

INTERVENTIONAL RADIOLOGY CARE PATHWAY

Patient's Name:			Referring consultant:		
Unit Number:			Ward:		
Date of Birth:			Name of procedure:		
Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/>					
Preparation instructions recorded on HIS <input type="checkbox"/>			Emergency contact: Contact number:		
Ward contacted to confirm procedure <input type="checkbox"/>					
Preoperative assessment needed	Yes	No			
Preoperative assessment booked	Yes	N/A			

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	Requirement	1 st Check	2 nd check	Comments
1	Patient ID wristband Hospital gown IV access Patient fasted for minimum 6 hours Blood results available	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
2	Anticoagulation stopped: DOAC to be stopped for 48hrs. Warfarin to be stopped for 5 days. Dalteparin/Enoxaparin to be stopped for 24 hours.	Yes No N/A	Yes No N/A	
3	Antiplatelets stopped: Stop for 7 days except angioplasty (see below) For angioplasty only: Aspirin or Clopidogrel only – continue. Aspirin and Clopidogrel – stop Clopidogrel for 7 days	Yes No N/A Yes No N/A	Yes No N/A Yes No N/A	
4	Patient has capacity to consent: If NO, consent form 4 should be completed on ward	Yes No	Yes No	
5	Past medical history: Record specific details in comments box. Diabetes Renal/kidney conditions Asthma COPD Other respiratory conditions including sleep apnoea. Epilepsy Glaucoma Heart disease (MI) Angina Pacemaker Hyper/hypotension Operations Previous vascular intervention Other relevant medical history	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
6	Allergies: Record details in comments box	Yes No	Yes No	
7	Other lifestyle concerns: Record details in comments box Smoker Alcohol consumption Mobility issues Communication issues	Yes No Yes No Yes No Yes No	Yes No Yes No Yes No Yes No	

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8 Blood Results		Date obtained	
Haemoglobin (Hb)		Urea	
White Blood Count (WBC)		Creatinine	
Platelets		eGFR	
INR		Group and Save	1 st sample <input type="checkbox"/> 2 nd sample <input type="checkbox"/>
Nursing Notes/Variances			
Sign and print:			
Date:			
9 Patient Property Disclaimer			
Patient Name:		Hospital number:	
<p>I understand that Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust accept no responsibility for any such property, including money which is lost or damaged unless it has been handed over for safekeeping and an official receipt has been obtained.</p> <p>Patient property excluded: - dentures, glasses, nightwear, toiletries and any other night items.</p> <p>Furthermore, although I have been encouraged to hand over my property for safeguarding, I have decided against this and accept sole responsibility for any loss or damage that may occur to any such property including money, retained in my possession during my stay and Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.</p> <p>I have read and fully understand the above statement.</p>			
Patient signature:			
Date and time signed:			
Trustee declaration (Please note: only complete if patient does not have capacity)			
<p>On behalf of the above-mentioned patient, I understand that Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust accept no responsibility for any such property, including money, which is lost or damaged unless it has been handed over for safeguarding and an official receipt has been obtained.</p> <p>Furthermore, although I have been encouraged to hand over the above-mentioned patient's property for safeguarding, I have decided against this and accept sole responsibility for any loss or damage that may occur to any such property including money, retained by the patient during their stay at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.</p> <p>I have read and fully understand the above statement.</p>			
Trustee sign and print:			
Relationship to patient:			
Witness sign and print:			
Date and time signed:			

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[illegible]

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11 Drug administration record						
Drug name	Route	Dose	Time	Prescriber's signature	Administered by	Checked by
Paracetamol						
Pethidine						
Fentanyl						
Midazolam						
Naloxone						
Flumazenil						
Aspirin						
Clopidogrel						
Glyceryl Trinitrate (GTN) for injection						
Nifedipine						
GTN Spray						
Cyclizine						
Metoclopramide						
Buscopan						
Chlorphenamine						
Other						
Other						

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12 Intra Procedure Information – to be completed by Radiologist	
Date:	Time:
Radiologist:	
Procedure performed:	
Puncture sites:	
Local anaesthetic: Lidocaine 1%	
Sedation / Analgesia:	
Other drugs:	
Monitoring: Blood Pressure <input type="checkbox"/> Pulse Oximetry <input type="checkbox"/> ECG <input type="checkbox"/> (tick appropriate box/es)	
Access set/Introducer sheath: 4F / 5F / 6F / F / not applicable	
Catheter size: 4F / 5F / 6F / 7F / 8F / not applicable	
Catheter type:	
Contrast: Omnipaque 300 / Visipaque 320 / Urograffin 150 / Gastromiro / Iomeron 300	
Arterial puncture closure device used: Angioseal 6F / Angioseal 8F / not applicable **Please read advice regarding re-intervention around the puncture site(s) if an arterial closure device has been used within 90 days of current procedure**	
Complications:	
Provisional report:	
Signature:	
Print name:	Designation:

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13	Equipment Log/Stickers – e.g. Angioplasty balloons/stents/embolisation coils

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14 Post procedure instructions (tick all applicable sections)

☐ **Angiogram / Angioplasty / Vascular Stent / Embolisation (not Varicocele) with Angioseal**

- Flat bed rest for 30 minutes then start mobilising.
- Monitor patient observations ½ hourly for 4 hours.
- Monitor puncture site ½ hourly for 4 hours.
- Analgesia and other medications as directed
- Day case patients reviewed by Vascular Radiologist before discharge.

☐ **Angiogram / Angioplasty / Vascular Stent / Embolisation (not Varicocele) no Angioseal**

- Flat bed rest for 4 hours then mobilise.
- Nil by mouth for 4 hours whilst on flat bed rest.
- Monitor patient observations ½ hourly for 4 hours.
- Monitor puncture site ½ hourly for 4 hours.
- Analgesia and other medications as directed.
- Day case patients reviewed by Vascular Radiologist before discharge.

☐ **Nephrostomy / Ureteric Stent Insertion**

- Bed rest for minimum of 2 hours.
- Nil by mouth for 2 hours.
- Ensure patient is well hydrated after period of nil by mouth has ended.
- Monitor urine output – maintain strict fluid balance.
- Monitor patient observations: ½ hourly for 2 hours...
4 hourly thereafter or as NEWS2 algorithm dictates
- Analgesia and other medications as directed by ward doctor.

☐ **Ultrasound Guided Biopsy**

- Monitor the site for bleeding.
- Bed rest ____ hours.
- Nil by mouth for ____ hours until ____.
- Monitor observations: ½ hourly for 2 hours...
1 hourly for 2 hours...
4 hourly thereafter or as NEWS2 algorithm dictates.
- Analgesia and other medications as directed by ward doctor.

☐ **Ultrasound / Fluoroscopy Guided Drainage**

- Monitor output of the drain.
- If output drops unexpectedly, check drain is not twisted or kinked.
- Flush drain at least ____ per day/week.
- Bed rest ____ hours.
- Nil by mouth for ____ hours until ____.
- Monitor observations: ½ hourly for 2 hours...
1 hourly for 2 hours...
4 hourly thereafter or as NEWS2 algorithm dictates.
- Analgesia and other medications as directed by ward doctor.

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☐ **Conscious Sedation**

- Bed rest for minimum of 4 hours.
- Nil by mouth for 4 hours or until effects of sedation have worn off.
- Monitor patient observations: ½ hourly for 2 hours...
4 hourly thereafter or as NEWS2 algorithm dictates.
- Analgesia and other medications as directed by ward doctor.

☐ **Percutaneous Transhepatic Cholangiogram (PTC) / Biliary Drain / Biliary Stent Insertion**

- Follow conscious sedation guidelines (above)
- Ensure patient is well hydrated – maintain strict fluid balance.
- Observe for sepsis – if suspected follow sepsis pathway.

☐ **Radiologically inserted gastrostomy (RIG)**

- If sedation is given follow conscious sedation guidelines (above)
- Check puncture site for bleeding.
- Check puncture site for leakage of gastric contents.
- Monitor gastrostomy catheter to ensure it is secure.

On commencement of feed - stop feed or medication if there is:

- Pain on feeding.
- Fresh bleeding.
- Visible leakage of gastric contents.

If any of the above occur, contact senior medical advice.

If patients are discharged within 72 hours of insertion.

Carers should be informed of potential issues and be provided with contact details of nutrition nurses should any issue arise.

☐ **Venous puncture – Varicocele Embolisation / IVC filter insertion or removal / SVC stent**

- For femoral puncture – flat bed rest for 2 hours then start mobilising.
For jugular puncture - sat up on bed rest for 2 hours then start mobilising
- Nil by mouth for 2 hours.
- Monitor patient observations ½ hourly for 4 hours.
- Monitor puncture site ½ hourly for 4 hours.
- Analgesia and other medications as directed by ward doctor.
- Varicocele embolisation patients are to be discharged after review by Urology.