UNIVERSITY OF Cincinnati

Kidney Transplant Recipient Care Plan

(This document may be accessed on the kidney transplant wiki page)

Recipients of Living Donor Kidney Allografts
Projected Length of Stay: 3 days

The Care Plan addresses key steps in patient care from the period through hospital discharge to home or transfer to a rehabilitation facility. It is expected that some patients may have more complicated clinical courses that may warrant changes in the Care Plan.

Kidney Transplant Recipient Key Clinical Care Goals

Begin discharge planning by POD#1, with all team members involved in the process.

1. **Patient Care:**
   - Remove central line after patient has 2 PIVs (or document clear need for ongoing CVC)
   - Remove foley catheter by POD#3 unless otherwise specified by the surgeon or there are appropriate, documented indications for continued use
2. **Patient Education:**
   - Responsibility of all team members to make sure all questions from family/patient answered to their satisfaction
   - Pharmacy: patient self-administration & specific teaching: meds, regimen and pillbox packing
3. **Discharge Readiness Assessment and Planning:**
   - Transplant PA/NP coordinates with ambulatory pharmacy to order discharge medications
   - Recognize obstacles to early ambulation and initiate appropriate intervention (PT, OT, alternative discharge plan as appropriate)
   - Assess collaboratively patient safety and readiness for discharge
   - Ensure that the patient has resources to obtain adequate nutrition, access to medications, access to physician follow-up appointments
   - Ensure that patient support system is in place (rehabilitation facility, visiting nurse, transportation)
4. **Communication:**
   - Ongoing, daily discharge plan communication between inpatient/outpatient transplant team
   - Timely, detailed communication between team members and at change of shifts to ensure patient safety, and facilitate discharge planning

Pre-Operative Area

Patient Care - Orders:

*Patients receiving **LIVING DONOR** transplant will arrive at SDS on day of transplant (consent obtained and orders placed at pre-operative clinic)

POD#0: (Transfer to SICU)

Orders:

"Kidney TXP Post Op Admission" order set

- Labs: daily CBC, differential, renal panel, magnesium
- Glucose qAC/HS (or q6hr if NPO)
- Start diet 6 hours out of OR unless peritoneum opened

Medications:

- Fluids:
  - When urine output is less than 50ml/hr, run 0.9 % NaCl infusion at rate of 50ml/hr
  - When urine output is between 50-150ml/hr, run 0.9 % NaCl infusion at rate of 100ml/hr
  - When urine output is greater than 150ml/hr, run 0.9 % NaCl infusion at 150ml/hr and replace 2/3 last hour urine output with 0.45 % NaCl
- SubQ heparin TID initiated in evening of POD#0 (unless bleeding concerns or IV heparin also ordered)
- IV antibiotics x 24 hrs post-op
- Initiate PCA once extubated and off sedation
- Continue Antithymocyte globulin dose #1 x24hrs (ensure running at rate of 20.8 ml/hr unless otherwise directed by transplant surgeon)
- Mycophenolate (Cellcept) 1000 mg BID
- methylprednisolone/steroid taper as per order set
- PRN Dopamine – continue as instructed/start only if instructed by transplant surgeon; parameters per transplant surgeon

Goals/Parameters/Targets:

- CVP ~8-12 (if <5, treat with IVF or albumin bolus)
- SBP>110
- Keep I>O for at least 24 hours

Lines/Drains:

- TLC
- Arterial line
- JP (surgeon dependent)
- Foley
- ETT - Wean vent to extubation (if not extubated in OR)

Nursing:

- Line/Foley/JP care
- Strict I&Os
- SCDs
- Vitals per unit routine
- Daily standing weights
- IS 10 times/hour while awake

****Do not change initial surgical site dressing for 48 hours**

Education: Responsibility of all members of team to make sure all questions from family/patient

answered to their satisfaction.

POD#1

Discharge: Update outpatient team.

Orders:

- Labs: daily CBC, differential, renal panel, magnesium, Tacrolimus trough level - 8am for SICU/6am for 8CCP
- Glucose qAC/HS (or q6hr if NPO)
- Advance diet
- Pend to floor (Modify labs to 6AM on 8CCP)

Medications:

- D/C replacements based on replacement protocol seen above
- SQH
- IV antibiotics at 24 hrs post-op
- DC PCA. Transition to tylenol/gabapentin/tramadol prn (unless on opioid for chronic pain pre-txp) and IV dilaudid prn breakthrough pain***
- Bowel regimen - polyethylene glycol (Miralax) and colace
- Restart appropriate home meds
- Antithymocyte globulin dose #2 x6hrs (ensure within ANC/PLT parameter prior to order)
- Start tacrolimus per Living Donor Kidney Transplant Immunosuppression protocol.
- Mycophenolate (Cellcept) 1000 mg BID
- Methylprednisolone/prednisone taper
- Pantoprazole

Goals/parameters/targets:

- Keep I>O for at least 48 hours

Lines/Drains:

- PIV x2 or TLC x1
- A-line -- DC if no insulin gtt and when no longer indicated for close hemodynamic monitoring
- JP (case/surgeon dependent)
- Foley

Nursing:

- Line/Foley/JP care
- Strict I&Os
- SCDs
- Vitals per unit routine
- Daily standing weights
- IS 10 times/hour while awake
- Up in chair/OOB TID
- Telemetry (8CCP)

****Do not change initial surgical site dressing for 48 hours**

Education: Completed prior to transplant. Responsibility of all team members to make sure all questions from family/patient answered to their satisfaction. Coordinator teaching (arrival on 8CCP). Pharmacist medication self-administration teaching (arrival on 8CCP). Nurse teaching.

Discharge Planning: Routine transplant medications ordered through Hoxworth pharmacy. Update outpatient team. Review placement/home care needs w/ social work.

POD#2

Orders:

- Labs: daily CBC, differential, renal panel, magnesium, tacrolimus level, Tacrolimus trough level - 8am for SICU/6am for 8CCP
- Glucose qAC/HS (or q6hr if NPO)
- Advance diet

Medications:

- D/C IVF/saline lock IV
- SQH
- Oral pain medications: Tylenol, gabapentin, and tramadol prn (unless on opioid for chronic pain pre-txp)
- Bowel regimen - polyethylene glycol (Miralax) and colace
- Antithymocyte globulin x6 hrs if indicated based on immunosuppression protocol
- Tacrolimus, adjust per level
- Mycophenolate (Cellcept) 1000 mg BID
- Methylprednisolone/prednisone taper
- Consider ID prophylaxis (antiviral/antibacterial) – need CMV/EBV status of donor/recipient
- Pantoprazole

Goals/parameters:

- Keep I>O for at least 48 hours

Lines/Drains:

- PIV x2 or TLC x1
- JP x 1
- Foley

Nursing:

- Line/Foley/JP care
- Strict I&Os
- SCDs
- OOB – ambulate TID
- Dressing change
- Vitals per unit routine
- Daily standing weights
- IS 10 times/hour while awake

- Up in chair
- OOB TID
- Telemetry (8CCP)

Education: Completed prior to transplant. Responsibility of all team members to make sure all questions from family/patient answered to their satisfaction. Coordinator teaching. Pharmacist medication self-administration teaching. Nurse teaching.

Discharge Planning: Follow up with ambulatory pharmacy regarding medication status. Review placement/home care needs w/ social work – complete COC or HC form.

POD#3

Orders:

- Labs: daily CBC, differential, renal panel, magnesium, tacrolimus level
- Glucose qAC/HS (or q6hr if NPO)
- Advance diet

Medications:

- SQH
- Oral pain medications
- Bowel regimen - polyethylene glycol (Miralax) and colace
- Antithymocyte globulin if indicated based on immunosuppression protocol
- Tacrolimus (Prograf) per level
- Mycophenolate (Cellcept)
- Methylprednisolone/prednisone taper
- Consider ID prophylaxis (antiviral/antibacterial) – need CMV/EBV status of donor/recipient
- Pantoprazole

Lines/Drains:

- PIV x2 or TLC x1
- Foley - D/C foley. Void check and PVR (page txp1 if PVR>150. Double void and re-check PVR).
- JP x 1 - D/C 6 hours after Foley out (monitor for increase or change in color of JP output)

Nursing:

- Line/Foley/JP care
- Strict I&Os
- SCDs
- OOB – ambulate TID
- Dressing change
- Vitals per unit routine
- Daily standing weights
- IS 10 times/hour while awake
- Up in chair

- OOB TID
- D/C telemetry

Education: Completed prior to transplant. Responsibility of all team members to make sure all questions from family/patient answered to their satisfaction. Coordinator teaching. Pharmacist medication self-administration teaching. Nurse teaching.

Discharge Planning: Update outpatient team. Review placement/home care needs w/ social work – complete COC or HHC form. Med reconciliation and discharge instructions completed. Pharmacist pack pill box. Schedule outpatient ureteral stent removal +/- PD catheter removal. If present, discuss removal of TDC prior to discharge home. Arrange follow-up with outpatient team and other services involved in patient care.