

Liver Biopsy Care Pathway

Patient details

ADDRESSOGRAPH

Date of pre assessment:

Date of Liver Biopsy:

Consultant:

Contact Details:

Home:

Mobile:

Religious beliefs/practices:

Communication/Language:

<p>Next of Kin: Name:</p> <p>Relationship:</p> <p>Contact numbers:</p> <p>Aware of admission:</p>	<p>Discharge Plans: Responsible adult for 24hrs:</p> <p>Name of adult:</p> <p>Contact number:</p> <p>Transport:</p>
<p>ALLERGIES/ALERTS:</p> <p>Any infection control alerts Y/N (check CPI & specify)</p> <p>Contact with Carbopenamase Producing Organisms Y/N</p>	<p>DIABETIC: Y/N</p> <p>Type:</p> <p>Can you administer own insulin: Y/N</p> <p>If no please ensure drug chart prescribed: Y/N</p>
<p>Anticoagulation and anti-platelet therapy (warfarin, aspirin, clopidogrel, dipyridamole or novel oral anticoagulant/NOAC such as Dabigatran, Apixaban, Rivaroxaban?): Y/N</p> <p>Type: Why: When last taken:</p> <p>Discuss with referring Consultant or radiologist regarding safety of stopping. PRINT OFF AND ATTACH "ANTICOAGULATION MANAGEMENT OF PATIENTS UNDERGOING INVASIVE PROCEDURES IN RADIOLOGY" AND FOLLOW MEDIUM RISK INSTRUCTIONS.</p>	
<p>Instruct to bring medication in on day of admission: Y/N</p> <p>Self-medication forms signed: Y/N</p> <p>If no please ensure prescription chart filled out by doctors Y/N</p>	
<p>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</p> <p>Signed:</p> <p>Dated:</p>	

Pre Assessment

Addressograph

Date:

Presenting Symptoms: (Reason for biopsy)

Previous Medical History

Does patient have (circle)?

artificial heart valve

artificial blood vessel graft

coronary artery stent

neurological shunt

pacemaker or defibrillator

any other implant

Medication

Anti-platelet medication or anti coagulation therapy.

Type:

Date stopped:

Discuss with referring consultant or radiologist regarding safety of stopping.
REFER TO MEDIUM RISK SECTION OF "ANTICOAGULATION MANAGEMENT OF PATIENTS UNDERGOING INVASIVE PROCEDURES IN RADIOLOGY" FROM RADIOLOGY SECTION OF INTRANET.

Examination:

BP:

SpO2:

Pulse:

Respiratory Rate:

Temperature:

Weight:

Signed:

Dated:

Pre assessment continued

Addressograph

Bloods that must be taken.

FBC Y/N
 Clotting screen Y/N
 Group and save Y/N
 U & Es Y/N
 LFTs Y/N

Relative contraindications for liver biopsy

Hepatic Encephalopathy	Y/N	CCF	Y/N
Hepatic Failure	Y/N	Known Amyloidosis	Y/N
Biliary obstruction	Y/N	Ascites	Y/N
Uncooperative patient	Y/N	Anticoag or antiplt drugs	Y/N
Bleeding diathesis (haemophilia, von Willebrand, antiphospholipid syndrome)			Y/N

If answered yes to the above questions then refer to doctors and not 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 prosthetic heart valves, bacteraemia, risk of biliary sepsis or liver transplant)

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 (0.5%)	Y/N	Pain (30%)	Y/N
Infection (<0.5%)	Y/N	Bruising (10%)	Y/N
Punctured lung, colon, kidney & gallbladder (<0.1%)	Y/N	Vasovagal (3%)	Y/N
Mortality of a liver biopsy (0.01%)	Y/N	Temperature (<1%)	Y/N
Failure to diagnose (<10%)	Y/N		

Consent obtained Y/N

Consent Form Signed Y/N

Signed: **Dated:**

Pre 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 Hb: WBC: Platelets:

Clotting INR: APTTR:

Renal Sodium: Potassium: eGFR:

Liver Bilirubin: Albumin:

INR and APTTR must be <1.5

Platelets must be >50,000 for percutaneous biopsy otherwise may need trans-jugular biopsy

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

Signed:

Dated:

Pre-Procedure Check List

Ward:

Date:

Admitting nurse:

Addressograph

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 INR, 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 to instructions under radiology section of intranet.			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 Radiology Department
Completed baseline observations on nursing obs chart and/or VitalPac			
If Diabetic then Blood sugar			BM:
Cannula inserted			Size: Position
Provide hospital gown and remove all excess jewellery			Taped Rings Y/N
Ensure canvas and draw sheet on the bed			
Ensure notes and prescription charts accompany the patient			

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, clotting and respiratory function tests acceptable Y/N
- Anticoagulation or antiplatelet drugs stopped Y/N/Not applicable
- WHO Interventional Radiology checklist completed Y/N

Baseline Observation in Radiology Department at hrs

Pulse: BP: SpO2: Resp rate:

Local anaesthetic: Amount:

Other drugs/ Sedation: Amount:

Comments regarding procedure:

Complications Pain Y/N Haemorrhage Y/N

Biopsy sample and histology request correctly labelled Y/N

Signed by radiologist: **Dated** **Time** : hrs

**Post procedure check
to be completed by
HCSW, nurse or
radiologist**

Addressograph

Post Procedure	Completed	Initials
Observations Time : 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

Post procedure (minimum 6 hours from leaving radiology)

Complete observation and record on obs chart and/or VitalPac:

**Every 15 minutes for 1 hour
Every 30 minutes for 2 hours
Every hour for further 3 hours**

Addressograph

Patient returned back to the ward

Time:

To remain NBM for 1 hour post procedure

Recommended:

To ensure patient lies on their right side for 2 hours after the liver biopsy

Until:

To remain on bed rest for a further 4 hours

Until:

Ensure call bell to hand

Y/N

Check wound every hour

Y/N

Assess level of pain every hour

Y/N

Observe for signs of haemorrhage

Y/N

If signs of haemorrhage keep NBM, continue to monitor every 15 minutes and lay patient on their right side and CONTACT SHO OR SPR FROM GATROENTEROLOGY OUTREACH TEAM IMMEDIATELY.

CONTACT SHO OR SPR FROM GATROENTEROLOGY OUTREACH TEAM IMMEDIATELY if NEWS score is 4 or greater or increases by 2 points and contact radiologist who performed the procedure as soon as possible.

Signed:

Dated:

Addressograph

Discharge Checklist**Senior Nurse or Gastro Outlying
Doctor to complete discharge.**

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		
Wound check No oozing, redness or obvious swelling	Y/N		Dressings for discharge Y/N
Pain free	Y/N		Discuss analgesia suitable to take.
Able to return to hospital within 30 minutes	Y/N		
Has a suitable adult with them for 24hrs	Y/N		
Remove cannula	Y/N		
Complete IDF ensuring OPA recorded on it.	Y/N		HCV pts OPA with hepatitis nurse 2-4 weeks Non HCV pts with Referring consultant
Post procedure advice and information sheet provided	Y/N		(Info leaflet provided in pre assessment)
If on anticoagulation or antiplatelet drugs, patient has been advised when to restart	Y/N		Follow instructions on Medium Risk section of "Anticoagulation Management of Patients Undergoing Invasive Procedures in Radiology"
Transport (Own or Hospital)	Y/N		Delete as necessary
Next of Kin informed	Y/N		
Valuables returned to patient if applicable	Y/N		

Discharged**Y/N****Bed manager contacted as not suitable as day case:****Y/N****Signed:****Dated:**