TRANSFER OF PATIENTS TO THE RADIOLOGY DEPARTMENT FOR INTERVENTIONAL PROCEDURES POLICY

POLICY

Reference	CPG-TW-RadIPPol		
Approving Body	Documentation Group		
Date Approved	09/06/2021		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	30th June 2021		
Version	v4.0		
Summary of Changes from Previous Version	Minor wording changes to introduction		
Supersedes	v3.0, Issued 26th March 2018 to Review Date June 2021 (ext[1])		
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Consultation Undertaken	Radiology Audit & CG meeting 09/03/2021 Documentation Group		
Date of Completion of Equality Impact Assessment	No changes June 2021		
Date of Environmental Impact Assessment (if applicable)	N/A		
Legal and/or Accreditation Implications	List all legal / accreditation implications		
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Review Date	June 2024		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Radiology Nurse Specialist, Marie Gambles		
Lead Division/ Directorate	Diagnostics and Rehabilitation		
Lead Specialty/ Service/ Department	Radiology		
Position of Person able to provide Further Guidance/Information	Radiology Nurse Specialist		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
• Radiology Department Patient Transfer Information Sheet (Radiology Transfer Sheet/ green form) – available from Radiology Intranet site or Radiology Nurse Specialist/ Radiology Department	March 2021
Template control	June 2020

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1.0 INTRODUCTION

This policy is designed to ensure the safety of patients being transferred to the Radiology Department from the wards within King's Mill Hospital through clear identification of the patient from leaving the ward to arriving in the Radiology department and this helps with communication of current and potential complications which might be encountered, for example this patient has epilepsy and might fall; has unstable diabetes.

Through adhering to this policy the legal and practice requirements for the preparation of patients undergoing radiological interventional procedures will be achieved.

2.0 POLICY STATEMENT

This policy aims to:

- Standardise and ensure good practice
- Improve communication between ward and department nursing staff
- Improve patient safety and reduce clinical risk through clear identification of the patient
- Identify patients who have a known infection risk for appropriate care management
- Identify patients who are known to have sensitivities or allergies i.e. latex
- Improve patient satisfaction through a more efficient and effective service
- Act as a legal record of care given
- The legal requirements of written consent will be met on the appropriate form
- Ensure policies and procedures will be adhered to and all relevant documentation completed correctly which will accompany the patient to the Radiology department
- Monitor patients throughout their procedure using the observational chart (NEWS)

This clinical policy applies to:

Staff group(s)

- All staff involved in the delivery of care regarding patients being transferred to and from the Radiology Department who are undergoing radiological interventional procedures.

Clinical area(s)

- All Trust wards with the exception of:
  - Paediatric department, KMH
  - Neonatal Unit, KMH
  - Maternity department, KMH
  - Newark Hospital; Mansfield Community Hospital and Ashfield Community Health Village – because these interventional procedures are not performed in these hospitals

Patient group(s)

- All adult patients undergoing radiological interventional procedures

Exclusions

- Paediatric patients
- Neonatal patients
- Maternity patients

3.0 DEFINITIONS/ ABBREVIATIONS

The Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employees of the Trust including those managed by a third party organisation on behalf of the Trust
Dept	Radiology department
KMH	King's Mill Hospital
RN	Registered Nurses
Radiology Transfer Sheet	Radiology Department Patient Transfer Information Sheet
NEWS	National Early Warning Score

4.0 ROLES AND RESPONSIBILITIES

All staff employed by the Trust or employed through other agencies has a responsibility to follow the correct checking mechanisms, guidelines and procedures to ensure that the correct patient is transferred to the department safely with appropriate awareness of the planned procedure.

All staff are responsible for gaining the appropriate consent prior to examination, treatment or care. If a patient is deemed to lack capacity, undertake a two stage test and if patient lacks capacity follow this by a best interests checklist and plan care in the patients best interests.

5.0 APPROVAL

Following consultation/ approval at the Radiology Audit and CG Group, this policy (v4.0) was finally approved by the trust's Documentation Group.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

The Radiology Department Patient Transfer Information Sheet (Radiology Transfer Sheet) contains relevant information necessary for the safe transfer of a patient to the Radiology department for interventional procedures. It will also enable the radiology nursing staff to record observations during the procedure and write an evaluation of care given in the department. This form will be filed in the patients' medical notes and will act as a legal document as necessary. The form **must be** printed on green paper. It can be found on the Intranet to be printed, or can be obtained from the Radiology Nurse Specialist / Radiology Department.

All patients undergoing the following Interventional procedures from the Trusts' wards require completion of a Radiology Transfer Sheet:

- Biopsy
  - abdominal
  - renal
  - liver
- Drainage of ascites / collections / pancreatic pseudocyst
- Gastrostomy
- Hickman Line insertion
- Nephrostomy
- Nephrostomy tube change

- Stent insertion
  - oesophageal
  - ureteric
- Trans- rectal drainage
- PICC line insertion

For specific blood tests required prior to each procedure please refer to Appendix A.

The RN will carry out the preoperative checks on the ward prior to transfer to the Radiology department. If the patient has been prescribed preoperative medication causing sedation, the routine preoperative checks will be made prior to administration of the premedication. The RN will complete the Radiology Transfer Sheet. The patient will be escorted to the Radiology department by an appropriate member of the ward staff. This may be a:

- Registered nurse
- Health care support worker who has attended the Escort Training Study Day and assessed in accordance with the Trusts Escort and Transfer Policy.

NB Patients who have had premedication causing sedation or who have complex care needs must be escorted to the department by a RN in accordance with the Trust Escort and Transfer Policy.

A full set of baseline observations must be taken and the National Early Warning Score (NEWS) documented on the Radiology Transfer Sheet or in Nervecentre where available.

The following documentation must accompany the patient to the Radiology department:

- Communication aids e.g. spectacles, hearing aid, note pad & pen etc
- Patients' medical notes
- Drug chart
- Appropriate consent form to be completed and signed
- NEWS Score (NEWS) – Where patients score 3 on a single parameter or 5 and above on an aggregate score, a printed copy of the chart taken from Nervecentre, must be sent with the patient (or the handwritten chart from areas where Nervecentre is not available). Where patients are triggering on NEWS the doctor and CCOT (or equivalent) must be alerted to this and the Radiology department informed prior to transfer
- Required medication e.g. GTN spray or inhaler

On arrival to the Radiology department the following checks will be carried out:

- A registered nurse or radiographer will correctly identify the patient using the CRIS request and the Trusts Identification Policy
- All preoperative checks are carried out using the Radiology Transfer Sheet prior to any interventional procedure being performed
- The appropriate consent form has been signed by both the doctor and the patient
- The drug chart will be reviewed for any anticoagulant medications
- The most recent observations will be reviewed and any concerns will be discussed with the Ward Nurse regarding the NEWS score, any triggers should be escalated to the doctor and CCOT or equivalent.

Prior to any interventions in the Radiology Interventional room the **Invasive Procedure Safety Checklist – Radiology** is completed, including:

- Identity and procedure confirmed
- Introductions are made

- Consent correct
- Bloods checked including eGFR / INR if on Warfarin
- Equipment checked and prepared
- Confirm if patient has diabetes
- Confirm any allergies
- Anticipated needs identified and prepared for
- Commencement of appropriate monitoring in place

If at any stage during the interventional procedure the radiologist proposes to perform an additional procedure for which the patient has not given prior written consent which is not identified on the consent form as a possible complication but is identified by the radiologist as being in the best interests of the patient this must be documented in the patients' medical notes.

During the interventional procedure the patient is monitored throughout using the National Early Warning Score (NEWS) calculated and recorded on the Radiology Transfer Sheet:

- Respirations rate
- Oxygen Saturation levels (SpO_2)
- Dose of oxygen delivered where appropriate as this is used in calculation of the NEWS
- Temperature
- Blood Pressure
- Heart Rate
- AVPU
- capillary blood sugar readings (if appropriate)
- urine output
- pain score

(If additional information is required, see the Observations and Escalation Policy for Adult In-Patients)

At the end of the interventional procedure the Radiology nurse will complete the evaluation on the Radiology Transfer Sheet and sign and date the form.

On transferring the patient back to the ward the Radiology nurse will either escort the patient back or the ward nurse will return to collect (depending on staffing levels), communicating the patients care during the procedure, informing if any drugs have been administered and passing on the radiologists instructions on aftercare of the patient on return to the ward.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Every 3 years the forms will be monitored over a 3 week period	Radiology Specialist Nurse	action plan will be developed	Every 3 years	Nursing, Midwifery and AHP Board Meetings

8.0 TRAINING AND IMPLEMENTATION

There are no specific training requirements associated with the application of this policy. However, all staff who are required to follow this policy in practice must be aware of its contents and ask for help should the need arise.

Training is mandatory for healthcare assistants to attend and be competent in escorting patients to and from the Radiology department.

This policy will be accessible in the department and on the wards at all times. It is also available via the Trust Intranet.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix B
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- National Patient Safety Alert, Royal College of Radiologists (March 2010) No. 1211 - WHO Surgical Safety Checklist: for radiological interventions only (adapted from WHO Surgical Safety Checklist)
- Royal College of Radiologists (2010) *Standards for the NPSA and RCR safety checklist for radiological interventions.* RCR. London.
- Royal College of Radiologists (2009) *Guidelines for radiologists in implementing the NPSA Safe Surgery Requirement.* RCR. London.
- Nursing & Midwifery Council (2009) *Record keeping: guidance for nurses and midwives.*
- Nursing & Midwifery Council (2014) *The code: Standards of conduct, performance and ethics for nurses and midwives*
- Department of Health (2007) *The Ionising Radiation (Medical Exposure) Regulations (2000)*
- www.rcr.ac.uk
- www.npsa.nhs.uk
- www.nrls.npsa.nhs.uk

Related SFHFT Documents:

- Policy and procedure for the positive identification of patients
- Escort and Transfer Policy
- Policy for the consent to examination, treatment and care
- The Observation and Escalation Policy for Adult In-Patients
- Invasive Procedure Safety Checklist – Radiology

11.0 KEYWORDS

Green sheet; form; KMH

12.0 APPENDICES

- Appendix A – Additional Blood Tests Required for Patients Undergoing Interventional Procedures at KMH
- Appendix B – Equality Impact Assessment Form

Appendix A – Additional Blood Tests Required for Patients Undergoing Interventional Procedures at KMH

Unless otherwise requested the following investigations are needed:

Interventional Procedure	Investigation
Antegrade pyelogram	**Clotting screen** **Full blood count**
Biopsies - liver and renal	**Clotting screen and Group & Save** **Full blood count**
Biopsy (other)	**Clotting screen** **Full blood count**
Drainage	**Clotting screen** **Full blood count**
Nephrostomy tube insertion / ureteric stent	**Clotting screen** **Urea & electrolytes** **Full blood count**

For further information please contact the x-ray department on extension 4057 or 3201 and ask for the Radiology Specialist Nurse on duty.

APPENDIX B – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Policy for the Transfer of Patients to the Radiology Department for Interventional Procedures (King's Mill Hospital only)			
New or existing service/policy/procedure: Existing policy			
Date of Assessment: June 2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	None	None
Gender	None	None	None
Age	None	None	None
Religion	None	None	None
Disability	None	None	None
Sexuality	None	None	None
Pregnancy and Maternity	None	None	None
Gender Reassignment	None	None	None
Marriage and Civil Partnership	None	None	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	None	None

What consultation with protected characteristic groups including patient groups have you carried out?

Contributors:	Communication Channel:	Date:
Radiology Audit and Clinical Governance Meeting	Circulated by email	16/03/2021
Documentation Group	Group meeting	09/06/2021

What data or information did you use in support of this EqIA?

-

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Marie Gambles

Signature: Marie Gambles

Date June 2021