**ENDOSCOPY CHECKLIST**

It is the responsibility of a qualified practitioner to complete, check and sign this list



BEFORE the patient leaves the ward.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Date:Ward: Consultant: |  | Patient Label: |  | Preferred Name: |

Proposed Procedure:…………………………………………………………………………………………

|  |  |  |
| --- | --- | --- |
| **CHECK LIST** | **WARD CHECK** | **ENDOSCOPY CHECK** |
| Is Patient Diabetic? If yes contact DiabeticTeam for instructions | Yes or No | Yes or No |
| Does the patient have a pacemaker? If yesContact Cardiac Investigation unit for instructions. **(Handover procedure instructions)** | Yes or No …………………………………… …………………………………… ……………............................... | Yes or No |
| Is the Patient on Anticoagulation medication or Clopidogrel? | **Yes** Ring 2804/2161 immediately for instructions**No** | Yes or No |
| ID bands in place x2 and correct | Yes or No | Yes or No |
| Consent Form: appropriate and correct for the patient, labelled, signed andunderstood | Yes or No | Yes or No |
| Intravenous cannula insitu | Yes or No | Yes or No |
| Nil by mouth for 6 hours pre-procedureClear fluids up until 2 hours prior procedure | Yes or NoYes or No | Yes or NoYes or No |
| Allergies (to includefood/latex/medications etc) | Yes\* or Nil Known\*Specify……………………………………………………………..………………………………….. | Yes\* or Nil Known\*Specify……………………………………………………………..………………………………….. |
| For sedation/contrast purposes, anyhistory of: (\*circle if yes) | Asthma or Lung ProblemsAngina or Heart Problems | Asthma or Lung ProblemsAngina or Heart Problems |
| Resuscitation status(circle as appropriate) | For Resus or Not ForResus | Not for Resus status notedand communicated to teamYes |
| Is there any known risk of CJD or vCJDfor public health purposes? | Yes or No | Yes or No |
| Correct Notes and labels with:- Drug ChartIV Fluid ChartFluid Balance Chart Observation Chart or POET print outDiabetic Chart (if applicable)  | Tick √ | Tick √ |
| Theatre Gown | Yes or No | Yes or No |
| Dentures – removedLoose teeth/caps/crowns | Yes No N/AYes No N/A | Yes No N/AYes No N/A |
|  | **Print Name****Ext. No.** | **Print Name****Ext. No.** |

**SEE OVER FOR SPECIFIC PRE-PROCEDURE INSTRUCTIONS.**

**SPECIFIC PRE-PROCEDURE INSTRUCTIONS**

|  |  |  |
| --- | --- | --- |
| **All** patients on **Warfarin** | INR | Yes (Result = ) NoDate: |
| **All** patients with a **PACEMAKER** | Notify cardiac investigation unit ofProcedure & date for any relevantinstructions |  Yes No |
| **All** patients for **ERCP** | INRCiprofloxacin 750mg PO at least 1 hour pre procedure or if NBM Ciprofloxacin 200mg IV stat 1 hour prior procedure. If penicillin allergy refer to General Surgery Antimicrobal Prophylaxis Guidelines  **IV Hydration minimum 1** **Litre Normal Saline in**   **previous 8 hours**  | Yes (Result = ) NoYes NoYes No |
| **All** patients for**Colonoscopy** | Oral bowel preparation and low Residue diet followed | Yes No |
| **All** patients for **Flexible****Sigmoidoscopy** | Phosphate Enema – liaise with Endoscopy team about timing | Yes No |
| **All** patients for **PEG****Insertion** | IV Co-Amoxiclav 1.2g 1 hour pre procedure.**Penicillin allergy**: IV Teicoplanin 400mg. **PATIENT NEEDS MRSA**  **SCREEN WITHIN** **THE LAST MONTH**  | Yes No Result:  Date: |
| **Bleeding varices** orpatients **having variceal banding** | IV Tazocin 4.5g TDS or Co-amoxiclav 1.2g TDS. **Penicillin allergy:** Consider 3rd generation  cephalosporin or liaise with Microbiology. **(If not started to be**  **commenced by**  **Endoscopist in** **Endoscopy)**  | Yes No |

 **POST PROCEDURE**

 Post procedure information/care guidelines to be handed over to ward staff:

|  |  |
| --- | --- |
| **Qualified Practitioner handing over** | **Print Name****Ext. No.** |
| **Qualified Practitioner receiving patient** | **Print Name****Ext.No** |