Liver 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 Liver 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 (Specify )Contact with CarbopenamaseProducing Organisms Y/N | **DIABETIC: Y/N**Type:Can you administer own insulin: Y/NIf no please ensure drug chart prescribed: Y/N |
| **Anticoagulation and anti-platelet therapy, please see trust guidelines on Microguide,** <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/NSelf-medication forms signed: Y/NIf 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:** |

Addressograph

# Referring Teams

# Assessment

Date:

Presenting Symptoms: (Reason for biopsy)

Medication

Anti-platelet medication or anti coagulation therapy.

Type:

Date stopped:

Refer to trust guideline on Microguide.

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

**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

**Examination:**

BP: Sp02:

Pulse:

Respiratory Rate:

Temperature:

Weight:

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 |

Underlying Bleeding diathesis Y/N 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/NInfection (<0.5%) Y/N Punctured lung, colon, kidney& gallbladder (<0.1%) Y/N Mortality of a liver biopsy (0.01%) Y/NFailure to diagnose (<10%) Y/N | Pain (30%) Y/NBruising (10%) Y/NVasovagal (3%) Y/NTemperature (<1%) Y/N |

Consent obtained Y/N

 Consent Form Signed Y/N

 Signed: Dated:

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** |
|  |  |  |
| **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:

**SIGNED:**

**DATED:**

# Pre-Procedure Check List

WardDate:

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 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. |  |  | 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 assesspatient’s understanding |  |  |  |
| Check consent signed |  |  | Can be consented by radiologist in RadiologyDepartment |
| Completed baseline observations on NEWSChart. |  |  |  |
| If Diabetic then take 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 Patients 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 tests acceptable Y/N

Anticoagulation or antiplatelet 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 Haemorrhage 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

**Complete observation and record.**

**Every 15 minutes for 1 hour**

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

Addressograph

Time patient started recovery :

To remain NBM for 1 hour post procedure Until:

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

 **Follow Radiology post procedure Guidelines.**

If signs of hemorrhage keep NBM, continue to monitor every 15 minutes and lay patient on their right side and Contact Interventional Radiologist.

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

Signed: Dated:

# Radiology Recovery

Addressograph

# 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 |  |  |
| Wound checkNo oozing, redness or obvious swelling | Y/N |  | Dressings for discharge Y/N |
| Pain free | Y/N |  | Discuss analgesia suitable to take. |
| Next of kin informed | Y/N |  |  |
| 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 |
| Valuables returned to the patient if applicable | Y/N |  |  |
| Patients own medication returned 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.