**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 160BLOOD 150PRESSURE 140 130 120 110 100 90HEART 80RATE 70 60 50 40 30RESPS 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:** |  |