Policy: ADMISSION TO OUTPATIENT OB PROCEDURE

Policy Number: 701-0010

Effective: 04/02/02 **Audit Review: 03/05/15**

POLICY

PURPOSE: **To outline the nursing management and responsibilities of scheduling and processing outpatient obstetrical procedures.**

SUPPORTIVE

DATA: Outpatient procedures to be scheduled include, but not limited to:

- Antepartum testing – NST – CST
- Cervical Ripening
- External versions
- Uterine Activity Monitoring – (UAM), assess for preterm labor
- Assess for rupture of membranes
- Assess for active labor
- Pre-surgical Admission Testing
- Pre Delivery Assessment
- Post discharge Assessment (mother)
- Newborn assessment post discharge

APPOINTMENTS

1. Appointments are scheduled according to the patient need and staff utilization.

2. Orders for the procedures may be obtained at the time the appointment is scheduled.

3. Appointments are recorded in the Daily Schedule Book with the following information included:
   - Patient Name, time & type of procedure,
   - Health Care Provider (HCP),
   - Reason for procedure.
   - If orders were orders given

4. All patients register at the Admitting Desk.

5. If a patient does not keep a scheduled appointment, the HCP will be notified and “NS” for no show is placed in the schedule book.

6. The HCP will be responsible to reschedule the procedure.

7. Follow up procedures will be coordinated by the Perinatal RN.

8. The attending HCP will be notified when the procedure is completed and will be given a verbal report.

9. Forward all charts to the medical records.

10. After any prenatal outpatient visits, the chart is coded and it is returned to the Birthplace for the Prenatal Outpatient File.

UTILIZATION

11. Minimum increment of time allotted for each type of procedure is as follows:

NST	30	minutes
CST	60	minutes
External version	60–90	minutes
Assess ROM	30–60	minutes
Assess Uterine Activity	60	minutes
Assess Active Labor	60–90	minutes
Pre- admit assessment	60	minutes
Post discharge assess	60	minutes

DOCUMENTATION

- Document exceptions, reportable concerns, and patient responses in the medical record.
- Include all communications with the health care provider.
- Document all outpatient procedures in the outpatient log with all care time in minutes of service.
- Document all charges on Charge Sheet and submit to Information Systems (Data)