|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Minor Procedure**Document in clinical note | **Invasive Procedure WITHOUT Sedation**Focus H&P | **Invasive with MODERATE Sedation**Focus H&P | **Surgery & Major Procedures**Complete H&P |  |
| **H&P Requirements**(Note: The inpatient admission H&P fulfills the H&P requirement for the duration of the patient’s stay. After the admission H&P/update conditions are met by progress notes) | **Minor Procedure:**Any procedure that can be performed in a brief period (usually less than 1 hour) under local anesthesia and under normal circumstances does not constitute a major hazard to life of function of organs or body parts. NO moderate sedation or anesthesia is used. Generally, does not require hospitalization. Examples:* Joint injections
* Abscess drainage
* Suturing of lacerations
* Cervical biopsies
* Fine needle aspiration
* Breast biopsy

**Invasive Procedure WITHOUT Moderate Sedation:**Any procedure that, by its nature, constitutes a significant hazard to life or function of organs or body parts and/or lasts longer than one (1) hour under local anesthesia. Examples:* Thoracentesis
* Paracentesis
* Central line / PIC placement
* Lumbar puncture

**Invasive Procedure WITH Moderate Sedation:**Any procedure that involves the use of MODERATE (conscious) sedation. Also, by its nature, these procedures constitute a significant hazard to life or function of organs or body parts. Examples:* Endoscopy
* Cardiac catheterization
* EP and Interventional Radiology procedures
* Procedures with Moderate sedation such as: thoracentesis, paracentesis, central line / PIC placement

**Surgery and Major Procedures:**Any procedure that involves the delivery of deep sedation or anesthesia and, by its nature, constitutes a significant hazard to life or function or organs or body parts. Examples:* All Operating Room procedures
* All procedures with DEEP sedation in procedural areas
 |
| Chief complaint | X | X | X | X |
| History of present illness | X | X | X | X |
| Current medication(s) | X | X | X | X |
| Drug allergies | X | X | X | X |
| Physical exam | X | X | X | X |
| Assessment | X | X | X | X |
| Plan | X | X | X | X |
| Past medical history |  | X | X | X |
| Past surgical history |  | X | X | X |
| Social history |  |  |  | X |
| Family history |  |  |  | X |
| **Informed Consent** |
| Informed consent (written in medical record/progress note or on consent form | X |  |  |  |
| Informed consent FORM for procedure/surgery |  | X | X | X |
| Informed consent FORM for sedation/anesthesia |  |  | X | X |
| **Pre-Sedation/Pre-Anesthesia Assessment** |
| Past medical history |  |  | X | X |
| Past anesthesia history |  |  | X | X |
| Current medication(s) |  |  | X | X |
| Drug allergies |  |  | X | X |
| Review of relevant systems |  |  | X | X |
| ASA score |  |  | X | X |
| Airway assessment |  |  | X | X |
| Mallampati score |  |  | X | X |
| Sedation/anesthesia plan |  |  | X | X |
| **Immediate Reassessment Prior to Sedation/Anesthesia** |
| Reassess patient immediately prior to sedation/anesthesia. If scrubbed in procedure, may document as first note after procedure by attestation |  |  | X | X |
| **Universal Protocol** |
| All three components of time-out using form designed for procedure type (minor, invasive, surgery) | X | X | X | X |
| **Operative Note Requirements** If unable to complete full OP note prior to transfer to another area or unit, an immediate post-op note may be written (marked with an \*) until the full note can be written. |
| Procedure note may be included as part of progress note or entered separately | X |  |  |  |
| \* LP who performed procedure and assistants |  | X | X | X |
| \* Name of procedure |  | X | X | X |
| Description of procedure |  | X | X | X |
| \* Findings of procedure |  | X | X | X |
| \* Estimated blood loss |  | X | X | X |
| \* Specimens removed |  | X | X | X |
| \* Post op diagnosis |  | X | X | X |
| **Post Anesthesia Assessment** Elements required prior to discharge but no later than 48 hours after surgery |
| Post sedation status documented by nursing – criteria approved by clinical leaders. Includes those listed below: |  |  | X |  |
| * GI status – including nausea/vomiting
 |  |  |  | X |
| * Hydration status
 |  |  |  | X |
| * Mental status
 |  |  |  | X |
| * Pain assessment
 |  |  |  | X |
| * Vital signs including temperature
 |  |  |  | X |
| * Cardiovascular status
 |  |  |  | X |
| * Pulmonary status
 |  |  |  | X |

*\*\* Note: modify above to meet your internal policies \*\**