UC San Diego Health

Policy Name and or Number:	Interventional Radiology Post Procedure Documentation Guidelines
Department/Unit:	Interventional Radiology
Effective Date:	6/2021
Revision Date(s):	2/2025

GUIDELINE STATEMENT:

1. A licensed Registered Nurse (RN) completes the electronic medical record (EMR).

2. In the Recovery area, post-procedure head to toe assessment is initiated and documented by a Registered Nurse on admission, 30 minutes after admission, with any change in patient status, and within 30 minutes of discharge from Interventional Radiology (IR).

RESPONSIBLE PARTY:

Interventional Radiology RN

GENERAL GUIDELINES:

1. Post-Procedure, the following parameters will be monitored (if sedation received)
    a. Cardiac monitoring (ECG)
    b. Pulse Oximetry
    c. Respiratory rate
    d. Blood pressure
    e. Level of consciousness
        i. For special cases such as neuro interventional cases follow specific doctor's orders
    f. Pain score and assessment is documented with each set of vital signs and after medication administration

2. Manage Orders: Release and acknowledge post-procedural orders.

3. Recovery Staff: Document recovery nurse

4. Allergies: Verify patient allergies

5. DC Scoring: Document appropriate Aldrete Score on admission, 30 minutes after admission, with any change in patient status, and within 30 minutes of discharge from IR.

6. Head to Toe Assessment: Complete a focused assessment

7. Daily Care: Document safe environment and other applicable tabs within the Daily Care flowsheet

8. Lines/Drains: Complete assessment of Lines and Drains and ensure all lines/tubes are charted appropriately

9. Documentation: Document vital signs, which include parameters mentioned above (or per MD orders). Also, document puncture site and neurovascular assessment Q 15 mins x 4 and Q 30 x 2.

    a. Please note if patients receive moderate sedation follow UCSDHP 370.1 per moderate sedation policy.

10. For non-sedation cases monitor vital signs hourly while they remain in the procedural area post procedure

11. Intake and Output: Document as applicable

12. Discharge Criteria: Document upon discharge

13. Transport Criteria: Document upon transfer out of Interventional Radiology department

14. OSA Discharge Assessment: Document on all patients who received sedation

15. Patient Belongings: Document belongings were returned to patient

16. Nursing Note: Document any additional information in the nurse note if needed

17. Resolve Plan: Resolve care plan and document status of identified problems

18. Verify: Verify required documentation is complete

19. Staff Handoff: Document handoff type, who report was given to, and date/time

20. Complete IV Assessment. Document the type of IV fluid hanging when the patient is admitted from the Procedure Room in the medication administration record (MAR).

21. MAR: Ensure that all medications are documented in the MAR as administered and as ordered by the Physician/provider. Any continuous infusions will be totaled in the “I & O” section prior to discharge.

22. Provider Notification/Critical Labs: If any issues have been encountered during the patients stay in the procedural area or if any critical lab values have come back, complete the provider notification tab in the flowsheet.

DEFINITIONS:

In Recovery: Patient status for those who did not receive general anesthesia. Unique status for patients recovering in either PACU or IR Recovery without the use of general anesthesia

Recovery Criteria Complete: Patient is ready to transfer out of recovery (to home or inpatient bed)

REFERENCES:

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

The American Society of Perianesthesia Nurses. (2023-2024) Perianesthesia Nursing Standards. ASPAN publisher

Joint Commission on Accreditation of Hospitals. (2018) Comprehensive Accreditation Manual for Hospitals. "Provision of Care, Treatment, and Services", "Information Management", "National Patient Safety Goals", "Record of Care, Treatment, and Services".

UC San Diego Health MCP 561.2: "Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery/Procedure"

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

APPROVALS:

This policy and procedure was approved by:

Name/Department: Approval Date:

UC San Diego IR Exec Committee 06/2021