PTC

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:

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 Medication: Instructed to bring medication on day of admission: Y/NSelf-medication form signed and attached to this document: Y/N If no, referring consultant has provide completed prescription chart Y/N |
| **Is patient on Anticoagulation and 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:  |

Confirm Bloods required: patient to come into pathology at least 2 days before appointment, if on blood thinners, patient requires INR within 24 hours.

FBC Y/N INR Y/N

UEC Y/N

Patient requires:

Nil By Mouth for 6HRS prior to procedure Y/N

Clear Fluids only until 2 hours prior to procedure Y/N

Transport discussed:

Own Transport Y/N

Hospital Transport Y/N

Booking details for hospital transport:

Responsible adult to collect and accompany patient for 24hrs Y/N

**Informed of restrictions post procedure**

no driving for 48 hours Y/N

avoid contact sports, heavy lifting or strenuous exercise including sexual intercourse for 2 weeks Y/N

Signed: Dated:

**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: Date: Hb: Platelets: INR: APTT:Sodium:Potassium: Urea: Creatinine: eGFR:  |  |  |  |
| NBM mouth 6 hours before procedure: Last ate: CF until 2 hours before procecure: Last drank: |  |  |  |
| Medication prep by ward: IV hydration: 1L over 8 hours Antibiotics: 1hr before procedure PO ciprofloxacin 750mg**OR**IV ciprofloxacin 200mg  |  |  |  |
| If Diabetic then take blood sugar: BM: …… |  |  |  |
| Cannula available:  |  |  |  |
| Completed baseline observations  |  |  |  |
| In gown  |  |  |  |
|  Anticoagulation or antiplatelet medication has been discussed and stopped.Date stopped:  |  |  |  |
| 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 / NA

**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

|  |  |
| --- | --- |
| 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) @*patient to be returned to ward after 2 hours* 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. | 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  |
| 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 6 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: ……………………………….**