**Somerset Cardiac Services Pacemaker Implant Pathway**

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| **Patient details**  **Name**  **DOB MRN**  **Address**  **Post code**  **Tel No.**  **Mobile No.**  **Occupation**  **Religion**  **Date of assessment**  **Planned procedure**  **Planned implant date**  **Available for short notice admission. Y / N** | **Next of Kin details**  **Name**  **Address**  **Postcode**  **Tel no.**  **Mobile No**  **Relationship** |
| **GP**  **Address**  **Tel no.** |
| **Falls risk identification Complete for all patients (circle)** | |
| **Admission due to a fall Y / N Patient is less than 48hrs post operative Y / N**  **Patient has a history of falls Y / N Patient or family anxious about falling Y / N**  **Impaired judgement Y / N Any issues with the patients balance Y / N**  (eg confused/agitated/forgets limitations) ( Including poor eyesight) | |
| **If ANY of the above risks are ticked a care and risk document must be completed** | |

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| **Social Situation** | | | | |
| **Lives alone Yes /No** | | | | **Are they a carer Yes / No** |
| **Do they have any pets to care for Yes /No** | | | | |
| **Responsible Adult to stay overnight Yes/No** | | | | |
| **Transport Home Yes /No Contact No:** | | | | |
| **Have practical arrangements been made for shopping, house-work, lifting or other strenuous activity?** ( any concerns refer to social worker) | | | | |
| **Medical History** (if yes give details) | | | | |
| **Angina/NSTEMI/STEMI** | **Y** | **N** |  | |
| **CABG/PCI** | **Y** | **N** |  | |
| **Valve disease/replacement** | **Y** | **N** |  | |
| **Heart failure / NYHA class** | **Y** | **N** |  | |
| **Hypertension** | **Y** | **N** |  | |
| **DVT/ pulmonary embolus** | **Y** | **N** |  | |
| **Clotting disorder** | **Y** | **N** |  | |
| **Stroke/ TIA(Affected arms)** | **Y** | **N** |  | |
| **Peripheral Vascular disease** | **Y** | **N** |  | |
| **Any shoulder problems** | **Y** | **N** |  | |
| **Fractured collar bone** | **Y** | **N** |  | |
| **Fractured Ribs** | **Y** | **N** |  | |
| **Back Problems** | **Y** | **N** |  | |
| **Able to lay flat** | **Y** | **N** |  | |
| **Restricted mobility** | **Y** | **N** |  | |
| **Skin disorders and chronic ulcers** | **Y** | **N** |  | |
| **Diabetes and type** | **Y** | **N** |  | |
| **Condition requiring steroids/other immunosuppressants** | **Y** | **N** |  | |
| **Lung disease/other thoracic surgery** | **Y** | **N** |  | |
| **Renal impairment** | **Y** | **N** |  | |
| **Pregnant** | **Y** | **N** |  | |
| **MRI Scan (ever had a scan likely to need again. ? MRI safe device)** | **Y** | **N** |  | |
| **Other medical conditions?** | **Y** | **N** |  | |

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| **Current Medication**  **DRUG** | **DOSE** | **FREQUENCY** | **ORALLY/INHALED** |
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| **Allergies ( Drugs, Metals, others).** | **EFFECTS** |
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| **Investigations** | **Date** | **Result** |
| **ECG** |  |  |
| **CXR** |  |  |
| **ECHO** |  |  |
| **NOVACOR etc** |  |  |
| **TILT TEST** |  |  |
| **REVEAL** |  |  |

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| **Examination** | | |
| **Pulse** | **Resp Rate** | **Right Dominant Arm Left** |
| **BP** | **Oxygen sat** | **HEIGHT** |
| **Weight(Max weight of table 250kg),** |  | **BMI** |

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| **History of Device** | **Comments** |
| **Implant date** |  |
| **Reason for implant** |  |
| **Type of implant** |  |
| **Problems at previous implant** |  |

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| **Actions undertaken** |  | **Comments** |
| **Bloods** | **Yes/ No** |  |
| **MRSA / MSSA screen** | **Yes/ No** |  |
| **Procedure/process explained** | **Yes / No** |  |
| **CXR organised ( new systems/ Box Change with new lead if no chest x-ray in last 3months)** | **Yes /No** |  |
| **Leaflets supplied (please list)** | **Yes / No** |  |
| **Capacity to consent** | **Yes / No** |  |
| **Consent forms supplied** | **Yes / No** |  |
| **Wound care advice** | **Yes / No** |  |
| **Warfarin/ antiplatelet advice** | **Yes / No** |  |
| **Eating/ drinking advice** | **Yes / No** |  |
| **Metformin/ Diabetic advice** | **Yes / No** |  |
| **Showering advice / decolonisation dispensed** | **Yes / No** |  |
| **Referred to BHF nurse** | **Yes / No** |  |
| **DFT discussed** (If appropriate) | **Yes / No** |  |
| **Discussed with operator** | **Yes / No** |  |
| **Social issues reviewed** | **Yes / No** |  |
| **Signature Name Date** | | |

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| **Pre procedure checklist** | | | | | | | | | | | | | | | |
| **Blood Results Date** | | | | | | **Height** | | | | | | **Weight** | | | |
| **Hb** |  | **WCC** |  | | | **Plt** | |  | **Allergies** | | | | | | |
| **Sodium** |  | **Potassium** |  | | | **Urea** | |  | **Creatinine** | | | | |  | |
| **INR** |  | **APTTR** |  | | | **CPR** | |  | **Other** | | | | |  | |
| **MRSA** | **Nose** | **Groin** | **other** | | | **MSSA** | | **Nose** | **Groin** | | | | | **other** | |
| **Date decolonisation commenced (skin wash)** | | | | | | | **If positive to MRSA / MSSA include nasal treatment** | | | | | | | | |
| **Admission observation Date and Time** | | | | | | | | | | | | | | | |
| **BP Pulse Resp O2 sats Temp PAR score** | | | | | | | | | | | | | | | |
| **Consent Sign & dated Yes / No** | | | | **ID Band Yes / No** | | | | | | **ECG Yes / No** | | | | | |
| **Nil By Mouth From** | | | | **Clear Fluids Stopped** | | | | | | **Diabetes Yes / No**  **Blood Glucose on admission**  **Last metformin dose** | | | | | |
| **Anticoagulation Therapy Yes / No** | | | | | | | **INR on admission (if on warfarin)** | | | | | | | | |
| **Hearing Aid Yes/ No** | | | | **Glasses Yes / No** | | | | | | **Dominant Arm Right / Left** | | | | | |
| **Chest Shave Yes / No** | | | | **Dentures / crowns / loose teeth Yes / No** | | | | | | | | | | | |
| **IV access Yes / No** | | | | **IV antibiotics given Yes / No** | | | | | | **Drugs Taken today** | | | | | |
| **Transport home arranged Yes / No**  **Contact name and number of person collecting** | | | | | | | | | | | | | | | |
| **Responsible adult present overnight Yes / No** | | | | | | | | | | | | | **Overnight stay required Yes / No** | | |
| **Any other comments** | | | | | | | | | | | | | | | |
| **Completed by Signature** | | | | | **Print** | | | | | | **Designation** | | | | **Date** |
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**Admission**

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| **Patient need/ Problem** | **Aims of Care** | **Actions** | **Completed** | **Sign & Date** |
| **Anxiety due to procedure** | **To reduce anxiety**  **To work in partnership with the patient**  **To ensure patient is fully informed about the procedure** | **Welcome patient and introduce principle carers**  **Orientate to ward area**  **Give patient opportunity to ask questions**  **Listen to anxieties**  **Explain procedure and plan for duration of stay** |  |  |
| **Health Professional Notes (Please date and sign each entry)** | | | | |
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| Nursing Observation Chart | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | |
| Procedure: In/Out Patient Doctor: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 200  190  180  170  160  BLOOD 150  PRESSURE 140  130  120  110  100  90  HEART 80  RATE 70  60  50  40  30  RESPS 20  10 |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |  | |
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| TIME |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |  | |
| Pacing set sticker | | | | | | | | | | Skin prep | | | | | | | | | | | | Lidocaine 1%and Adrenaline1:200,000 mls | | | | | | | | | | | |
| Drugs given | | | | | | | | | | | | | | | | | | | | | | | |
| Wound closure | | | | | | | | | | | | | | | | | | | | | | | |
| **PAR score** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **O2 sats** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **O2 therapy** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **Sedation score** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **Pain score** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **Wound check** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **Fluid in / out** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **Temperature** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |
| **Signature** |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | |  | |  |

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| **Health Professional Notes** |
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**Pacing Discharge Checklist**

**In order for the patient to be discharged all questions must be completed**

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| **Questions** | **Yes** | **No** | **N/A** | **Comments** | **Sign & Date** |
| **Tomcat implant record in notes?** |  |  |  |  |  |
| **New system or lead replacement**  **4 hours post implant?** |  |  |  |  |  |
| **Box change;**  **2 hours post implant?** |  |  |  |  |  |
| **Reveal device;**  **1 hour post implant?** |  |  |  |  |  |
| **Pacing checks completed?** |  |  |  |  |  |
| **Chest X ray completed and review by operator?** |  |  |  |  |  |
| **Vital signs prior to discharge acceptable?** |  |  |  |  |  |
| **Wound site inspected?** |  |  |  |  |  |
| **Post wound care advice given?** |  |  |  |  |  |
| **Any issues reviewed by a Doctor?** |  |  |  |  |  |
| **Appointment made for suture removal if required?** |  |  |  |  |  |
| **Pacemaker ID card given and appointment?** |  |  |  |  |  |
| **Is pain controlled?** |  |  |  |  |  |
| **Has the patient been out of bed without incident?** |  |  |  |  |  |
| **Can the patient dress unaided?** |  |  |  |  |  |
| **Has the patient eaten and drunk since the procedure?** |  |  |  |  |  |
| **Has the patient passed urine?** |  |  |  |  |  |
| **Does the patient feel ready to go home?** |  |  |  |  |  |
| **TTA form completed with analgesia If needed?** |  |  |  |  |  |
| **TTA’s given to patient?** |  |  |  |  |  |
| **Cannula removed?** |  |  |  |  |  |
| **Does the patient live alone?** |  |  |  |  |  |
| **If yes is appropriate social support in place?** |  |  |  |  |  |
| **Any outpatient’s appointment made if required?** |  |  |  |  |  |
| **DFT discussed if appropriate?** |  |  |  |  |  |
| **Transport arranged?** |  |  |  |  |  |
| **Nurse discharging patient** | **Name:** | | | |  |