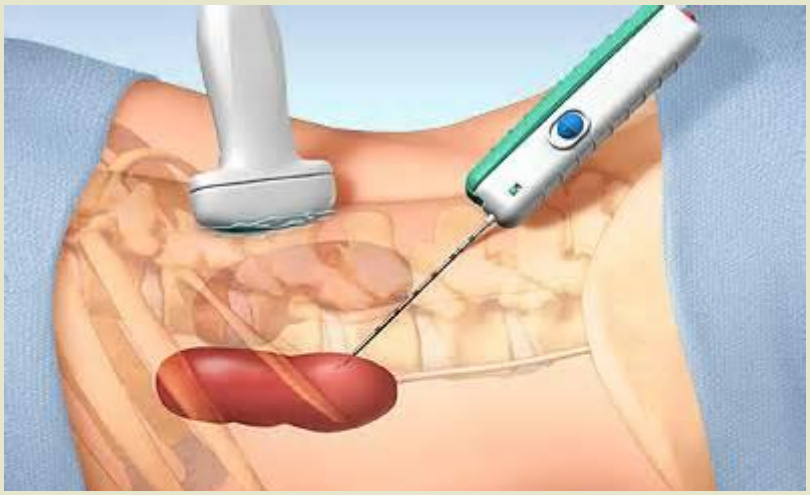

Assisting for Renal Biopsy

Key Terms

Kidney biopsy	Microscope	Curapore

ASSISTING FOR RENAL BIOPSY

INTRODUCTION:

A kidney biopsy is the removal of a small piece of kidney tissue or cells. A pathologist (a doctor who specializes in tissue diagnosis) uses a microscope to look at the tissue for abnormalities.

INDICATIONS:

- Persistent abnormal renal blood tests
- To diagnose any abnormality in the kidney
- Renal abnormality found on ultrasound, CT scan, or nuclear scan.

EQUIPMENT

- Sterile gloves
- Sterile dressings pack including Gauze packs, Artery forceps, Central hole towel, Two small towels, Toothed and Non toothed thump forceps, Sponge holding forceps, sterile drapes
- AHD for cleansing the skin
- Local anesthetic agent (xylocaine 2%),and 5cc syringe 2 for its administration
- Sterile disposable scalpel 11 size
- Sterile renal biopsy needle18 gauze, biopsy gun,
- Curapore 10 x 7

- Sterile specimen contained with formalin, appropriately labeled and with completed Pathology requisition form and plastic specimen bag for transportation
- Dry sterile specimen container
- Trolley for equipment
- Receptacle for soiled disposables
- Monitor

PROCEDURE:

NURSING ACTION	RATIONALE
Pre-Procedure:	
Explain the procedure to the patient including the benefits, risks and potential complication	Ensures the patient can make an informed decision about going ahead and knows what to expect
Give the patient a time for the procedure and explain that they should refrain from eating food for 3 hours pre procedure.	Reduce the risk of regurgitation and inhalation of stomach content if sedation is administered.
Check PT, and PTT and inform the physician.	Minimizes the risk of hemorrhage.
Reserve one unit of PRC as per physician's order.	
Consent from the patient will be obtained by the clinician performing the procedure.	Ensuring that the patient has full understanding of what is involved and the benefits and risks, and wishes to proceed.

Ensure the patient is wearing an identification band, with the correct information.	To ensure correct identification and prevent possible problems/ errors
Insert an intravenous access	Allows immediate administration of sedation and emergency drugs and IV fluids
Record the patients vital signs	To provide comparison during and post procedure
Check the patient has undergone relevant procedures for eg Ultrasound, Blood test	To ensure all relevant information is available to the operator or the radiologist
Complete the pre procedure checklist	Ensure all details are correct and safe to proceed.
Shift the patient to the respective department and handover patient information to the radiology Nurse.	Ensure safe delivery of the patient, and allays their anxiety.

Peri – Procedure

Explain the procedure to the patient	Reassure the patient and reduces any anxiety
Perform hand hygiene	To prevent cross infection
Assist with positioning the patient, Ensure patient's privacy, ensuring that they are covered by the gown or blanket	To maintain the patient's dignity and body temperature
Connect the patient to the monitor and record blood pressure, SPO2, and pulse rate. Record	Allows early identification of complication, ensuring prompt action.

at 15 min interval.

Prepare a sterile trolley with all equipment needed for the radiologist using aseptic techniques.	Reduces risk of infection and smooth running of procedure
At the end of the procedure dispose all the sharps and clinical waste in accordance with hospital policy	Reduce the risk to patients and staffs.
Assist the medical practitioner as necessary during the procedure	For smooth proceeding of the procedure
Observe the patients throughout this activity	Any changes in the patient's activity is a sign of complication
Document the administration of the drug, if prescribed	Documentation is a proof of any proceedings during the procedure
Dispatch the labeled specimen to the laboratory, with the completed laboratory form	Avoids missing and mixing of samples

Aftercare:

Ensure the placement of a pressure dressing over the biopsy site.	Tight dressing controls oozing and bleeding from site.
Position patient in supine position for 24 hrs	This position helps in giving compression to the puncture site.

Check BP every 15minuts for the first 1 hour and every 30 min for next 1hr, 1hr for next 6 hours and every 4 hours for 24 hours.	Vital signs are the first indicator for any complication.
Assess pain hourly, and administer analgesia as prescribed, documenting administration of drugs as necessary;	Pain can be an indicator for any complication after procedure
Monitor for after effects and report any abnormalities immediately. Inform duty registrar if there is hyper tension or hypotension, bleeding in the Puncture site, Pain or detoriation in general condition.	To assess the patient at the earliest for any complication
Do not ambulate for 24 hrs	Not to disturb the puncture site
Collect 3 consecutive urine samples in separate container and keep in bed side for observation. and report to the duty doctor if any hematuria	To assess the status of the patient after procedure.

Watch out

Call the renal registrar immediately if:

- The patient complaints of severe pain in the abdomen;
- Any abnormal swelling of the abdomen;
- Hematuria at any stage
- Any disturbance in the general condition of the patient

DOCUMENTATION

- Document hemodynamic parameters every 15minuts for the first 1 hour and every 30 min for next 1hr, 1hr for next 6 hours and every 4 hours for 24 hours.
- Document pain every hourly
- Document in receiving notes regarding the puncture site, general condition and vital signs while receiving.
- Report if any abnormal findings to the physician.

PATIENT FAMILY EDUCATION:

- Instruct the patient to lie down supine position for 24 hours after procedure
- To intimate intolerable pain to the nurse.
- Do not ambulate for 24 hrs

- Instruct the patient to collect 3 consecutive urine samples in separate given container and keep in bed side for observation.