1. Investigations							
a)	NEWS ❑	FBC ❑	U/E ❑	LFT ❑	Coag ❑	Gluc ❑	$Ca/PO_4/Mg$ ❑
b)	Blood cultures ❑			Urine Dip/ MSU ❑	CXR ❑	Request USS abdo ❑	CRP ❑
c)	Perform ascitic tap in **all patients with ascites** using green needle **irrespective of clotting parameters** and send for ascitic PMN/WCC, culture and fluid albumin					Done **Y N**	N/A ❑
d)	**Record recent daily alcohol intake**			..... Units			

2. Alcohol - if the patient has a history of current excess alcohol consumption (>8 units/day Males or >6 units/day Females) **N/A** ❑		
a)	Give IV Pabrinex (2 pairs of vials three times daily)	**Y N**
b)	Commence CIWA score if evidence of alcohol withdrawal	**Y N N/A**
3. Infections - if sepsis or infection is suspected **N/A** ❑		
a)	What was the suspected source?.....	
b)	Treat with antibiotics in accordance with Trust protocol **Y N**	
c)	If the ascitic neutrophils >0.25 x 10^9/L (>250/mm^3) (i.e. SBP) then give: **Y N**	
I)	Treat with antibiotics as per trust protocol **Y N NA**	
II)	IV albumin (20% Human Albumin solution) 1.5g/kg **Y N NA** (20g of albumin in 100ml of 20% Human Albumin Solution)	

4. Acute kidney injury and/or hyponatraemia (Na <125 mmol/L) **N/A** ❑		
AKI defined by modified RIFLE criteria	1: Increase in serum creatinine ≥ 26□mol/L within 48hrs ***or***	
	2: ≥50% rise in serum creatinine over the last 7 days ***or***	
	3: Urine output (UO) <0.5mls/kg/hr for more than 6 hrs based on dry weight ***or***	
	4: Clinically dehydrated	
a)	Suspend all diuretics and nephrotoxic drugs	**Y N NA**
b)	Fluid resuscitate with 5% Human Albumin Solution or 0.9% Sodium Chloride (250ml boluses with regular reassessment: 1-2L will correct most losses)	**Y N**
c)	Initiate fluid balance chart/daily weights	**Y N**
d)	Aim for MAP>80mmHg to achieve UO>0.5ml/kg/hr based on dry weight	**Y N**
e)	At 6 hrs, if target not achieved or EWS worsening then consider escalation to higher level of care	**Y N NA**
5. GI bleeding – if the patient has evidence of GI bleeding and varices are suspected **N/A** ❑		
a)	Fluid resuscitate according to BP, pulse and venous pressure (aim MAP >65 mmHg)	**Y N**
b)	Prescribe IV terlipressin 2mg four times daily (caution if known ischaemic heart disease or peripheral vascular disease; perform ECG in >65yrs)	**Y N NA**
c)	Prescribe prophylactic antibiotics as per Trust protocol (cefuroxime unless contraindicated)	**Y N**
d)	If prothrombin time (PT) prolonged give IV vitamin K 10mg stat	**Y N NA**
e)	If PT> 20 seconds (or INR >2.0) – give FFP (2-4 units)	**Y N NA**
f)	If platelets <50 – give IV platelets	**Y N NA**
g)	Transfuse blood if Hb <7.0g/L or massive bleeding (aim for Hb >8g/L)	**Y N NA**
h)	Early endoscopy **after** resuscitation (ideally within 12 hours)	**Y N**

6. Encephalopathy **N/A** ❑		
a)	Look for precipitant (GI bleed, constipation, dehydration, sepsis etc.)	**Y N**
b)	Encephalopathy – lactulose 20-30ml QDS or phosphate enema (aiming for 2 soft stools/day)	**Y N**
c)	If in clinical doubt in a confused patient request CT head to exclude subdural haematoma	**Y N N/A**
7. Other		
a)	Venous thromboembolism prophylaxis – prescribe prophylactic LMWH (patients with liver disease are at a high risk of thromboembolism even with a prolonged prothrombin time; withhold if patient is actively bleeding or platelets <50)	**Y N NA**
b)	GI/Liver review at earliest opportunity (ideally within 24 hrs)	❑