Kidney Biopsy

Care Pathway

Please complete pages 1-6 prior to referral, if not completed the procedure **will not be performed**.

# Patient details

ADDRESSOGRAPH

Date of Referring Teams Assessment:

Date of kidney biopsy:

Consultant:

Contact Details: Home: Religious beliefs/practices:

Mobile: Communication/Language:

|  |  |
| --- | --- |
| **Next of Kin:**Name: Relationship: Contact numbers:Aware of admission: | **Discharge Plans:**Responsible adult for 24hrs: Name of adult:Contact number:Transport: |
| **ALLERGIES/ALERTS:**Any infection control alerts Y/N (check CPI & specify )Contact with Carbopenamase Producing Organisms Y/N | **DIABETIC: Y/N**Type:Can you administer own insulin: Y/NIf no please ensure drug chart prescribed: YN |
| **Anticoagulation and anti-platelet therapy? Please see Microguide for trust guidelines.**<https://viewer.microguide.global/guide/1000000295#content,87c8200f-f90b-4c09-86bc-926c015369c8> **Y/N****Type: Why: When last taken:****Discuss with referring consultant or radiologist regarding safety of stopping.** |
| **Instruct to bring medication in on day of admission: Y/N****Self-medication forms signed: Y/N**If no please ensure prescription chart filled out by doctors Y/N |
| **Disclaimer :** I am the patient named above.I accept responsibility for my property during my stay in hospital.I agree to inform staff of any concerns of questions I may have during my admission**Signed:Dated:** |

# Referring Teams

Addressograph

# Assessment

Date:

**Previous Medical History**

Presenting Symptoms: (Reason for biopsy) Biopsy Type:

|  |  |
| --- | --- |
| **Does patient have (circle)?** |  |
| artificial heart valve | coronary artery stent | pacemaker or defibrillator |
| artificial blood vessel graft | neurological shunt | any other implant |

Anti-platelet medication or anti coagulation therapy.

Type:

Date stopped:

Refer to trust guidelines on Microguide.

<https://viewer.microguide.global/guide/1000000295#content,87c8200f-f90b-4c09-86bc-926c015369c8>

Medication

Note: Ensure antihypertensive medication is taken on day of procedure.

**Examination:**

BP: Sp02:

Pulse:

Respiratory Rate:

Temperature:

Weight:

Signed: Dated:

# Referring Teams

Addressograph

# Assessment continued:

Bloods that must be taken.

FBC Y/N

Clotting screen Y/N

Group and save Y/N

U & Es Y/N

**Urine dipstick negative** Y/N (send for MCS if positive for nitrates)

|  |  |
| --- | --- |
| **Absolute contraindications for kidney biopsy** |  |
| Underlying Bleeding diathesis  | Y/N |
| Uncontrolled BP (diastolic > 90 or systolic > 160) | Y/N |
| Uncooperative patient | Y/N |
| **Relative contraindications for kidney biopsy** |  |
| Known Amyloidosis Y/N Urinary tract infection | Y/N |
| Obesity Y/N Pregnancy | Y/N |
| Anticoag or antiplt drugs Y/N Solitary native kidney | Y/N |

If yes to the above questions then refer to doctors as may not be suitable for day case biopsy.

 Self-medication form signed Y/N

Antibiotic cover required Y/N If yes please ensure drug chart prescribed.

(for patients with bacteraemia, risk of renal sepsis or renal)

**Informed to buy Paracetamol for post procedure Y/N Information sheet provided prior to assessment Y/N**

Has the patient read the information sheet Y/N Procedure explained Y/N

|  |  |
| --- | --- |
| **Risks explained** | **Symptoms explained** |
| Significant bleeding (<5%) Y/N Need for Transfusion (<1%) Y/N Need for Embolization (<0.5%) Y/N Urinary Retention (<2%) Y/NInfection (<1%) Y/NFailure to diagnose (<5%) Y/N Mortality of a kidney biopsy (<0.1%) Y/N | Pain (10%) Y/NBruising (10%) Y/NHematuria < 24 h (3%) Y/N |

|  |  |  |  |
| --- | --- | --- | --- |
| **Consent obtained** | **Y/N** | **Consent Form Signed** | **Y/N** |
| **Signed:** | **Dated:** |  |  |

# Referring Teams assessment continued:

Addressograph

Date:

Inform the patient of being NBM FOR 6HRS prior to procedure Y/N

Transport discussed: Y/N Own Transport: Y/N Hospital transport booked: Y/N

Responsible adult to be present for 24hrs post procedure Y/N

Able to return to a hospital within 30 min drive Y/N Informed of restrictions post procedure

* no driving for 48 hours
* avoid contact sports, heavy lifting or strenuous exercise

including sexual intercourse for 2 weeks **Y/N Date of blood results:**

|  |  |  |  |
| --- | --- | --- | --- |
| **FBC****Clotting** | Hb:INR: | WBC:APTTR: | Platelets: |
| **Renal** | Sodium: | Potassium: | eGFR: |

INR and APTTR must be <1.5

Platelets must be >50,000 for percutaneous biopsy

Inform consultant interventional radiologist if INR/APTTR >1.5 or PLATELETS <50,000 or any other concerns.

Signed: Dated:

**SIGNED:**

**DATED:**

# Pre-Procedure Check List

Ward: Date:

Addressograph

Admitting nurse:

|  |  |  |  |
| --- | --- | --- | --- |
| **Check list** | **Tick** | **Initial** | **Comments** |
| Admit and orientate the patient to the ward |  |  |  |
| Confirm patient ID and provide patient ID band and allergy alert band |  |  |  |
| Check next of kin details are correct |  |  |  |
| Check Clotting Screen, FBC and group & Save taken within 1 week of biopsy. **If on anticoagulation therapy ensure within last 24 hours** |  |  | Platelet: (>50,000)INR: ( <1.5)APTTR: ( <1.5) |
| Anticoagulation or antiplatelet medication has been discussed and stopped with reference with Radiologist and Trust Guidelines. <https://viewer.microguide.global/guide/1000000295#content,87c8200f-f90b-4c09-86bc-926c015369c8> |  |  | Which doctors was it discussed with?When was it stopped: |
| Ensure patient has been NBM for 6 hrs |  |  | NBM from hrs |
| Offer full explanation of procedure and assess patient’s understanding |  |  |  |
| Check consent signed |  |  | Can be consented by radiologist in RadiologyDepartment |
| Completed baseline observations on NEWSchart .  |  |  |  |
| If Diabetic then take a Blood sugar |  |  | BM: |
| Cannula inserted |  |  | Size:Position |
| Provide hospital gown and remove all excessjewellery |  |  | Taped Rings Y/N |
| Ensure notes and prescription chartsaccompany the patient |  |  |  |
| Secure patient’s own medication for admission period.  |  |  |  |

Signed: Dated:

# Procedure

Addressograph

RADIOLOGIST:

PROCEDURE:

BIOPSY SITE:

Full explanation of the procedure given

and the patients understanding assessed Y/N

Written informed consent obtained: Y/N

Pre-assessment and pre-procedure checklists completed Y/N FBC and clotting Y/N

Antiplatelet or anticoagulation drugs stopped Y/N

Baseline Observation in Radiology Department at hrs

|  |  |  |  |
| --- | --- | --- | --- |
| **Pulse:** | **BP:** | **Sp02:** | **Resp rate:** |
| **Local anaesthetic:** |  |  | **Amount:** |

Other drugs/ Sedation: Amount:

Comments regarding procedure:

**Complications** Pain Y/N Hemorrhage Y/N

Biopsy sample and histology request Y/N

Correctly labelled

Signed by radiologist: Dated Time hrs

# Post procedure check to be completed by RDA, nurse or radiologist

Addressograph

|  |  |  |
| --- | --- | --- |
| **Post Procedure** | **Completed** | **Initials** |
| ObservationsTime hrs | Pulse ……………SpO2 ……………BP ……………Site …………… |  |
| Radiologist has completed procedure notes | Y/N |  |
| Specimen & histology form labelled correctly | Y/N |  |
| Hand over done | Y/N |  |
| Specimen location | Sample to pathology Y/N |  |

Signed : Dated Time hrs

Addressograph

|  |  |  |
| --- | --- | --- |
| **DATE AND****TIME** | **Multidisciplinary notes and evaluations** | **Signature/print Profession/ bleep/number** |
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# Post Procedure (minimum 6 hours)

**Complete observation and record**

**Every 15 minutes for 1 hour**

**Every 30 minutes for 2 hours, Every hour for a further 3 hours**

Addressograph

Recovery Start time Time:

To remain NBM for 1 hour post procedure Untill:

To remain on bed rest for 6 hours Until:

Ensure call bell to hand Y/N

Check wound every hour Y/N

Assess level of pain every hour Y/N

Ensure patient has passed urine Y/N

Follow Radiology post procedure Guidelines.

Observe for signs of hemorrhage Y/N

If signs of hemorrhage keep NBM, continue to monitor every 15 minutes and contact Interventional Radiologist.

Follow NEWS 2 (trust Policy) and escalate when triggers NEWS score.

Signed: Dated:

# Radiology

Addressograph

# Discharge Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| **Check list** | **Tick/ Circle** | **Initial** | **Comment** |
| Is the patient alert and orientated | Y/N |  |  |
| Vital signs stable | Y/N |  |  |
| Has patient mobilised post procedure? | Y/N |  |  |
| Has patient passed urine? | Y/N |  |  |
| Is there significant hematuria? | Y/N |  | Concentration of hematuria should be starting to subside. Callurology team if not settling. |
| Wound checkNo oozing, redness or obvious swelling | Y/N |  | Dressings for discharge Y/N |
| Pain free | Y/N |  | Discuss analgesia suitable to take. |
| Has a suitable adult with them for 24hrs | Y/N |  |  |
| Remove cannula | Y/N |  |  |
| If on anticoagulation or antiplatelet drugs,patient has been advised when to restart | Y/N |  |  |
| Transport (Own or Hospital) | Y/N |  | Delete as necessary |
| Next of Kin informed | Y/N |  |  |
| Valuables returned to patient if applicable | Y/N |  |  |
| Return patients own medication if applicable  | Y/N |  |  |

Discharged Y/N

Signed: Dated:

Inpatient Recovery post Biopsy

Patient has had 2 hour Recovery in Radiology starting from:

Patient requires 30 minutes observation for 1 hour,

Followed by hourly observations for a further 3 hours.

Follow Radiology post procedure guidelines.

If signs of hemorrhage keep NBM, and refer to post procedure guidelines and Interventional Radiologist report.