Kidney Biopsy Care

Pathway

**Checklist for referring consultant:**

* Bloods request for: FBC, UEC, INR/APTT, LFT’s and 2x Group & Save
* Is this patient on Anticoagulation Y/N
* BP must be completed prior to referral

Please complete pages 2-4 prior to referral, if not completed the procedure **will not be performed**.

Patient Information:

Date of Referral:

Consultant:

|  |  |  |
| --- | --- | --- |
| **Contact Number:**  | Home: | Mobile:  |
| Religious beliefs/practices: |  |
| Communication/Language:  |  |
| **Next of Kin:** | Name:  | Relationship: | Contact: |
| **Allergies:**  |  |
| **Infection control alerts:** |  |

**Procedure to be discussed with patient, including risks and complications.**

|  |  |
| --- | --- |
| **Risks explained** | **Symptoms Explained** |
| Significant bleeding (5%) Y/NNeed for transfusion (<1%) Y/N Need for embolization (<0.5%) Y/NUrinary retention (<2%) Y/NInfection (<1%) Y/N Failure to diagnose (<5%) Y/NMortality of a kidney biopsy (0.1%) Y/N  | Pain (10%) Y/NBruising (10%) Y/NHaematuria <24h (3%) Y/N |

Reason for Biopsy:

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 UTI Y/N

Obesity Y/N Pregnancy Y/N

Anticoag or Antiplt drugs Y/N Solitary native kidney Y/N

Patient BP: \*this must be carried out in clinic, prior to referral

If answered yes to the above questions then contact IR nurses (Extn: 4830) as may not be suitable for day case biopsy.

Patient Information:

|  |
| --- |
| Past Medical History:  |
| Diabetic: Y/N Type: Insulin dependent: Y/N |

|  |
| --- |
| Medication: Instructed to bring medication on day of admission: Y/NSelf-medication form signed and attached to this document: Y/N |
| **Is patient on Anticoagulation and/or anti-platelet therapy? Y/N****CAN THIS BE SAFELY STOPPED BEFORE PROCEDURE? Y/N**If patient is on anti-coagulation/anti-platelet therapy and you are not sure it can be safely stopped, please discuss with anti-coagulation clinic. It is the decision of the referring team as to whether it is safe to stop. Please refer to trust guidelines on Microguide: <https://viewer.microguide.global/guide/1000000295#content,87c8200f-f90b-4c09-86bc-926c015369c8> Type: Why is it prescribed: Date/time last taken: Date stopped:  |

Blood Tests:

Bloods Requested by referring team:

FBC Y/N

INR/APTT Y/N

Group and save Y/N

U & Es Y/N

LFTs Y/N

 This Form was completed by:

 Signed: Dated:

Pre-assessment and Appointment Booking by

IR-Nurse

Name of Nurse filling out form: Date:

Confirmed patient understands procedure and wants to proceed Y/N

Confirm Medication:

Confirm Past-medical History: Y/N

Confirm Allergies: Y/N

Confirm bloods within date/ or ask patient to attend for bloods Y/N

If patient requires blood test, ensure correct bloods

are ready for collection from Radiology Department

or are on Review. Y/N

Patient requires:

Nil By Mouth for 6HRS prior to procedure Y/N

Clear Fluids only until 2 hours prior to procedure Y/N

Transport discussed:

Own Transport Y/N

Hospital Transport Y/N

Booking details for hospital transport:

Responsible adult to collect and accompany patient for 24hrs Y/N

**Informed of restrictions post procedure**

no driving for 48 hours Y/N

avoid contact sports, heavy lifting or strenuous exercise including sexual intercourse for 2 weeks Y/N

Signed: Dated:

**SIGNED:**

**DATED:**

# Pre-Procedure Check List

Admitting nurse:

|  |  |  |  |
| --- | --- | --- | --- |
| **Check list** | **Tick** | **Initial** | **Comments** |
| Admit and orientate the patient to the ward |  |  |  |
| Confirm patient ID  |  |  |  |
| ID and Allergy Band  |  |  |  |
| Check next of kin details are correct |  |  |  |
| Bloods: Hb: Platelets: INR: APTT:Sodium:Potassium: Urea: Creatinine: eGFR: G&S:  |  |  |  |
| Last ate: Last drank: |  |  |  |
| If Diabetic then take blood sugar: BM: …… |  |  |  |
| Cannula inserted: Size: Position: Number of attempts: ANTT technique used: Successful Saline Flush:  |  |  |  |
| Completed baseline observations  |  |  |  |
| In gown  |  |  |  |
|  Anticoagulation or antiplatelet medication has been discussed and stopped.Date stopped:  |  |  |  |
| Patient consented by IR consultant:  |  |  |  |
| Ensure notes and prescription chartsaccompany the patient |  |  |  |
| Secure Patients own medication for admission period. |  |  |  |

Signed: Dated:

# Procedure

RADIOLOGIST:

PROCEDURE:

BIOPSY SITE:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Amount | Route | Time | Prescribed by:  |
| Lidocaine 1% |  | SC |  |  |
|  |  |  |  |  |
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IR Procedure Note/Report:

**Complications:**

 Pain Y/N

 Haemorrhage Y/N

Biopsy sample and histology request correctly labelled: Y/N

Signed by radiologist: Date Time

|  |  |  |
| --- | --- | --- |
| **DATE AND TIME** | **Multidisciplinary notes and evaluations** | **Signature/print Profession/ bleep/number** |
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Out Patient Post procedure

Patient into recovery at:

Ensure call bell to hand Y/N

|  |  |
| --- | --- |
| Care Guidelines:  | Rationale: |
| Observations to be taken: blood pressure, pulse, temp, resp rate, O2 sats and wound check (see chart below)every 15 minutes for hour 0-2 (2 hour) @every 30 minutes for hours 2-4 (2 hours) @every 60 minutes for hours 4-6 (2 hours) @Unless otherwise directed. ***If there are signs or symptoms of blood loss, hemodynamic instability or new abdominal discomfort/pain, lie patient on right side and contact the radiologist who performed the procedure if the patient is still in radiology. If they are no available, contact the on call medical registrar. If the patient is back on the ward contact a senior member of the responsible clinical team. If signs of hemorrhage keep NMB.*** **Follow NEWS 2 (trust policy) and escalate when triggers NEWS score.**  | Quick response to emergency call/review if indicatedDetection of post-procedure complications that may require urgent intervention. 61% of complications arise <2 hours, almost all significant bleeding happens in the first 6 hours. CONTACT SHO OR SPR FROM UROLOGY TEAM IMMEDIATELY IF SIGNS OF HAEMORRHAGE, NEWS SCORE IS 4 OR GREATER OR INCREASES BY 2 POINTS AND CONTACT RADIOLOGIST WHO PERFORMED THE PROCEDURE AS SOON AS POSSIBLE. |
| Patient to remain on bed rest for 4 hours post biopsy, unless otherwise directed.Until: | To exert pressure on the puncture site and needle track to reduce risk of bleeding  |
| Patient may have: Clear fluids 1 hours post biopsy Light meal 2 hours post biopsy Eat and drink normally at 6 hours post biopsy | Precautionary in case of post procedure complications requiring radiology intervention/surgery. |
| Ensure patient has passed urine | Collect a urine sample each time the patient urinates and record time on specimen pot, keep specimen by bedside.  |

**At each observation check, wound check must also be completed.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Time:**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Wound:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Key:** | **Dry = D** | **Ooze = O** | **No Change = NC** | **Leaking = L** |  |  |  |  |  |  |  |  |

 **Follow Radiologists direction if this deviates from above.**

Signed: Dated:

Pre-Discharge Checklist

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Circle** | **Initial** | **Comment** |
| Is the patient alert and orientated | Y/N |  |  |
| Vital signs stable | Y/N |  |  |
| Patient has mobilised post procedure | Y/N |  |  |
| Wound check, safe for discharge | Y/N |  |  |
| Pain controlled/ free | Y/N |  |  |
| Remove cannula | Y/N |  | VIP score: Action:  |
| If appropriate, when to restart medication | Y/N |  |  |
|  Valuables returned to the patient if applicable | Y/N |  |  |
|  Patients own medication returned if applicable | Y/N |  |  |
|  Patient information leaflet given to patient  | Y/N |  |  |
|  Patient collected by adult, to be accompanied for 24 hrs  | Y/N |  |  |

Discharged Y/N

Signed: Date:

In Patient Post procedure

PATIENT TO BE RECOVERED IN RADIOLOGY FOR 2 HOURS POST PROCEDURE.

Patient into recovery at:

Ensure call bell to hand Y/N

|  |  |
| --- | --- |
| Care Guidelines:  | Rationale: |
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**At each observation check, wound check must also be completed.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Time:**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Wound:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Key:** | **Dry = D** | **Ooze = O** | **No Change = NC** | **Leaking = L** |  |  |  |  |  |  |  |  |

 **Follow Radiologists direction if this deviates from above.**

**Handover given to ward member responsible for patient: Y/N**

**Ward Staff Name/Sig: …………………………. IR Nurse Name/Sig: ………………………………….**