HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Radiology Department		
Document:	Multidisciplinary Policy and Procedure		
Title:	Fluoroscopy Policy		
Applies To:	All Radiology Staff, Physicians and Nurses		
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1. PURPOSE:

1.1 To provide the fast, effective and high quality imaging services for all patients in Maternity and Children Hospital, Hafer Al Batin, Radiology Department.

2. DEFINITIONS:

2.1 **Fluoroscopy** – is a study of moving body structures - similar to an X – ray "movie." A continuous X – ray beam is passed through the body part being examined. The beam is transmitted to a TV – like monitor so that the body part and its motion can be seen in detail.

3. POLICY:

3.1 All Fluoroscopy procedures are available by an appointment during the regular (Morning) duty only, which is from: Sunday to Thursday – (7:30 am to 3:30 pm), Not during weekends or official holidays.
3.2 The reporting time for Fluoroscopy procedures is **48 hours**.
3.3 All Outpatients coming to the department to perform the X – ray should have companion especially the pediatric.
3.4 All Inpatients patients should a companied by staff nurse or physician (If needed).
3.5 All fluoroscopy procedures should be documented by the **"General Consent Form"** from the referring physician **before scheduling the appointment**.
3.6 Applying the 10 days rule for all female patients.
- 3.6.1 Ten Days Rule:
  - 3.6.1.1 A rule proposed by the International Commission on Radiological Protection (ICRP) for women reproductive age, that "whenever possible, one should confine the radiological examination of the lower abdomen and pelvis to the 10 days interval following the onset of menstruation."

3.7 The radiologist or radiographer will be notified if the patient is allergic or sensitive to medications, contrast dyes or iodine. The way of administering the contrast media will be explained to the patient either via swallowing, enema, or an intravenous (IV) line in the hand or arm.
3.8 Fluoroscopy examinations that is available in the department include:
- 3.8.1 Barium Studies
- 3.8.2 Hysterosalpingography (HSG)
- 3.8.3 Micturating Cystourethrogram (MCUG)
- 3.8.4 Intravenous Pyelogram (IVP), also called an Intravenous Urogram (IVU)
- 3.8.5 Precautions should be taken for I.V contrast media injection to control life threatening reaction & contrast induced nephropathy.
  - 3.8.5.1 General precautions include:
    - 3.8.5.1.1 "General Consent Form"
    - 3.8.5.1.2 A recent "Creatinine" result.
  - 3.8.5.2 Strict precaution in case of :
    - 3.8.5.2.1 Previous contrast reaction

3.8.5.2.2 Asthmatics.
3.8.5.2.3 Renal impairment
3.8.5.2.4 Diabetes mellitus

3.8.6 In these cases , IV contrast should be avoided by changing to another modality & if necessary general precautions, high risk consent from the patient must be taken , the referral physician must attend the exam and in case of renal impairment or diabetes an internal medicine physician or nephrologist must be consulted to take specific precautions.

3.8.7 Immediate reactions take place within an hour after injection of the contrast medium, These reactions can be:

3.8.7.1 Mild Reaction: (Nausea, Vomiting, Mild Urticaria)
3.8.7.1.1 It will stop the procedure and it require monitoring the patient.

3.8.7.2 Moderate Reaction: (Severe Vomiting, Extensive Urticaria, Dyspnea, Rigor, Laryngeal Edema)
3.8.7.2.1 The first aid will be given to the patient by Radiologist
3.8.7.2.2 The patient will be sent to ER immediately.

3.8.7.3 Severe Reaction: (Pulmonary Edema, Cardiac Arrhythmias or arrest, Circulatory Collapse)
3.8.7.3.1 Call for "Code Blue" (by calling **emergency number#: 2222**) after giving the patient the first aid by the Radiologist.

4. PROCEDURE:

4.1 Fluoroscopy procedures will be performed after receiving radiology request through PACS with complete and correct patient identification which is:
4.1.1 Full patient name.
4.1.2 Medical record or national ID number or Iqama number.
4.1.3 Requested examination.
4.1.4 Complete and benefit clinical indications for the requested exam.
4.1.5 Name of Referring physician.

4.2 Patient identification will be verified before starting a radiological examination. The Radiographer/ Physician is responsible for correctly identifying the patient to be examined, and it is important to ensure that it is the correct procedure like what is mentioned in the request and the general consent form .

4.3 Before performing the radiological examination, it is important to inform the patient about the procedure and answer any questions related to the examination.

4.4 Provide a private place for the patient for changing and **keep the door close** during the examination.

4.5 The patient is appropriately prepared by removing clothing, jewellery, and /or other articles from the body that may obstruct the interesting area to be examined.

4.6 The patient will be positioned on the X-ray table. Depending on the type of procedure, the patient may be asked to assume different positions, move a specific body part, or hold the breath at intervals while the fluoroscopy is being performed.

4.7 Wear the lead aprons during the examination for (Radiographer – Physician – Nurse) and companion for OPD paediatric patients.

4.8 Give the clear and correct instructions before the exposure to the physician and ensure that it is the correct positioning for the patient.

4.9 After performing the examination, all images will be delivered to PACS and reviewed by radiologist for reporting.

5. MATERIAL AND EQUIPMENT:

5.1 Fluoroscopy machines
5.2 HSG set
5.3 Catheters
5.4 Contrast media
5.5 Barium sulphate or Gastrografin

6. RESPONSIBILITIES:

6.1 All radiology staff
6.2 Physicians
6.3 Nurses

7. APPENDICES:

7.1 MOH General Consent Form: GDOH-COR-GC-351

8. REFERENCES:

8.1 https://www.hopkinsmedicine.org

9. APPROVALS:

	Name	Title	Signature	Date
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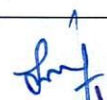
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 09, 2025
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
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KINGDOM OF SAUDI ARABIA وزارة الصحة Ministry of Health Hospital: _____ مستشفى: Region: _____ المنطقة/المحافظة: Dept./Unit: _____ القسم/الوحدة:	MRN: ☐☐☐☐☐☐☐☐☐☐ رقم الملف الطبي: Name: _____ الاسم: Nationality: _____ الجنسية: Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر: Date of Birth: ____/____/14____ H ____/____/20____ تاريخ الميلاد: Gender: ☐ Male ☐ Female الجنس:

GENERAL CONSENTS إقرارات عامـــة

I (for Named Patient) signed below, authorize and give consent to my attending physician and/or his/her assistant to provide medical, nursing care and other clinical diagnostic or therapeutic procedures with the exception of surgical and invasive procedures, induction of anesthetics, infusion of blood and blood products and other procedures that require special consent.	أفوض أنا (المريض) الموقع أدناه، وأعطي موافقتي للطبيب المعالج ولمن يختار لمساعدته وذلك لتقديم عناية طبية وتمريضية وأي تشخيصات سريرية أو أية طرق علاجية بإستثناء العمليات الجراحية والإجراءات التداخلية حقن الدم أو مشتقاته أو أي عمل آخر يتطلب موافقة خاصة.
I understand that Dr. _____ _____ is attending physician and is the person responsible for the assessment of my medical condition & my care plan & he/she will have the responsibility according to my medical condition, to Discharge or Transfer.	لقد تم إعلامي أن الطبيب المعالج د. _____ _____ هو الشخص المسؤول عن تقييم حالتي الطبية وخطة علاجي وتقع عليه/ عليها مسؤولية أمر خروجي من المستشفى أو تحويلي الى أية جهة عناية صحية أخرى وذلك بناء على ما تستدعيه حالتي الصحية.
I understand that the hospital and its employees will respect my rights and privacy at all times and that the confidentiality of my medical information will be guarded carefully and released only to authorized person.	أفهم وأعي أن المستشفى وموظفيه سوف يحترمون خصوصياتي هي كل الأوقات وأن سرية المعلومات الطبية الخاصة بي سوف يحافظ عليها بعناية وسوف تستخدم فقط وحصريا لأجل العلاج وأن تعطى فقط لهؤلاء الأشخاص الذين يقومون على رعايتي. ولن يتم إعطاء المعلومات لأي شخص أو جهة إلا في حالة موافقتي الشخصية أو موافقة الشخص المصرح كبديل عني.
I shall abide by the hospital rules and regulations.	سوف التزم واطيع كل القوانين والنظم الخاصة بالمستشفى.
I understand that the hospital is not responsible for the loss or damage of my money, valuables and other personal property and that in case of emergency or no alternative situations the items should be handed over to the security for safekeeping.	أفهم إن المستشفى لا تتحمل مسؤولية فقدان النقود، المقتنيات الثمينة أو أية ممتلكات خاصة بي الا في الحالة الطارئة أو في حالة عدم وجود بديل للحفاظ على ممتلكاتي حيث ان هذه الممتلكات يجب أن تعطى لمسؤولي الامن في المستشفى للحفاظ عليها.
If it is found that I am not eligible for free treatment, I am obligated to pay for all services rendered as per my healthcare needs, I agree that the authorities and Kingdom's courts will decide any dispute in connection with such costs.	إذا اتضح إني غير مؤهل للعلاج المجاني فإني أتفهم إني مطالب بدفع كل المصاريف المتعلقة بعلاجي وأوافق أن الجهات المختصة والمحاكم بالمملكة العربية السعودية هي التي تقرر مسؤولية الدفع في حالة وجود خلاف حول المصاريف الواجب دفعها.
In case of emergency, where I am not coherent or conscious and unable to make my healthcare decision, I hereby grant the following person (s) the right to take decision of my medical treatment on my behalf:	إذا كان هناك طارىء أو حالة غيبوبة أو عدم تركيز وكنت غير قادر على إتخاذ قرار بشأن حالتي الصحية فأني أمنح حق إتخاذ القرار بالنيابة عني بشأن حالتي الصحية إلى الاشخاص التالية أسمائهم.
1. Name: _____ Relation to the Patient _____ Date: ____/____/____ Time: _____	الإسم: _____ صلة القرابة: _____ تاريخ: ____/____/____ وقت: _____

Name:_____ الاسم:	MRN: رقم الملف الطبي:
I acknowledge that my signature on this form signifies that I am in agreement with all the statements. Signature of Patient:_____ Date: ____/____/____ Time: _____	أقر أن توقيعي على هذه الاستمارة يعني إنني موافق على كل بنودها وإنني قرأتها بالكامل قبيل توقيعي هذا. توقيع المريض: _____ تاريخ: ____/____/____ وقت: _____
Substitute Decision Maker	**من ينوب عن المريض (أو صانع القرار البديل)**
In case of emergency and the patient is unable to make decision and not granted any person to sign on his behalf. Substitute Decision Maker Name_____ Relation to the Patient _____ Signature: _____ Date: ____/____/____ Time: _____ Reason for Patient not signing to Consent: _____	في الحالة الطارئة وحين يكون المريض غير قادر على إتخاذ القرار ولم يمنح أحد حق التوقيع بالنيابة عنه. إسم من ينوب عن المريض:_____ صلة القرابة:_____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____ سبب عدم توقيع المريض: _____
In case of emergency and no Substitute Decision Maker and patient not granted any person to sign on his behalf We certify that, we have examined the patient and it is our professional opinion that this patient lacks decision capacity to take health care decision and any delay providing medical treatment will endanger his life or lead to serious body harm. **1. Physician Name & ID No.:** _____ Position: _____ Signature: _____ Date: ____/____/____ Time: _____ **2. Physician Name & ID No.:** _____ Position: _____ Signature: _____ Date: ____/____/____ Time: _____	**في الحالة الطارئة وغياب من ينوب عن المريض**، وكون المريض لم يمنح أحد حق التوقيع بالنيابة عنه. نحن نأكد ونوثق أنه عند فحص المريض وحسب رأينا المهني أن هذا المريض غير قادر على إتخاذ القرار بشأن حالته الصحية وأن أي تأخير في تقديم العناية الطبية اللازمة سوف يعرض حياته للخطر أو قد يؤدي الى عواقب وخيمة **إسم الطبيب والرقم الوظيفي:** _____ وظيفته: _____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____ **إسم الطبيب والرقم الوظيفي:**_____ وظيفته: _____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____

WITNESS شاهد

Name (الإسم)	Signature (التوقيع)	Date & Time (التاريخ والوقت)
1.)		
2.)		
3.)		