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Digestive Disease Center

PATIENT SAFETY POLICY & PROCEDURE

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure patient safety, before, during, and after a patient's procedure.

Procedure:

A. All patients will be identified at each patient encounter using two (2) identifiers that include the patient's name & birth date.
B. All caregivers to the patient shall, before & after each patient encounter perform hand hygiene.
C. All providers shall be fully informed of their patient's physical status as it pertains to their surgery/procedure.
D. The surgery/procedure is appropriately performed (correct site/correct procedure) and clinically accurate and the informed consent reflects this.
E. A final "Time Out" verification will be performed before any procedure requiring formal consent.
F. Each patient will have a History & Physical examination documented in their chart within 7 days of their procedure.
G. Each patient will complete the Medical History Questionnaire prior to his or her procedure.
H. All patients will receive a copy of the Patient Rights and Responsibilities at the time of scheduling their procedure.
I. All medical staff are CPR certified, and aware of the location and use of all emergency equipment. All DDC Physicians are ACLS certified.
J. At least one ACLS certified Registered Nurse is staffed when patients are present in the facility, along with ACLS trained CRNA is present with sedated patients.
K. Once a patient has been admitted to the facility, non-sedated patients are visualized frequently to ensure needs are met. Sedated patients are monitored closely checking vital signs with observation to assure patients are free from complications related to the procedure and/or medical problems.
L. All DDC patient facilities are ADA compliant in regard to the accessibility of the buildings, restrooms, and patient care areas. Each facility has at least one ADA compliant gurney reserved for patients with disabilities.
M. Accommodations are made for patients needing language interpreters for their procedure. All accommodations are set up when scheduling the procedure and all pertinent information is relayed to the nursing staff prior to the procedure date.

N. Patient safety checklists shall be employed throughout the patient's stay in the facility. These are documented in the patient's electronic health record.
O. Patients will be educated in post operative self-management, including aftercare concerning diet, activity & wound care.
P. Instructions provided on the use of the medications prescribed for use after the procedure.
Q. Any other pertinent instructions specific to the procedure performed.
R. Any questions initiated by the patient will be answered as completely as possible.
S. Each patient will meet the required discharge criteria set forth by DDC, and anesthesia standard, prior to being discharged. The physician will have the final decision to discharge the patient, which will be documented, signed and become part of the patient's record.
T. A written copy of discharge instructions will be issued to each patient prior to discharge, providing instructions for after care including precautions, resumption &/or use of newly prescribed medications and contact information for post op complications and after hour care. A copy of this document will become part of the patient's record.
U. The facility staff will make a follow up appointment for the patient as ordered by the physician.
V. Each patient will be contacted within 72 hours after having their procedure to ensure that they are not experiencing any complications related to the procedure.
W. The Patient Safety Committee shall meet at least quarterly.

Revised 2/16/2010, 8/30/2011, 2/13/2018, 2/24

References:

1. CDC Guide to infection prevention in outpatient settings: Minimum expectations for safe care.
2. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings