Abstract P089 Figure 2 Final prototype liver model (1:1.3 scale) with embedded vasculature and tumour (above) and endoscopic view of right hepatic vein inside model (inset)

and was not adversely impacted by the COVID-19 pandemic. Patients do not need to travel to central hubs, and can remain under the care of their local hepatologist maintaining continuity of care and also promoting their involvement in decision making process. However, monitoring of 6- and 12-month response after starting OCA can be challenging as it is reliant on receiving follow-up data from the referring clinician. OCA dose must be adjusted based on the stage of liver disease and presence of pruritus.

REFERENCE

1. Nevens F, et al. A placebo-controlled trial of obeticholic acid in primary biliary cholangitis. *The New England Journal of Medicine* 2016;**375**:631–643.

P090

ASSESSING DOCUMENTATION OF ASCITIC PARACENTESIS IN LANCASHIRE TEACHING HOSPITALS NHS TRUST

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Ascites is a common presentation of decompensated liver cirrhosis and is associated with 50% mortality over 2 years.¹ Although complication rates of paracentesis are low (1.6%) and usually mild, significant complications including bleeding and death can ensue.²

The aim of the study was to measure the Lancashire Teaching hospitals NHS Trust's compliance for paracentesis documentation using the British Society of Gastroenterology and British Association of study of liver disease's paracentesis safety toolkit.³ The study involved retrospectively collected data from patients between January and April of 2020. A total of 13 patients were identified in keeping the inclusion criteria (known liver cirrhosis patients admitted with large volume ascites).

We found poor documentation practices involving procedure in the person performing procedure (84%), consent (53%), pre-procedure weight (15%), the plan for the amount of human albumin solution to be given (61%) and total given (38%), platelet count documentation (84%), recorded time of insertion (85%), color of the fluid drained (53%), and plan on when to remove the drain (61%). The audit also noted poor documentation post procedure including recorded time of removal (38%), total ascites drained (46%), and patient's weight recorded after removal (0%).

An updated version of the BSG toolkit was designed (divided into 2 main forms; 1 for insertion and the other for removal of drain), which will be implemented on the wards as well as the local trust's online system to aid documentation on the acute medical wards and emergency department. Furthermore, teaching sessions will be implemented to the medical and nursing staff rotations. Moreover, there is a plan to liaise with the education team to add a learning module on the induction for medical and nursing rotations.

This audit found poor documentation practices on a commonly performed procedure on the wards especially in patients with decompensated liver cirrhosis. The purpose of this audit was to highlight this and to point out that a unified documentation including all parameters should be present. This aids the clinicians in making decisions regarding patient care, enhances patients' safety and prevents important information from being missed. In addition, this could potentially save time especially on ward rounds.

REFERENCES

1. Powell WJ, Klatzkin G. Duration of survival in patients with Laennec's cirrhosis. Influence of alcohol withdrawal, and possible effects of recent changes in general management of the disease. *Am J Med* 1968 Mar;**44**(3):406–20.
2. McVay PA, Toy PT. Lack of increased bleeding after paracentesis and thoracentesis in patients with mild coagulation abnormalities. *Transfusion (Paris)* 1991 Feb;**31**(2):164–71.
3. Large Volume Paracentesis in Cirrhosis: Safety Toolkit [Internet]. *The British Society of Gastroenterology* [cited 2021 Jul 4]. Available from: <https://www.bsg.org.uk/clinical-resource/large-volume-paracentesis-in-cirrhosis-safety-toolkit/>

P091

A COORDINATED NATIONAL RESPONSE MAINTAINED A SAFE AND EFFECTIVE UK LIVER TRANSPLANT PROGRAM DURING THE FIRST YEAR OF THE COVID-19 PANDEMIC

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Background UK healthcare provision has been severely affected by the COVID-19 pandemic, with specific challenges in liver transplantation (LT). Here, we describe the co-ordinated response to, and impact of, the first year of COVID, across all 7 adult and 3 paediatric UK LT centres.

Methods A series of national policy changes affecting the LT process were agreed. A 'high-urgent' (HU) category was established, prioritising for LT those with UKELD >60, HCC reaching transplant criteria, and others likely to die within 90 days. Donor age restrictions and changes to offering were phased throughout the year. These changes were flexed in response to the 'first wave' (implemented: March–July 2020) and 'second wave' (implemented: Jan–April 2021). During the second wave, organ and patient 'back-up' arrangements were introduced, selected centres were designated 'protected' by