

## **Good Practice Standards for controlled removal of fluid from chest drains (adults)**

### ***Background***

Pleural effusions cause breathlessness due to accumulation of fluid between the lung and chest wall. Pleural effusions are a common medical problem with more than 50 recognised causes, and treatments vary accordingly. Large effusions, such as those caused by pleural malignancy and pleural infection, may require insertion of a chest drain and controlled drainage of fluid to enable lung re-inflation.

If large volumes of pleural fluid are released too quickly, especially in the first hour post insertion, patients quickly deteriorate due to a reduction in blood pressure and increased breathlessness; associated with Re-Expansion Pulmonary Oedema (RPO). Mortality from RPO can be as high as 20% therefore this initial period requires very close nursing surveillance.

Any concerns or complications should be reported to the medical team urgently.

### ***Good Practice Points***

#### ***General***

- ✓ Ensure effective communication between clinical personnel before, during, and after procedure to minimise the risk of adverse events.
- ✓ Carefully assess the risks/benefits for out of hour's chest drain insertion.

#### ***Pre-procedure***

- ✓ A LocSSIP checklist must be completed for all pleural procedures.
- ✓ Review chest imaging.
- ✓ Review blood clotting and other risk factors for coagulopathy.
- ✓ Review allergies and medication (specifically antiplatelet, anticoagulation etc.).
- ✓ Ensure written consent has been obtained or act in best interests for those who lack capacity.

#### ***Post-procedure***

- ✓ Ensure continual direct observation for the 15 mins following chest drain insertion and no transfer should be taken during that time.
- ✓ Ensure a post drain insertion CXR has been requested and reviewed.
- ✓ Post procedure observations must be recorded, and any concerns escalated.
- ✓ Ensure the patient is left comfortable and analgesia is prescribed.
- ✓ Ensure that the patient is informed to keep the chest drain bottle positioned below the level of the chest to prevent any backflow of fluid.

✓ Escalate any serious or life-threatening complications, such as RPO, or suspected vascular or visceral injury, urgently to a senior decision maker.

### **Documentation**

✓ Pre procedure and post procedure observations should be clearly recorded as per local hospital guidelines

✓ Pre-procedure documentation must include:

- LocSSIP document
- Written informed consent/ best interests

✓ The practitioner inserting the chest drain must document the procedure in the medical notes and provide clear written and verbal information to nursing staff of fluid drainage management.

✓ Patient comfort, NEWS2 score and fluid drainage must be closely monitored and recorded on the post-procedure document for the first hour as this is the greatest risk period for the development of RPO. Observations, taken every 15 min for the first hour is advised, so any deterioration in the patient's condition can be acted on quickly.

✓ Post-procedure documentation must include:

- Specific chest drain flushing instructions and any thoracic suction requirements as necessary.
- Post-procedural observations and chest drain volume checks, which should occur
  - every 15 minutes in the first hour,
  - every hour for the next 3 hours
  - then 4 hourly until chest drain is removed
- Plan for controlled pleural drainage with the use of a 3-way tap for seldinger drains (not clamping) – see below.
- Clear guidance that no more than 1500mls of pleural fluid to be drained in the first hour (in selected cases, 1000ml drainage may be appropriate eg in smaller adults); then allow up to 500ml per hour to drain before returning to free drainage.
- Information on key red flags (see below) and local escalation procedures.
- See ARNs website [here](#) for an example of a post-procedure document that fulfils these requirements.

### **Controlled pleural drainage**

Preventative strategies to reduce the risk of deterioration and RPO include the use of a 3-way tap to facilitate controlled pleural drainage in order to limit initial drainage as described above.

✓ Ensure controlled pleural drainage by using a 3-way tap to open and close the drain. The recommended standard approach is for nursing or AHP staff to stop drainage by closing the three way tap if the patient develops any of the key red flags/triggers below;

- Pain or chest discomfort
- Persistent cough, worsening breathlessness, or vagal symptoms
- A deteriorating NEWS2 score, and/or



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- When 1500ml has been removed.
- Reopen the tap after 1 hour, allowing no more than 500ml to be removed per hour after this.  
When less than 500mls per hour is draining, leave on free drainage.

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These Good Practice Standards are endorsed by the <a href="#">Royal College of Nursing</a> .
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