|  |  |  |  |
| --- | --- | --- | --- |
| Bookings check list | | | |
| Appointment | Date: | Time: | Ward admission: |
| □ CRIS  □ Outlook diary  □ Bookings list  □ Letter  □ PIL  □ Bloods/forms/MRSA swab  □ site team and wards emailed | | | |

Radiologically Inserted Gastrostomy (RIG)

Care

Pathway

**(outpatient route)**

Patient Information:

Date of Referral:

Consultant:

Managing Team:

|  |  |  |  |
| --- | --- | --- | --- |
| **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 G&S Y/N

INR and APTTR must be <1.5

Platelets must be > 50 x 109/L

Inform consultant interventional radiologist if

INR/APTTR >1.5 or

PLATELETS <50 x 109/L or any other concerns.

Patient requires:

Stop diet 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:

**Patient requires overnight bed**

Patient informed of admission Y/N

Downton/Chilmark informed by email (patient ID, procedure required, procedure date, diagnosis,

Managing/referring team, named consultant, antibiotic requirement, NG tube insertion, whether

contrast is required pre-procedure) Y/N

Chilmark admissions require a negative MRSA, arrange for 72 hours prior to admission Y/N

|  |  |
| --- | --- |
| **Downton Ward**  [sft.clinical.siteteam@nhs.net](mailto:sft.clinical.siteteam@nhs.net)  [donna.arnold2@nhs.net](mailto:donna.arnold2@nhs.net)  [beth.hernandez@nhs.net](mailto:beth.hernandez@nhs.net)  [gemma.crowther@nhs.net](mailto:gemma.crowther@nhs.net)  [raechel.george@nhs.net](mailto:raechel.george@nhs.net)  [e.hassanzadeh@nhs.net](mailto:e.hassanzadeh@nhs.net) | **Chilmark Ward**  [sft.clinical.siteteam@nhs.net](mailto:sft.clinical.siteteam@nhs.net)  [lisa.clarkson3@nhs.net](mailto:lisa.clarkson3@nhs.net)  [gloria.ngoma@nhs.net](mailto:gloria.ngoma@nhs.net)  [e.ceniza@nhs.net](mailto:e.ceniza@nhs.net)  [laura.draper3@nhs.net](mailto:laura.draper3@nhs.net)  [kate.cleverley@nhs.net](mailto:kate.cleverley@nhs.net) |

Signed: Dated:

**WARD ADMISSION**

**Planned date and time of admission**

**Date: Time:**

**REFERRING TEAM:**

|  |  |  |
| --- | --- | --- |
| Checklist | | |
| Task | Signed | Print name |
| If contrast is requested by IR consultant - give omnipaque 300, 100mls **orally** or via NG tube 12 hours pre-procedure |  |  |
| Confirm NBM  No food 6 hrs prior to admission □  Clear fluid 2 hours before procedure □ |  |  |
| Cannulate patient  Cannula size …….  Position………  No. of attempts ……  Flushed with NaCl □ |  |  |
| Bloods:  FBC □  INR □  UEC □ |  |  |
| Insertion of fine bore NG tube at bedside **as agreed by**  **Referring team**  (Contact managing team if any issues or concerns for assistance) |  |  |
| Contact Radiology X 2857/4830 to confirm time of procedure |  |  |
| Confirm antibiotics prescribed |  |  |
| Cefuroxime 750mg IV given 1 hour prior to procedure |  |  |
| Capacity to consent  If consent 4 required, to be completed by ward doctor |  |  |

# 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: |  |  |  |
| NBM mouth 6 hours before procedure:  Last ate:  CF until 2 hours before procedure:  Last drank: |  |  |  |
| Contrast given 12 hours pre-procedure if directed |  |  |  |
| Antibiotics given: Cefuroxime 750mg |  |  |  |
| NG tube inserted |  |  |  |
| If Diabetic then take blood sugar:  BM: …… |  |  |  |
| Cannula insitu and patent: |  |  |  |
| Completed baseline observations |  |  |  |
| In gown |  |  |  |
| Anticoagulation or antiplatelet medication has been discussed and stopped.  Date stopped: |  |  |  |
| Procedural Sedation and Analgesia (PSA) pathway insert completed (as required) |  |  |  |
| Patient consented by IR consultant  Or consent 4 available |  |  |  |
| Ensure notes and EPMA record  accompany the patient |  |  |  |

Signed: Dated:

# Procedure:

RADIOLOGIST:

PROCEDURE:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Drug** | **Amount** | | | | | **Time given** | **Route** | **Prescribed by** | **Given by** |
| **LIDOCAINE 1%** |  | | | | |  | **SC** |  |  |
| **HYOSINE BUTYLBROMIDE mg** |  | | | | |  | **IV** |  |  |
|  | **Amount/time given** | | | | | **Total** | **Route** | **Prescribed by** | **Given by/checked** |
| **FENTANYL mcg** |  |  |  |  |  |  | **IV** |  |  |
| **MIDAZOLAM mg** |  |  |  |  |  |  | **IV** |  |  |

IR Procedure Note/Report:

Bumper measurement ……….cm

**Complications:**

Pain Y/N

Haemorrhage Y/N

Post procedure directions

NG tube to be removed post procedure Y/N

NG tube to be removed on ward at …………….

Commence trial oral fluid at 6 hours (if drinking pre-procedure) Y/N

Then commence pre-procedural diet if tolerated Y/N

Restart anticoagulation in 24 hours if no bleeding complications Y/N N/A

For 1-hour recovery in radiology prior to return to wards Y/N

RIG tube feeding to commence as per dietitian direction day after procedure Y/N

Signed by radiologist: Date Time

|  |  |  |
| --- | --- | --- |
| **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 2 hours @  Patient to be returned to ward if no further complications  every 30 minutes for 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.*** | Detection of post-procedure complications that may require urgent intervention (bleeding, over-sedation, sepsis)  As instructed by Clinical team/Senior sister |
| 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. |
| Instructions for use of RIG tube to be indicated by Dietitian.  The RIG should not be used until the following day.  Ensure the patient has been prescribed IV hydration.  If the patient is able to eat and drink orally, they can trial oral fluid 6 hours post procedure (unless directed otherwise by IR consultant) then progress to diet. | Precautionary in case of post procedure complications requiring radiology intervention/surgery.  To maintain hydration |
| Do not change dressings around insertion sites, they should be reinforced only. The dressing will be changed by the dietitian prior to discharge.  If RIG leaks or appears blocked inform the Clinical Team who may wish to contact Radiology for further advice. | To avoid dislodging gastrostomy tube  To confirm placement and patency |
| The dietitian will visit the ward first thing in the morning to teach the patient how to use the RIG and start a feeding plan.  Please ring X 4333 if a dietitian has not visited by 10:30 am.  Patient can be discharged home once seen by dietitian if no complications. | To provide patient education on RIG care and management |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Time:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **RIG site:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **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: ……………………………….**