PleurX

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/N  Self-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

**Ring Access-To-Care for a community referral Y/N**

Wiltshire use access-to-care @ Medvivo number is: 0300 111 5818 option 3

Dorset use access-to-care @ Dorset Health Care number is: 0300 033 4000

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:  Hb:  Platelets:  INR:  APTT:  Sodium:  Potassium:  Urea:  Creatinine:  eGFR: |  |  |  |
| Last ate:  Last drank: |  |  |  |
| If Diabetic then take blood sugar:  BM: …… |  |  |  |
| Cannula inserted:  Size:  Position:  Number of attempts: |  |  |  |
| 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 charts  accompany the patient |  |  |  |
| Secure Patients own medication for admission period. |  |  |  |

Signed: Dated:

# Procedure

RADIOLOGIST:

PROCEDURE:

SITE:

IR Procedure Note/Report:

**Complications:**

Pain Y/N

Haemorrhage Y/N

Sample and histology request correctly labelled: Y/N

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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Out Patient Post procedure

Patient into recovery at:

Ensure call bell to hand Y/N

|  |  |
| --- | --- |
| Care Guidelines: | Rationale: |
| Recovery time required:  Monitor and record blood pressure, pulse, temperature, respiration rate, oxygen saturation and puncture site every 15 minutes for the recovery time advised by the Radiologist.  Unless otherwise directed. Observations should then continue as per ward care plan.  ***If there are signs or symptoms of blood loss, hemodynamic instability or new discomfort/pain contact the radiologist who performed the procedure if the patient is still in radiology. If they are no available, contact the on call medical registrar. If the patient is back on the ward contact a senior member of the responsible clinical team. If signs of hemorrhage keep NMB.***  **Follow NEWS 2 (trust policy) and escalate when triggers NEWS score.** | Quick response to emergency call/review if indicated  Detection of post-procedure complications that may require urgent intervention.  As instructed by Clinical team/Senior sister |
| Patient is required to be nil by mouth for 1hr following the drainage, they then can have clear fluid for a further hour. After this they can eat and drink as normal. | Precautionary in case of post procedure complications requiring radiology intervention/surgery. |

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

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

**Follow Radiologists direction if this deviates from above.**

Signed: Dated:

Pre-Discharge Checklist

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Circle** | **Initial** | **Comment** |
| Is the patient alert and orientated | Y/N |  |  |
| Vital signs stable | Y/N |  |  |
| Patient has mobilised post procedure | Y/N |  |  |
| Wound check, safe for discharge | Y/N |  |  |
| Pain controlled/ free | Y/N |  |  |
| Remove cannula | Y/N |  | VIP score: |
| If appropriate; when to restart medication | Y/N |  |  |
| Valuables returned to the patient if applicable | Y/N |  |  |
| Patients own medication returned if applicable | Y/N |  |  |
| Patient information leaflet given to patient | Y/N |  |  |
| Patient collected by adult, to be accompanied for 24 hrs | Y/N |  |  |
| Please complete: community training request form | Y/N |  |  |
| Please complete district nurse referral | Y/N |  |  |

Discharged Y/N

Signed: Date:

In Patient Post procedure

Patient into recovery at:

Ensure call bell to hand Y/N

|  |  |
| --- | --- |
| Care Guidelines: | Rationale: |
| Recovery time:  Monitor and record blood pressure, pulse, temperature, respiration rate, oxygen saturation and puncture site every 15 minutes for the recovery time advised by the Radiologist.  Unless otherwise directed. Observations should then continue as per ward care plan.  ***If there are signs or symptoms of blood loss, hemodynamic instability or new discomfort/pain contact the radiologist who performed the procedure if the patient is still in radiology. If they are no available, contact the on call medical registrar. If the patient is back on the ward contact a senior member of the responsible clinical team. If signs of hemorrhage keep NMB.***  **Follow NEWS 2 (trust policy) and escalate when triggers NEWS score.** | Quick response to emergency call/review if indicated  Detection of post-procedure complications that may require urgent intervention. 61% of complications arise <2 hours, almost all significant bleeding happens in the first 6 hours.  As instructed by Clinical team/Senior sister |
| Patient is required to be nil by mouth for 1hr following the drainage, they then can have clear fluid for a further hour. After this they can eat and drink as normal. | Precautionary in case of post procedure complications requiring radiology intervention/surgery. |

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

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

**Follow Radiologists direction if this deviates from above.**

Signed: Dated:

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

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