Patient Name MRN

Somerset Cardiac Services Pacemaker Implant Pathway

Patient details	Next of Kin details
Name	**Name**
DOB **MRN**	**Address**
Address	**Postcode**
Post code	**Tel no.**
Tel No.	**Mobile No**
Mobile No.	**Relationship**
Occupation	**GP**
Religion	**Address**
Date of assessment	**Tel no.**
Planned procedure	
Planned implant date	
Available for short notice admission. Y / N	

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

File in Section D nursing notes

Patient Name MRN

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**	

Current Medication **DRUG**	**DOSE**	**FREQUENCY**	**ORALLY/INHALED**

Patient Name MRN

Allergies (**Drugs, Metals, others).**	**EFFECTS**

Investigations	**Date**	**Result**
ECG		
CXR		
ECHO		
NOVACOR etc		
TILT TEST		
REVEAL		

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

File in Section D nursing notes

Patient Name MRN

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

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**

File in Section D nursing notes

Patient Name MRN

Pre procedure checklist

Blood Results				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

File in Section D nursing notes

Patient Name MRN

Admission

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)

File in Section D nursing notes