**STANDARD OPERATING PROCEEDURE FOR POST-OPERATIVE CARE FOLLOWING RENAL TRANSPLANT**

The patient will be transferred to ITU immediately after operation for approx 24-72 hours.

**Transfer from ITU to Ward**

Time of transfer will depend on patient's clinical condition

Patient will have central venous access (neckline) inserted in theatre
Various peripheral IV cannula
IV Fluids
Epidural/PCA
Wound Infusion
Wound drain
Naso-Gastric tube/Peg
Urethral catheter

**Handover from ITU**

The patient will arrive with a nurse and porter.

- It is **VITAL** to obtain correct **TOTAL FLUIDS IN** and **TOTAL FLUIDS OUT**
- Ensure Drug Kardex is up-to-date as ITU use computerised Drug Kardex.
- Check Vital signs and update fluid chart.
- Notify medical staff of patient arrival to review and for medical plan.

**FLUID AND ELECTROLYTES**

- Monitor all fluid input and output hourly with regular fluid chart used on ward and - documenting hourly totals/balances using **24 HOUR BALANCE sheet.**
- Replace urine output ml for ml with prescribed fluids. IV fluids will need to adjusted accordingly every hour.
  e.g. PATIENT X passes 136mls urine within the hour. IV fluids will be increased to 136mls/hr for next hour. **Please see Fluid Charts Example**
- if urine output falls to less than 1.5ml/kg/hr (or otherwise stated by medical staff), check for kinks and flush urinary catheter. Medical staff will need to review and may consider IV furosemide.
- If urine output large, check urinary sodium and notify medical staff.
- Double check all totals and balances every 1-2 hours.

**VITAL SIGNS**

- Check Vital signs hourly for 12-24 hours post ITU transfer if stable may continue 2-4hourly with medical instruction.
- High BP is common post transplant; however renal consultant will set BP limits to aim for.

**MEDICATIONS**

- Patient will be commenced on dose of tacrolimus BD, however dependant on tacrolimus levels may be increased or decreased.
- Reducing daily dose (4 days) of prednisolone
- Mycophenalate Mofetil (MMF)
- Basilixamab (dose given day 0 (prior to surgery) and day 4
- Aspirin (for 3 months)
- Cefotaxime BD
- Omeprazole

**DAILY INVESTIGATIONS**

- Full set on Renal Bloods ( U+E, LFTs, Bone, Glu, Mag, CRP & FBC) taken each day, normally for first 48-72 hours 6 hourly depending on medical instruction.
- Daily tacrolimus level also required (in the am, preferable 10-12 hours post last dose, and before 8am at weekend) **Ensure level is taken PRIOR to dose administered**.
- Daily Urinalysis and PCR.
- Medical Team will also instruct on Renal Ultra Sounds, and any further
- Daily Weights required

**PAIN MANAGEMENT**

Patient will return with:

- Wound infusion (local anaesthetic dripping directly into the wound, similar to epidural)
- Patient/Nurse Controlled Analgesia (PCA/NCA) a morphine infusion controlled by patient or nurse dependant on age.
- Wound Infusion and Morphine will be reviewed on a daily basis by pain team.
- Regular Paracetamol should be administered (Via IV in the first 24-72 hours until patient tolerates oral intake)
- If unable to control pain please seek further advice from pain team

**NG TUBE/PEG**

- If minimal drainage over first 24 hours, may be spigotted on surgical instruction.
- If medical/surgical team happy, sips to begin with and aim for all fluids and light diet taken orally by 24-48 hours.
- Can be removed when tolerating fluids and drugs.

**WOUND DRAIN**

- If drainage minimal consider removal within 24-72 hours, discuss with surgeon prior.

**URETHRAL CATHETER**

- Should remain in situ for first 7 days
- Daily urine sample can be obtained from catheter.
- Flush if urine output poor flush catheter

The medical team will provide a clear plan for day shift and nightshift.