St. Helens & Knowsley Teaching Hospitals NHS Trust

Decompensated Chronic Liver Disease Care Bundle & Advancing Quality (AQ) Targets

Patient ID / Sticker

Name ……

Hospital No: ……

D.O.B. ……/……/……

Date & Time: ……

Clinician: ……

Decompensated CLD is a **medical emergency** with a high mortality. Effective early interventions can improve clinical outcomes reducing length of stay and save lives.

This evidence-based checklist should be completed for **ALL unplanned admissions** with decompensated cirrhosis & supplements the Chronic Liver Disease (CLD) Management Toolkit.

Performance targets, set by the **NHS North West Advancing Quality Alliance**, are highlighted.

Initial Investigation & Management: ALL Patients

Early Warning Score (EWS) **<60-minutes** of hospital arrival ☐

Bloods:
- FBC, U+E, LFT, Clotting, Bone Profile, Mg, CRP, Glucose ☐
- Results seen & acted on **<6-hours** of hospital arrival ☐

Sepsis screen:
- Cultures: Blood / Urine +/- Stool (including CDT) if diarrhoea +/- Ascitic tap (see below) ☐
- Plain chest film ☐

Consider **USS liver & doppler portal vein** if new jaundice / ascites / variceal bleed ☐

Prescribe **prophylactic LMWH irrespective of clotting** (Enoxaparin 40mg OD) ☐
- Contra-indications: Platelets <50x10^9/L, anti-coagulated or active bleeding

Alcohol

Estimated intake _____ units / day and date / time of last alcoholic drink _____
- Risk of *Acute Alcohol Withdrawal* (AAW) greatest 6-24 hours after last drink
- If evidence **AAW** refer to AAW Policy ☐

AUDIT-C Score (Tool on Acute Medical Assessment Proforma pg 2): _____ (range 0-12)
- If **≥5** refer to *Alcohol Nurse Specialist* (ANS) on #7233 ☐

Prescribe **Pabrinex** © (1 ampoule pair TDS for 3 - 5 days) **<6-hours** of arrival ☐
for prophylaxis against *Wernicke-Korsakoff Syndrome* (WKS)
- If deemed not required or not given document reason e.g. Recent admission & administration <4-weeks, patient declined: _____ ☐
- Prescribe oral alternative (Thiamine 100mg PO BD & Vit B I BD for 3-months) ☐

Ascites

Diagnostic ascitic tap in **ALL** patients with clinically detectable ascites **<6-hours** of arrival to hospital to exclude spontaneous bacterial peritonitis (SBP) **Yes / No**
SBP = Ascitic fluid neutrophil count ≥250mm^3
- Should be undertaken **irrespective of INR & platelet count** ☐
- Results should be chased (lab #1652) and acted upon **<6-hours** (CLD Toolkit) ☐

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Acute Upper GI Bleeding (AUGIB): Refer to AUGIB Protocol

Suspected variceal haemorrhage? **Yes / No**

Suspected variceal bleeds require antibiotics and vasoactive therapy **<4-hours**: ☐

- Tazocin 4.5g IV TDS for 5-days (if Penicillin allergic follow Antibiotic Policy)
- Terlipressin 2mg IV QDS ☐

Advice on Resuscitation & Blood Product Support:

- Aim for systolic BP 90-100mmHg (crystalloid preferred to colloid)
- Transfuse if Hb <7.0g/L or massive bleeding / instability
  - Avoid over-transfusion (aim for Hb ~8-9 g/L)
- If pro-thrombin time (PT) prolonged give Vitamin K (10mg IV stat)
- If PT >20 seconds or INR >2.0 give FFP (2 - 4 units)
- If Platelets <50x10^9/L give IV Platelets

Early (<24-hours) gastroscopy post resuscitation: ☐

- 0900 - 1700: Contact the Endoscopy Unit #2224
- Out-of-hours: Contact on-call Endoscopist if emergency endotherapy needed
- Consider utilising '*early morning bleeder*' slots (0830 & 0845) Monday – Saturday

Acute Kidney Injury (AKI) & Hyponatraemia

If **Acute Kidney Injury alert** triggered follow the AKI Bundle: '*ACT & BEAT AKI*' **Yes / No**

- Stop nephrotoxins (e.g. NSAIDS, $COX2_i$, Diuretics, ACE_i, ARB) & anti-hypertensives ☐
- Assess fluid status, commence fluid balance chart and daily weights ☐
- Consider urinary catheterisation ☐
- Consider IVF – If indicated prescribe as per Fluid Policy ☐
  - Advice in CLD: - Use crystalloids or 4.5% Human Albumin Solution (HAS)
    - Aim: Urine output >30ml/hour & systolic BP >90mmHg

If Sodium **≤126mmol/L** suspend all diuretics ☐

Hepatic Encephalopathy

Consider and address any precipitants: ☐

- Sepsis
- Sedatives
- Electrolyte disarray
- Constipation
- Dry / AKI
- Alcohol
- Paracentesis
- GI bleed

Lactulose (10 - 30ml PRN / QDS) +/- Phosphate enema (aim x2 - 3 stools / day) ☐

Consider CT-Brain especially if suspicion of head injury or focal neurological signs ☐

Early Specialist Input

All decompensated CLD admissions should be triaged to the **Gastroenterology Ward (3D)** or **seen by a Gastroenterologist <48-hours** of hospital arrival

- Triaged to Ward 3D with bed expected <48-hours of arrival to hospital ☐
- Referral faxed for Specialist Gastroenterology Review (#1577) ☐