**IN PATIENT**

CARE PATHWAY FOR

**ENDOSCOPY UNIT PROCEDURES**

**GI BLEED OGD COLON FLEXI SIG**

**PEG ERCP COLONIC STENT FOOD BOLUS**

REFERRED BY:

Date of procedure:

INDICATIONS FOR INVESTIGATIONS:

NAME:

HOSPITAL NUMBER:

CONSULTANT:

This is the official patient care record where all professionals involved in this patient care need to document any intervention carried out.

It is essential that timings e.g. discharge times are clearly recorded.

If there is a deviation from the care planned then this must be documented on the communication sheet

**ENDOSCOPY CHECKLIST**

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

BEFORE the patient leaves the ward. If yes to any questions with a \* please contact endoscopy on 2804

Proposed Procedure: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Resuscitation status . . . . . . . . . . . . . . . . . .

|  |  |  |
| --- | --- | --- |
| Following questions should be answered Yes, No or N/A | Ward Check | Endoscopy Check |
| Is the patient being barrier nursed ? \*  Reason if yes . . . . . . . . . . . . . . . . . . . . . . . . . . . . | YES NO N/A | YES NO N/A |
| Does the Patient have any allergies?  Please State . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | YES NO N/A | YES NO N/A |
| Does the patient have diabetes?  If yes indicate treatment: Insulin ⬜ Tablets ⬜ Diet ⬜ | YES NO N/A | YES NO N/A |
| Does the patient suffer from epilepsy? | YES NO N/A | YES NO N/A |
| Does the patient have any Cardiac problems, Heart Disease, Angina | YES NO N/A | YES NO N/A |
| Does the patient have a pacemaker/ICD ? If yes \*  Contact Cardiac Investigation unit for instructions. (Handover procedure instructions) | YES NO N/A | YES NO N/A |
| Is the Patient on Anticoagulation medication or Clopidogrel? \*  If yes what . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  If Yes ring 2804/2161 for advise | YES NO N/A  Most recent INR . . . . . .  Date . . . . . . . . . . . | YES NO N/A |
| Does the patient have any neck or spinal problems? | YES NO N/A | YES NO N/A |
| Does the patient have Glaucoma? | YES NO N/A | YES NO N/A |
| Does the patient have any joint prosthesis:  Site: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | YES NO N/A | YES NO N/A |
| ID bands in place x2 and correct | YES NO N/A | YES NO N/A |
| Nil by mouth for 6 hours pre-procedure  Clear fluids up until 2 hours prior procedure  If on feed, has the feed been stopped for the last 6 hours? | YES NO N/A | YES NO N/A |
| Has patient had bowel preparation?  Enema / Klean prep / picolax / nothing | YES NO N/A | YES NO N/A |
| Intravenous cannula insitu?  Pink or grey if GI bleed  Right hand/arm if ERCP | YES NO N/A | YES NO N/A |
| Is the patient able to consent?  If no please ensure referring Dr has completed consent 4 | YES NO N/A | YES NO N/A |
| Does the patient have any asthma or lung problems?  If yes what: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | YES NO N/A | YES NO N/A |
| Has the patient ever been notified that they are at risk of CJD or \* vCJD for public health purposes? | YES NO N/A | YES NO N/A |
| Does the patient wear glasses or contact lenses? | YES NO N/A | YES NO N/A |
| Does the patient have dentures in situ? | YES NO N/A | YES NO N/A |
| Is the patient wearing hearing aids | YES NO N/A | YES NO N/A |
| Theatre gown | YES NO N/A | YES NO N/A |
| Have prophylactic antibiotics been given  PEG / ERCP / Variceal banding | YES NO N/A | YES NO N/A |
| Signatures | . . . . . . . . . . . . . . . . . . . . | . . . . . . . . . . . . . . . . . . . . |

**SPECIFIC PRE-PROCEDURE INSTRUCTIONS**

|  |  |  |
| --- | --- | --- |
| **ALL patients**  Correct Medical Notes and labels with:-  Drug Chart  IV Fluid Chart  Fluid Balance Chart  Observation Chart or POET print  Diabetic Chart (if applicable**)** | Yes No  ⬜ ⬜  ⬜ ⬜  ⬜ ⬜  ⬜ ⬜  ⬜ ⬜  ⬜ ⬜ |  |
| **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** | Patient NBM 6 hours.  INR check within 24 hrs of the procedure.  INR level ≤ 1.3 (discuss with principle endoscopist if outside this window)  Platelet level ≥ 80 (discuss with principle  endoscopist if outside this window)  Antiplatelet agents withheld 5 days prior to procedure.  DOAC withheld ≥ 48 hrs before procedure (Dabigatran with eGFR 30-50 🡪 withheld  ≥ 72 hrs before procedure),  Warfarin to be stopped 5 days before  procedure, aiming for INR ≤ 1.3. Consider administration of Vitamin K to achieve  required INR.  Covid test as per latest trust guidelines  Explanation of procedure (1st stage consent process)  Ciprofloxacin 750mg PO at least 1 hour prior to the procedure  Ciprofloxacin 400mg IV stat 1 hour prior to the procedure  If penicillin allergy refer to general surgery antimicrobial prophylaxis guidelines  IV hydration minimum 1 ltr Normal saline in previous 8 hours (if no clinical contra indications)   1. **On the day**  * Establish ratio of male and female patients * Inform Endoscopy Coordinator the required amount of patients that will need transferring to Endoscopy post ERCP/stent. This needs to be the smallest denominator. * Nursing staff will prepare the ERCP procedure room and Patient at 08:00 for a 09:00 start.   **Pre-Procedure**   * All out-patients will report to the Ultrasound reception desk. * Out-patients/in-patients will be made ready by the Endoscopy admission/recovery nurse, utilising the Endoscopy checklist once Pre procedure checks have been completed, within the admission cubicle * Patients will be asked to change into a gown, cannulated and wait on a trolley to be consented * PR diclofenac may be given at this point along with IV Ciprofloxacin 400mg stat * Dr to consent Patient before entering the procedure room. * Once consented will be wheeled through on the trolley to the procedure room or walk if able.   **Post procedure:**   * Patients will require PR Diclofenac suppository either pre , peri or post ERCP procedure * IV Fluids may be prescribed post procedure * Highest gender denominator of patients to be recovered in radiology recovery therefore transferred from room 7 to recovery. * Lowest gender denominator of patients to be transferred to endoscopy for recovery on a trolley via the endoscopy inpatient entrance. Room 7 to Endoscopy recovery. * Full hand over to be given to receiving recovery nurse. * If the recovery nurse has any concerns during the recovery process, the recovery nurse will contact the principal Endoscopist for advice and review of the patient. It is the responsibility of the Endoscopist to assess their patient.  1. **Managing flow of the lists**   Consultants will be responsible for ensuring that ALL in-patients are pre-consented on the ward before the date/time of their appointment. They will ensure out-patients are consented in a timely manner and when requested.  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 ⬜ No ⬜  Yes ⬜ No ⬜  Yes ⬜ No ⬜  Yes □ No □  Yes □ No □  Yes □ No □  Yes □ No □  Yes □ 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 ⬜ |

**Entonox Checklist (for all lower procedures)**

Has the patient suffered any of the following within the last 12 weeks?

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Pneumothorax |  |  |
| Air Embolism |  |  |
| Emphysema / COPD |  |  |
| Bowel Obstruction |  |  |
| Recent ear / eye surgery |  |  |
| Decompression Sickness |  |  |

Do any of the following apply to the patients:

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Scuba diving within the last 48 hours |  |  |
| Appears Intoxicated |  |  |
| Taking Methotrexate |  |  |
| Within the first 12 weeks of pregnancy |  |  |
| Head injury with impaired GRS |  |  |
| Maxillofacial injuries |  |  |

If the answer is ‘yes’ to any of the above Entonox is NOT appropriate

The use of Entonox gas has been explained to me. None of the above applies to me, and I would like to have the option to use Entonox for pain relief if required.

Patients Signature: …………………………………………… Print: …………………………………….

Admitting Nurse Signature:………………………………………………….. Band :………………

Print ………………………………………………..

OBSERVATIONS on admission: BP………….. SATS ………% HR……….. RESPS…………

|  |  |
| --- | --- |
| ***Sign in*** | |
| Team introduction | **(tick)** |
| Patient to confirm name, DOB | **(tick)** |
| Check name, DOB & hospital number on wristband | **(tick)** |
| Patient to confirm procedure expected, if able | **(tick)** |
| Consent form signed & patient confirm signature, if able | **(tick)** |
| Adequately fasted for procedure | **Y N** |
| Resuscitation status | **DNAR / For Resus** |
| Metal work/pacemaker/prosthesis/body piercing/dentures/contact lenses | **Y N** |
| Allergies to food or medication (not hay fever) | **Y N** |
| Anticoagulants name & date stopped if applicable |  |
| Any blood born infections (vCJD/HEPC/HIV etc.) | **Y N** |
| IV drug ampules checked | **Y N N/A** |
| Monitoring (IV access/O2 etc.) | **(tick)** |
| Confirm correct scope & equipment ready | **(tick)** |
| Right Scope tickets for right scope | **(tick)** |
| Right name on stack & endoscopy report | **(tick)** |
| Signature: | Date: |

|  |  |
| --- | --- |
| **Sign out** | |
| Comfort score agreed (For ALL procedures) | **Y N** |
| Samples and Histology forms checked and labelled | **Y N/A** |
| **Remind Endoscopists to post process reports** | **Y N** |
| CD Book signed | **Y N/A** |
| Medication chart signed | **Y N/A** |
| Post procedural care/pt specific concerns (detail in part 5) | **Y N** |
| Equipment Issues identified that need to be addressed/escalated | **Y N** |
| Signature: | Date: |

|  |  |
| --- | --- |
| **RECOVERY HANDOVER** | |
| Patient name, procedure, meds, post procedure care, patient concerns handed over | **Y N** |
| Name of person taking handover: | |
| Signature: Time & date: | |

**RECORD OF TREATMENTS PERFORMED / SPECIMENS COLLECTED**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | **Upper** | **Lower** | **ERCP** | **Site** |
| Clo Tests |  |  |  |  |  |  |
| Biopsies |  |  |  |  |  |  |
| Hot Biopsies |  |  |  |  |  |  |
| APC |  |  |  |  |  |  |
| Polypectomy |  |  |  |  |  |  |
| Poly Retrieved |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

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| **Before leaving the room- Agreed combined comfort score** | **1= none 2= minimal 3= mild 4= moderate 5= severe (circle which)** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **THERAPEUTICS** | Size | Yes | No | **Upper** | **Lower** | **ERCP** | **Site** |
| Balloon/Bougie Dilatation |  |  |  |  |  |  |  |
| Lifting solution  Indigo Carmine/ Gelofusin/Adrenaline 1:10,000 |  |  |  |  |  |  |  |
| Spot tattoo |  |  |  |  |  |  |  |
| Banding Varices |  |  |  |  |  |  |  |
| Clips |  |  |  |  |  |  |  |
| Banding Haemorrhoids |  |  |  |  |  |  |  |
| Gold probe |  |  |  |  |  |  |  |
| PEG |  |  |  |  |  |  |  |
| Stent |  |  |  |  |  |  |  |

**Procedure room nurse**

**Signature ……………………………………………… Print ………………………………………**

|  |  |
| --- | --- |
| Scope Number | Sterility of scope (proof attached) |
| Scope socially cleaned by: | Time socially cleaned: |

**ADDITIONAL INFORMATION**

**-Please use this page to attach all of the following:**

**Disposable items e.g. biopsy forceps, snares, injection needles etc.**

**Part 5 – Additional Nursing/Clinical Notes/further comments**

**POST PROCEDURE**

|  |  |
| --- | --- |
| **Practitioner handing over (print name)** | **. . . . . . . . . . . . . . . . . . . . . . . . . . . . . .** |
| **Practitioner receiving patient (print name)** | **. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .** |