


<b>Name of Policy:</b> <u>Living Renal Donor Management and Follow Up Care After Donation</u> <b>Policy Number:</b> 3364-140-02 <b>Department:</b> Renal Transplant Program <b>Approving Officer:</b> Chief Nursing Officer Director, Renal Transplant <b>Responsible Agent:</b> Director, Renal Transplant Program, Transplant Administrator/Coordinators <b>Scope:</b> The University of Toledo Medical Center	  <b>Effective Date:</b> May 1, 2024 Initial Effective Date: October 23, 2007
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> New policy proposal (for Med Staff)  <input type="checkbox"/> Major revision of existing policy </div> <div> <input checked="" type="checkbox"/> Minor/technical revision of existing policy (UTMC)  <input type="checkbox"/> Reaffirmation of existing policy </div> </div>	

**(A) Policy Statement**

The University of Toledo Medical Center (“UTMC”) strives to improve the human condition through consistent rigor and high standards with respect to quality and safety for its living kidney transplant program.

**(B) Purpose of Policy**

To ensure that all living renal donors are under the care of a multidisciplinary team coordinated by the donor surgeon throughout donor evaluation, donation, and discharge phases of donation and to ensure adequate post donation follow up care.

**(C) Scope**

This policy applies to members of the medical staff performing transplantation procedures at the University of Toledo Medical Center, UTMC Personnel and any other persons involved in the transplantation programs of the University of Toledo.

**(D) Procedure**

1. All living renal donors will be under the care of a multidisciplinary team coordinated by the donor’s surgeon (“Donor Surgeon”) from the point of evaluation, surgical donation and discharge. The multidisciplinary team will be represented by the following disciplines:
  - a. Medicine (organ recovery surgeon or transplant physician). The donor surgeon or transplant physician will be involved in the pre donation evaluation, admission, multidisciplinary rounds and discharge planning.
  - b. Nursing/Advanced Practice Provider (APP). The Transplant coordinator/APP will provide education and direction throughout the living donor process during evaluation, admission, and discharge planning. The transplant coordinator/APP will have involvement in multidisciplinary rounds.
  - c. Nutrition will provide and document evaluation screens on all living donors. Post donation the dietician will have involvement during multidisciplinary rounds and discharge planning process.
  - d. Social Services. The social worker will complete and document psychosocial evaluation pre donation. The social worker will participate in MDR’s and discharge planning during the admission for donor nephrectomy. The social worker will remain available in the post donation phase if warranted to address psychosocial needs, information, and referrals.

- e. Living donor advocate or living donor advocate team (as applicable). The living donor advocate will evaluate and document the advocate assessment pre donation. The living donor advocate will provide documentation of inpatient assessment following donor nephrectomy and will remain available in the post donation process.
  - f. Transplant Pharmacist will do a chart audit on all donors prior to donation and will meet with the donor if needed. Transplant Pharmacist will meet with living donor post donation and a note will be documented addressing any in house concerns and recommendations for discharge.
2. All patients will be seen by the Donor Surgeon and Living Donor Coordinator throughout patient hospitalization.
3. The Living Donor Team will conduct discharge planning with the donor patient on post-op day1 which will include the following:
- a. Post-op medication administration;
  - b. Restrictions on activity/limitations;
  - c. Potential surgical complications that would necessitate a call to the doctor;
  - d. Medication restrictions post op;
  - e. Risk of hypertension;
  - f. Contact numbers of transplant program staff that should be contacted for questions;
  - g. Nutrition plan (if needed);
  - h. Psychosocial plan (as applicable);
  - i. Need for other health services and assistance securing these health services;
  - j. Assistance required to access local medical care equipment or support; and
  - k. Ensures all members of the multidisciplinary team visit and document care in the patient record during the inpatient postoperative and discharge phase of donation.
4. After hospital discharge (post-donation) all living donors will be advised to follow up in the outpatient transplant clinic. They will be seen by the Donor Surgeon and/or Donor Coordinator at the following intervals:
- a. 1 week
  - b. 6 weeks
  - c. 6 months
  - d. 1 year
  - e. 2 years

**Approved by:**

/s/

Kurt Kless, MSN, MBA, RN, NE-BC  
Chief Nursing Officer/CNO

Date

/s/

Michael Rees, M.D.  
Director, Renal Transplant

Date

Review/Revision Completed By:  
Transplant Coordinator  
Transplant Administrator

## Review/Revision Date:

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**Next Review Date:** 5/1/2027

**Policies Superseded by This Policy:**