Musgrove Park Hospital

Somerset Cardiac Services.

DFT Care Pathway.

This care pathway is intended to be used as a guideline for Patients undergoing a DFT.

To ensure the legality of this document all staff Should sign in the relevant section.

Patient Addressograph.

Taunton & Somerset NHS Trust
Musgrove Park
Taunton
Somerset TA1 5DA.
Telephone 01823 342067.

Printed Name	Profession	Initials	Full signature

Pre procedure checklist.

Patients name;
Hospital Number
Date

Observations;

BP	Heart Rate	Oxygen sats
Blood Glucose (If diabetic)	ECG on admission. Y / N Bloods taken on admission Y / N	Nil by Mouth from;-
Consent Signed&dated	Allergies	Diabetes Type Y / N
Seen by Anaesthetist Y / N	Dentures Loose teeth / crowns/ Caps.	IV access ; Site; Sign; Hearing Aids Y / N

ID Band		Chest Shave Y / N	Implant Date	
Warfarin Y / N		Relevant Medical History		
INR Results	**Date**			
		Blood Results	**Date**	
		Hb	WBC	Platelets
		Potassium	Sodium	Urea
		Creatine	MRSA	Other

Next of Kin ;

Transport Home;

Has responsible person with them overnight.

RN signature

DFT Care plan

Pre-procedure assessment Name Hospital No;

Patient problem/needs	Aims of care	Nursing Actions	Completed RN sign and date
Anxiety due to procedure.	1. To reduce anxiety. 2. To work in partnership with patient. 3. To ensure patient is fully informed about the procedure.	1. Welcome patient and introduce principle carers. 2. Orientate to dept. 3. Give patient opportunity to ask questions. 4. Listen to patients anxieties. 5. Offer clear and concise explanations. 6. Explain the procedure and plan for duration of stay.	
Correct preparation needed for procedure.	1. To ensure patient is fully, correctly and safely prepared.	1. Nil by mouth for 6 hours from …….. 2. Clear fluids given 2hours prior to the procedure…….. 3. Identity bracelet. 4. Allergies identified and recorded. 5. Chest area shaved for Defib pads. 6. Presence and fitting of dentures noted also crowns and loose teeth. 7. Gown. 8. IV cannula. 9. Consent signed and dated. 10. Assessed by Anaesthetist. 11 Recent FBC U& E if needed and INR (2.0 or greater for 4 weeks).	

Patients name **Hospital No**

NURSING PROCEDURE NOTES;-
MEDICAL PROCEDURE NOTES;-
RECOVERY NOTES;-

Patient Name; **Hospital no;**

Post procedure care.

Observations.

On Return to CDU Time ;			
BP;	Pulse;	0xygen Sats	Respiratory rate;
30 minutes post return. Time :			
BP;	Pulse;	Oxygen Sats	Respiratory rate;

Post procedure check list				
	Yes	No	Comments	Signature
Patient sat up Time;				
Fluids and food taken.				
Post procedure ECG.				
Seen by DR.				
Venflon removed				
Mobility unchanged from admission.				
Post procedure advice given.				

Patient Name Hospital No;

Post procedure care.

Patient problem/needs.	Aims of care.	Nursing Actions	Time completed.	RGN signature.
Potential risk of reaction to Anaesthetic.	To ensure safe recovery from procedure.	1. Assess patient's level of awareness and orientation. 2. Observation upon return to ward. 3. Repeat observations after 30 minutes. 4. Cot sides in an upright position. 5. Able to sit up immediately on return to ward. 6. Post procedure ECG.		
Possible skin irritation if external shock given.	Reduce discomfort.	1. Assess level of discomfort and administer analgesia as required. 2. Assess skin on chest		
Hydration and nutritional needs.	To maintain needs.	1. May eat and drink 30 minutes post procedure if appropriate.		
Patient un-prepared for discharged following DFT.	To facilitate safe discharge.	1.Ensure venflon is removed 2. Contact appropriate adult with collection time. 3. Provide post procedure information list. 4. Confirm patient has been seen by Dr. 5. Ensure patient is collected from ward by appropriate adult and post procedure advice given. 6. Ensure patient has a responsible adult with them overnight.		

Patients Name **Hospital No**

DFT discharge checklist.
In order for the patient to be discharged from the ward by a registered nurse all the questions must be completed.

Social circumstances.
Does the patient live alone? YES NO

If yes – do they have a responsible adult to stay with them? YES NO

Does the patient feel ready to go home? YES NO

Activity
Has the patient been out of bed with out incident? YES NO

Has the patient consumed food and drink since procedure with out Incident? YES NO

Vital signs prior to discharge.
Have the vital signs been stable.
YES NO

Information
Have patient and significant other received and understood post care instructions?

YES NO

Discharge decision (discuss discharge plans with doctor if any cause for concern.)

_____ is fit / is not fit for discharged based on the above assessment

Completed by