Nephrostomy/ Ureteric Stent Insertion

Care

 Pathway

Patient Information:

Date of Referral:

Consultant:

|  |  |  |
| --- | --- | --- |
| **Contact Number:**  | Home: | Mobile:  |
| Religious beliefs/practices: |  |
| Communication/Language:  |  |
| **Next of Kin:** | Name:  | Relationship: | Contact: |
| **Allergies:**  |  |
| **Infection control alerts:** |  |

Pre-assessment and Appointment Booking by

IR-Nurse

Name of Nurse filling out form: Date:

|  |
| --- |
| Confirm Medication: Instructed to bring medication on day of admission: Y/NSelf-medication form signed and attached to this document: Y/N |
| **Is patient on Anticoagulation and/or anti-platelet therapy? Y/N****CAN THIS BE SAFELY STOPPED BEFORE PROCEDURE? Y/N**Please refer to trust guidelines on Microguide: <https://viewer.microguide.global/guide/1000000295#content,87c8200f-f90b-4c09-86bc-926c015369c8> Type: Why is it prescribed: Date/time last taken: Date stopped:  |

Confirmed patient understands procedure and wants to proceed Y/N

|  |
| --- |
| Confirm Past Medical History:  |
| Diabetic: Y/N Type: Insulin dependent: Y/N*Advise patient discusses diabetic medication with their diabetic nurse.*  |

Confirm Bloods required:

FBC Y/N INR Y/N

UEC Y/N

**If patient requires overnight bed**

Patient informed of admission Y/N

Patient date confirmed for MRSA swab …………………………………………………………………… Y/N

Chilmark informed (patient ID, procedure required, procedure date, MRSA info, referral info, abx) Y/N

Signed: Dated:

# Pre-Procedure Check List

Admitting nurse:

|  |  |  |  |
| --- | --- | --- | --- |
| **Check list** | **Tick** | **Initial** | **Comments** |
| Admit and orientate the patient to the ward |  |  |  |
| Confirm patient ID  |  |  |  |
| ID and Allergy Band  |  |  |  |
| Check next of kin details are correct |  |  |  |
| Bloods: Hb: Platelets: INR: APTT:Sodium:Potassium: Urea: Creatinine: eGFR:  |  |  |  |
| Last ate: Last drank: |  |  |  |
| Antibiotics given: Gentamicin IV as prescribed by urology team  |  |  |  |
| If Diabetic then take blood sugar: BM: …… |  |  |  |
| Cannula inserted: only if patient requiring sedationSize: Position: Number of attempts: ANTT technique used: Successful saline flush:  |  |  |  |
| Completed baseline observations  |  |  |  |
| In gown  |  |  |  |
|  Anticoagulation or antiplatelet medication has been discussed and stopped.Date stopped:  |  |  |  |
| Patient consented by IR consultant:  |  |  |  |
| Ensure notes and prescription chartsaccompany the patient |  |  |  |

Signed: Dated:

# Procedure

RADIOLOGIST:

PROCEDURE:

SITE:

IR Procedure Note/Report:

**Complications:**

 Pain Y/N

 Haemorrhage Y/N

Sample and microbiology form correctly labelled: Y/N

**Time in Radiology before return to ward: ……………….**

When to restart anti-coagulation:

Signed by radiologist: Date Time

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Amount | Route | Time | Prescribed by:  |
| Lidocaine 1% |  | SC |  |  |
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| **DATE AND TIME** | **Multidisciplinary notes and evaluations** | **Signature/print Profession/ bleep/number** |
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In Patient Post Procedure

Patient into recovery at:

Ensure call bell to hand Y/N

District Nurse Referral Y/N

|  |  |
| --- | --- |
| Care Guidelines:  | Rationale: |
| Observations to be taken: blood pressure, pulse, temp, resp rate, O2 sats and wound check (see chart below)every 15 minutes for hour 0-2 (2 hour) @every 30 minutes for hours 2-4 (2 hours) @Observations should then continue as per ward care plan. **Follow NEWS 2 (trust policy) and escalate when triggers NEWS score.** ***If there are signs or symptoms of blood loss, hemodynamic instability or sepsis, keep NBM and contact IR Dr who performed the procedure AND a senior member of the responsible clinical team.*** Monitor and record volume drained on fluid balance chart. Observe for hematuria, report to Clinical Team  | Detection of post-procedure complications that may require urgent intervention (bleeding, over-sedation, sepsis)As instructed by Clinical team/Senior sisterTo monitor effectiveness of drain/stent Early detection of complications e.g. bleeding  |
| Observe for rashes, wheezing, and shock. Call for help immediately if detected. This may require the Crash Team (2222) if the patient is having a severe reaction.  | Early detection of contrast or adverse drug reaction. More likely to occur peri- or immediately post procedure but can be delayed.  |
| Patient may have: Clear fluids 1 hours post insertionLight meal 2 hours post insertionEat and drink normally at 6 hours post insertion  | Precautionary in case of post procedure complications requiring radiology intervention/surgery. |
| Patient to remain on bed rest for 4 hours post insertion | To reduce risk of bleeding  |
| Do not change dressings around drain sites, they should be reinforced only. If drainage catheter leaks or appears blocked inform the Clinical Team who may wish to contact Radiology for further advice.  | To avoid dislodging or removing catheter and therefore avoiding damage to kidney or need for further procedure.  |

**At each observation check, drain check must also be completed.**

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| **Time:**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Drain:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Key:** | **Dry = D** | **Ooze = O** |  | **No Change = NC** | **Leaking = L** |  |  |  |  |  |  |  |  |

**Handover given to ward member responsible for patient: Y/N**

**Ward Staff Name/Sig: …………………………IR Nurse Name/Sig: ……………………………….**