment, and instruments. Verify pre-procedure checklist, consent, and H&P.

d. Primary language: Document if other than English, and the need for an interpreter in EMR.

e. Vital Signs (VS): Initial VS upon entering the room to include heart rate, respiratory rate, blood pressure, pulse oximetry. Pain code and safety to be included in the vital sign documentation. End tidal CO2 and RASS to be included if patient receiving sedation or anesthesia.

i. For non-sedation cases, VS monitoring to be completed Q15 minutes for duration of procedure.
ii. For sedation cases, VS monitoring to be completed Q5 minutes for duration of procedure.
iii. For anesthesia cases, defer to anesthesia provider.

f. Staff: Add appropriate staff with “in” times
g. Delays: Document any delays for procedure.
h. Positioning: Select position of patient and who positioned patient
i. Skin Condition: Select appropriate skin condition for patient
j. Site Prep: Select appropriate skin preparation
k. Orders: Acknowledge orders for patient
l. Timeout: Document timeout, and brief as applicable
m. Procedure Review: Ensure the correct provider and anesthesia types are selected.
n. Intra procedure meds: Document all medications patient received.
o. Central Line Infection Prevention (CLIP) documentation: Document on all patients who had a central line inserted.
p. LDAs: Add or remove any lines, drains, or airways (LDAs) into EMR as appropriate
q. Puncture Site: Document puncture site in EMR.
r. Supplies/Implants: Supplies and implants utilized or implanted during the procedure to be entered into EMR.
   i. Implants will include the lot number and expiration date
   ii. Explanting to also be charted if removing implants
s. Event times: Ensure all accurate event times are documented (in room, out of room, procedure start, procedure end, sedation start, and sedation stop)
   i. See definitions below
t. Nursing note: Enter if applicable
u. Verify: Verify chart when all sections are appropriately documented
v. Staff Handoff/Transport Criteria: Document handoff for any transfer of care within the department. If patient is being transported off unit document transport criteria and ensure you chart the name of the receiving RN.
w. Procedure not performed: Fill out appropriate documentation if procedure is not performed. Enter a separate nursing note with information on why the procedure was not performed.
x. For any angiogram procedure performed: Document time sheath pulled, time of hemostasis, and type of closure device utilized in the EMR.
y. For Stroke patients: Document in IR Neuro & Stroke flowsheet.
   i. Obtain and document initial neuro and neuro vascular assessment
   ii. Complete the Endovascular Therapy section of the IR Neuro & Stroke tab in its entirety as applicable.
z. Obtaining ACT’s: Ensure POC order is placed in manage orders and document ACT value

in the POC flowsheet.

IIII Definitions

Event Time Charting:

a. In Room: Indicates that the patient is in the room or over the threshold in procedure room.
b. Procedure Start: Indicates that the procedure has started. For example, when the initial dose of lidocaine is administered.
c. Procedure End: Alerts post-op team that procedure is complete. For example, this is when hemostasis is achieved and/or dressing in place.
d. Sedation Start: Indicates that sedation has started and charging for sedation begins. This is always your first dose of sedation.
e. Sedation End: Indicates that sedation has ended and charging for sedation ends. This is 30 minutes after the last dose of sedation or when the procedure ended
f. Out of Room: When patient physically leaves the room, as this alerts post-op teams to prepare to receive patient

III. ATTACHMENTS:

None

IV. RESOURCES/REFERENCES

UC San Diego Health System MCP: 320.4 “Medication Preparation, Labeling, and Administration” (7/5/2025)

UC San Diego Health System MCP: 321.3 “Patient Treatment and Medication Orders” (5/24/2024)

Association for Radiologic and Imaging Nursing. 2014. Core Curriculum for Radiologic and Imaging Nursing

American Society of PeriAnesthesia Nurses. 2023-2024 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. ASPAN; 2022

Case Tracking Event Definitions: Case Tracking Events - Definitions 2023.03.pdf (ucsd.edu)

V. APPROVALS

This policy and procedure was approved by:

Name/Department:

Approval Date: UC San Diego IR Exec Committee