**Chest drain audit tool**

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| **Ward:** |  | **Date:** |  |
|  |
| **Audit Indicator** | **Pass** | **Fail** | **N/A**  |
| A *chest drain insertion sticker was completed and placed* in the patient's notes |  |  |  |
| Following insertion observations were recorded:* every 15 minutes for the first hour
* hourly for 3 hours
* 4 hourly until removal
 |  |  |  |
| A *Chest Drain Observation Chart* was used and fully completed  |  |  |  |
| The member of staff completing the *Chest Drain Observation Chart* had received training |  |  |  |
| The member of staff caring for the patient had an understanding of the Trust policy  |  |  |  |
| Analgesia was prescribed by the medical team  |  |  |  |
| A pain assessment was carried out and acted upon by the nursing staff  |  |  |  |
| Following removal observations were recorded:* every 15 minutes for the first hour
* hourly for 3 hours
* 4 hourly until removal
 |  |  |  |
| The patient had received a copy of the [patient information leaflet](http://icid/ClinicalManagement/Respiratory/Pages/ChestDrainPI0338.aspx) (ICID) and were aware of: * Maintaining the drainage bottle below chest level
* keeping the tubing straight
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**Comments:**