**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 Diabetic  Team for instructions | Yes or No | Yes or No |
| Does the patient have a pacemaker? If yes  Contact 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 and  understood | Yes or No | Yes or No |
| Intravenous cannula insitu | Yes or No | Yes or No |
| Nil by mouth for 6 hours pre-procedure  Clear fluids up until 2 hours prior procedure | Yes or No  Yes or No | Yes or No  Yes or No |
| Allergies (to include  food/latex/medications etc) | Yes\* or Nil Known  \*Specify…………………………  …………………………………..  ………………………………….. | Yes\* or Nil Known  \*Specify…………………………  …………………………………..  ………………………………….. |
| For sedation/contrast purposes, any  history of: (\*circle if yes) | Asthma or Lung Problems  Angina or Heart Problems | Asthma or Lung Problems  Angina or Heart Problems |
| Resuscitation status  (circle as appropriate) | For Resus or Not For  Resus | Not for Resus status noted  and communicated to team  Yes |
| Is there any known risk of CJD or vCJD  for public health purposes? | Yes or No | Yes or No |
| Correct Notes and labels with:- Drug Chart  IV Fluid Chart  Fluid Balance Chart Observation Chart or POET print out  Diabetic Chart (if applicable) | Tick √ | Tick √ |
| Theatre Gown | Yes or No | Yes or No |
| Dentures – removed  Loose teeth/caps/crowns | Yes No N/A  Yes No N/A | Yes No N/A  Yes 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 = ) No  Date: |
| **All** patients with a **PACEMAKER** | Notify cardiac investigation unit of  Procedure & date for any relevant  instructions | Yes No |
| **All** patients for **ERCP** | INR  Ciprofloxacin 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 = ) No  Yes No  Yes 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** |