HSC Business Services Organisation

Directorate of Legal Services

Practitioners in Law to the Health & Social Care Sector

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:
BPC-004-11

Our Ref:
HYP B04/1

Date:
25.10.11

Brian Cullen
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letter of 31st August 2011 (BPC-0004-11).

I am instructed that Belfast City Hospital has never produced a written protocol for the peri-operative medical management of renal transplant recipients but has followed a standardised practice in line with the recommendations of the Renal Association and the British Transplantation Society at the time. The Belfast City Hospital has also always followed the policies of NHS Blood and Transplant and its predecessor bodies. A Nursing Care Pathway was produced in 2010 and is enclosed.

Yours faithfully,

Joanna Bolton
Solicitor Consultant

Direct line: - [redacted]
Email: - [redacted]

Belfast Health and Social Care Trust

Care Pathway for Renal Transplant Patients

Patient Name: .....

Address: .....

Ward: ..... DOB: .....

Hosp No: ..... H&C No: .....*(or affix label)*

EDD: .....

Patient Information

This Care Pathway is a document detailing the delivery of care of patients who are attending for Renal Transplant Surgery. It has been agreed and documented as the most common pathway that this care may follow. As an individual your health requirements may vary from those laid out in this pathway, in which case the health professionals will use their judgement to adapt that care accordingly. Any variations from the pathway will be explained to you. If you do not have a clear understanding of what is going to happen, please ask a member of staff to explain.

Staff Information

This care pathway should be used as a guideline towards the most efficient and effective delivery of care necessary for a Renal patient who is attending for Renal Transplant Surgery which includes transplant guidelines on page 53-55. It replaces all other documentation. However if a patient remains an inpatient for longer than 14 days this pathway should be discontinued, filed in the patient's notes and an appropriate nursing care plan commenced. Only abbreviations on page 62-63 must be used in the Care Pathway.

Initialling the Care Pathway

You should use the initials column to confirm that an intervention has been carried out or an outcome achieved.
If an intervention is not applicable, please tick the N/A box as well as initialling.

Variances: "what is a variance"?

A variance is any non-completion of a planned intervention, e.g. "Consent form ***not*** completed correctly" or an outcome ***not*** achieved, e.g. "Fasting regime ***not*** adhered to". If more than one variance occurs on the same page, they should be documented in numerical order, e.g. **V1, V2, V3 etc.** If several variances occur for the same reason, they should be accorded the same number.

Signature Register

Since you are only required to initial parts of the Care Pathway itself, this page serves as a record of your full signature and thus satisfies medico-legal requirements. Accordingly, all staff using this Pathway ***MUST*** complete their details below.

Name *(block capitals)*	Designation	Professional Registration Number	Initials	Full signature

Infection Prevention and Control Admission Risk Assessment Form

(To be completed by the nurse admitting a patient OR accepting a transfer)

Patient Details	Transferring Hospital Details
Name:	Date of Admission: .....
Address:	Ward: .....
.....	Consultant: .....
.....	Reason for original admission/Transfer:
Hosp. No.:	.....
Date of Birth:	.....
Date of Admission:	Name of staff member in transferring hospital supplying
Ward:	information:
	.....

Risk Assessment for Infective Diarrhoea

Is the patient/client currently having diarrhoea and/or vomiting where infection is the suspected cause? Yes/No

Has the patient/client been in a ward or nursing home where other patients have been having Diarrhoea and/or vomiting? Yes/No

Have the patient's/client's family had diarrhoea and/or vomiting Yes/No

Is viral Gastroenteritis/Norovirus suspected or confirmed? Yes/No Suspected ☐ Confirmed ☐

Has the patient/client a history of *Clostridium difficile*? Yes/No

If yes, date of first *C. difficile* toxin positive specimen: .....

Known History of Multi-resistant Organisms or Other Infection Risk

Has the patient/client a history of having? MRSA Yes/No ESBL Yes/No VRE/GRE Yes/No Other: .....

Is the patient in a Target group for MRSA screening? *(see MRSA screening and management of colonised patients policy)* Yes/No

Screening swabs taken? Yes/No

Is the patient/client and their family aware of their infection status? Yes/No/Unknown	Is the patient/client currently being nursed in a single room? Yes/No Was the patient/client placed in an isolation room on admission- Yes/No

Other relevant information: *(e.g. Current antibiotic treatment/part of outbreak/MRSA decolonization history)*

.....

.....

.....

Infection Prevention and Control Nurse informed? Yes/No

Name of staff member completing form

Signature & Print Name: .....

Contact Number: ..... Date: .....

Pre-Transplant Checklist

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

	Yes	No	N/A	Initials
On Arrival to Ward				
Bloods completed				
Infection Control Assessment				
Braden score				
Moving and Handling Assessment				
Is patient on: Aspirin ☐ Clopidgrel ☐ Warfarin ☐				
If patient is on more than one anticoagulant inform surgeon				
Clinical Chemistry				
Nutrition profile/LFT/Bone profile/CRP/Lipid/Glucose				
PTH (EDTA) sample purple top				
Haematology				
FBP				
Coagulation/INR				
Group and cross match To Theatre – 2 units packed cells To the Ward – 4 bottles of HPPF				
Virology				
CMV/EBV/Hep B and C/Varicella Zoster				
Has patient been tested for HIV in the last 12 months				
Tissue Typing				
Tissue Typing – *(10mls clotted) (keep on ward and send with samples in donor box)*				
Additional Investigations				
Bacteriology				
Nose and throat swabs				
Chest X-ray				
Complete ECG *(put into notes)*				
On Awaiting Results				
Order old notes				
MO Clerk in ☐ Admission ☐ Consent ☐ Compression stockings ☐ Fasting time:				
Recent Dialysis History				
Lock H/D lines Sodium Citrate				
Last Haemodialysis:				
Dialysis – CAPD drained out Weight: ..... Dry weight:				
Venflon inserted Site:				
Cannulation form completed				
Commence IV fluids ☐				
If Cross-Match Negative *(cadervic transplant only)*				
Blood results available				
Old notes and X-Rays available *(Old and New)*				
Order x 2 Units packed cells to Theatre				
Order x 4 bottles of HPPF to Ward				
Blood Group Donor:				
Blood Group Recipient:				

Date: ..... Time: .....

Admission Information

Admission Date: ..... Time: ..... Initials: .....

Own dialysis unit phoned — Yes ☐ N/A ☐
Patient ID x 2 — Yes ☐ No ☐

Patients Details

Patient's Preferred Name: .....
Date of Birth: .....
Marital Status: .....
Occupation: .....
Contact numbers Home: .....
Work: ..... Mobile: .....

Next of Kin Details
Name: .....
Address: .....
.....
Contact numbers Home: .....
Work: ..... Mobile: .....

GP Name: ..... Phone number: .....

Reason for Admission

.....

Relevant Past Medical History

.....
.....
.....

Cause of Renal Impairment

Primary: .....
Access History: .....
Creation: .....
Problems: .....

Patient's Understanding of Reason for Admission

.....

Admission Observations

Temp: ..... Pulse: ..... BP: ..... SpO_2: ..... Resps: .....

Weight: ..... Height: ..... EWS Score: .....

Initials: .....Date: ..... Time: .....

Date	Reason for Variances	Action taken *(if any)*	Initials

Patient Assessment

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

Allergies/Medicine Sensitives *(This section must be completed)*

Date	Medicine/Allergy	Type of reaction *(e.g.rash)*	Initials

or

No known allergies ☐ Initials: ..... Date: ..... Time: .....

Cause of Renal Failure: .....

Planned operation: Cadaveric ☐ Non heart beating ☐ Live related ☐ Live unrelated ☐

Dialysis dependant Yes ☐ No ☐

Dialysis modality: ..... Dialysis Days: ..... Time: .....

Dialysis access: ..... Dialysis centre: .....

Valuables

Has patient's property been sent home: Yes ☐ No ☐ N/A ☐

Property kept at patient's own risk: Yes ☐ No ☐ N/A ☐

Valuables stored in hospital via property book Yes ☐ No ☐ Receipt No: .....

Communication and Mental State

Orientated to:

Time Yes ☐ No ☐

Place Yes ☐ No ☐

Person Yes ☐ No ☐

Bedside hand set explained to patient, including buzzer Yes ☐ No ☐

Ward layout explained to patient Yes ☐ No ☐

Vision: Good ☐ Poor ☐

Spectacles Yes ☐ No ☐ N/A ☐

Registered blind Yes ☐ No ☐ N/A ☐

Hearing: Good ☐ Poor ☐

Hearing aid required Yes ☐ No ☐ N/A ☐

Speech: Clear/Coherent ☐ Slurred ☐ *(Dysphasia)*

Fears and concerns: .....

Initials: ..... Date: ..... Time: .....

Date	Reason for Variances	Action taken *(If any)*	Initials

Patient Assessment
(continued)

Mobility and Appliances (e.g. zimmer, stick, prosthesis etc)

Patient at Risk of Falls: Yes ☐ No ☐ N/A ☐

If Yes risk assessment completed: Yes ☐ No ☐

Respiratory

No symptom	Yes ☐ N/A ☐	Patient wishes to continue smoking against advice	Yes ☐ N/A ☐
Home oxygen	Yes ☐ N/A ☐	Referral to Smoking Cessation Nurse	Yes ☐ N/A ☐
Breathless at rest	Yes ☐ N/A ☐		
Minimum exertion	Yes ☐ N/A ☐		
Moderate exertion	Yes ☐ N/A ☐		
Smoker	Yes ☐ N/A ☐		
Trust No Smoking Policy explained to patient	Yes ☐ N/A ☐		
Patient wishes to stop	Yes ☐ N/A ☐	Date:	
Patient wishes to use Patches	Yes ☐ N/A ☐		

Skin Condition on admission

Intact *(Totally)*	Yes ☐ No ☐	If No, specify site and describe: .....
Discoloured	Yes ☐ No ☐	If No, specify site and describe: .....
Broken/Lacerations	Yes ☐ No ☐	If No, specify site and describe: .....
Rash/Bruises	Yes ☐ No ☐	If No, specify site and describe: .....
Leg Ulcers	Yes ☐ No ☐	If No, specify site and describe: .....

Consent gained for Patient/NOK prior to examination of patient's skin: Yes ☐ No ☐ If No, why: .....

Sleep Pattern

Sedation used Yes ☐ No ☐ If Yes, specify: .....

Retires to bed at: .....

Manual Handling Assessment

Sitting to standing										
Up/Down bed										
Side to side										
Bed/Chair										
Sitting forward										
Walking										

Braden Score: ..... Yes ☐ No ☐ Date: .....

Falls Yes ☐ No ☐ Date: .....

Other: .....

Key for assessing patients requirements

0 = Independent
1 = Requires assistance of one
2 = Requires assistance of two
3 = Hoist

B = Belt
S = Slide
R = Rope ladder
H = Hoist

Reassess as patient's condition improves or deteriorates

Initials: ..... Date: ..... Time: .....

Date	Reason for Variances	Action taken *(if any)*	Initials

Patient Assessment *(continued)*

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

Dietary Requirements

Nausea/Vomiting Yes ☐ No ☐

Swallowing difficulties Yes ☐ No ☐

Recent weight loss Yes ☐ No ☐

Special diet: ..... Dietary restrictions: .....

Fluid restrictions: ..... mls/24hrs Alcohol intake Yes ☐ No ☐ units per week: .....

Condition of mouth: ..... Dentures: Top ☐ Bottom ☐ Plate ☐ None ☐

Nutritional *(MUST)* Score: ..... Yes ☐ No ☐ Date: .....

Eliminating *(Present)*

Bowel habit: ..... Urinary habit: ..... 24hr urine volume: .....

Catheter in use Yes ☐ No ☐ Urinalysis: .....

Date of LMP: ..... N/A ☐

Comments: .....

Cardiovascular

Hypertension *(HTN)* Yes ☐ No ☐

On medication for HTN Yes ☐ No ☐

Hypotension Yes ☐ No ☐

Chest pain Yes ☐ No ☐

Vascular problems Yes ☐ No ☐

If yes, specify: .....

Community and Social Information

Social History Accommodation

Patient lives alone Yes ☐ No ☐ Patient lives with: .....

Patient is carer for someone Yes ☐ No ☐

Is Patient known to Social Services Yes ☐ No ☐

Name of social worker: .....

Details: .....

Initials: ..... Date: ..... Time: .....

Date	Reason for Variances	Action taken *(if any)*	Initials

Additional Nursing Notes

Date/Time	Notes	Initials

Additional Nursing Notes	Patient Name: .... Ward: .... Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials

Belfast Health and Social Care Trust

Adult Pressure Ulcer Risk/ Skin Assessment Chart

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

If the individual is fully conscious and does not give a history of pressure damage, neurovascular deficits or immobility, dignity will be respected and the absence of pressure damage determined verbally. Otherwise, pressure points must be inspected.

Enter code for each pressure point *(see below)*

Note: Non blanching erythema cannot be seen in black skin; clues to pressure damage include heat, pain and /or a bluish discolouration over bony prominences.

Occiput	Sacrum	Buttock	Hip	Heel	Other (state area affected)
_____	_____	Right ___ Left ___	Right ___ Left ___	Right ___ Left ___	_____ _____

CODE	
A = Intact	1 = Grade 1 Pressure damage (non blanching erythema)
VA = Verbal Check (area intact)	2 = Grade 2 Pressure damage (shallow crater / serous blister)
B = Blanching erythema	3 = Grade 3 Pressure damage (subcutaneous fat)
UC = Unable to check	4 = Grade 4 Pressure damage (muscle / tendon / bone visible)
	DTI = Upgradable/ Potential Deep Tissue Injury (discoloured skin/ slough/eschar/blood blister)

Braden Score (see over) If the patient scores 18 or below OR they already have a pressure ulcer they must be commenced on the Adult Pressure Ulcer Care Pathway. Re-evaluate risk score at least weekly in acute care, monthly in continuing care and 6-8 monthly in community.

Sensory Perception							
Moisture							
Activity							
Mobility							
Nutrition							
Friction & Shear							
Total Score							
'At risk'/Pressure Ulcer - **Pressure ulcer care pathway commenced?**	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Grade 2-4 Pressure damage - **Wound Assessment chart commenced?**	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Grade 2-4 Acquired Pressure Ulcer - **Clinical Incident form completed?**	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Grade 3-4 Pressure Ulcer – TVN informed?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Date							
Time							
Signature							

*****If you have answered NO to any of the questions in the table above you must document the reason why the expected care/procedure has not been followed*****

Braden Pressure Ulcer Risk Assessment Tool

Sensory Perception Ability to respond meaningfully to pressure related discomfort	**1. Completely limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** Limited ability to feel pain over most of body surface	**2. Very limited** Responds only to painful stimuli. Cannot communicate except by moaning or restlessness **OR** Has a sensory impairment that limits the ability to feel pain or discomfort over most of the body.	**3. Slightly limited** Responds to verbal commands, but cannot always communicate discomfort or need to be turned **OR** Has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No impairment** Responds to verbal commands. Has no sensory deficit, which would limit ability to feel or voice pain or discomfort.
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	**2. Very moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely moist** Skin is usually dry; linen only requires changing at routine intervals.
Activity Degree of physical activity	**1. Bedfast** Confined to bed	**2. Chair fast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks frequently** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Mobility Ability to change and control body position	**1. Completely immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited** Makes frequent though slight changes in body or extremity position independently.	**4. No limitation** Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern NPO[1] - Nothing by mouth IV[2] - Intravenously TPN[3] - Total parenteral nutrition	**1. Very poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly, does not take a liquid dietary supplement **OR** is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. Probably inadequate** Rarely eats a complete meal and generally eats only about 1/3 of any foods offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over ½ of most meals. Eats 4 servings of protein (meats, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered **OR** is on tube feeding or TPN[3] regimen that probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and Shear	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	**3. No apparent problem** Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	

Please document score overleaf.

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Risk Assessment for the use of Bed Rails

The assessment must be reviewed if:

- Patient becomes confused or agitated
- Patients condition significantly changes
- Patient falls form the bed
- Mattress or type of bed rail is changed

Date of Assessment: .....

Section A

Is alternative to bed rails more appropriate? →

- Patient requires assistance to move in bed — Yes ☐ No ☐
- Alternative equipment effective — Yes ☐ No ☐
- Patient likely to attempt to climb out of bed — Yes ☐ No ☐
  If YES, nurse patient with bed in lowest position

If still going to use bed rails, give reasons and complete assessment: .....

.....

.....

Action taken with reasons: .....

.....

If NOT using bed rails complete Section D otherwise go to Section B

Section B

Is there a requirement for Extra height bed rails? →

- Bariatric (Large) patient — Yes ☐ No ☐
- Use of second/especially deep mattress — Yes ☐ No ☐
- If YES to either, use extra height rails and complete assessment. If extra height rails unavailable, leave bed in lowest position except when administering direct care

Action taken: .....

Section C

Is there likelihood of Patient becoming Entrapped in bed rails? →

- Is head or body small enough to become trapped in:
  Bed rail bars — Yes ☐ No ☐
- Gap between lower rail and compression mattress — Yes ☐ No ☐
- Gap between rail and side of mattress — Yes ☐ No ☐
- Is there a gap between end of bed rail and headboard or wall of between 60-250 mm — Yes ☐ No ☐
- If YES to any, there is a risk of entrapment and rails MUST be taken down or correctly fitted and repeat assessment
- Decision to use Bed Rails — Yes ☐ No ☐

Actions taken:

Reason used if risk of entrapment identified: .....

If Bed Rails used : Type of Bed — Hospital profiling ☐ Bariatric ☐ Trolley ☐

Type of Bed Rails — Prefixed to bed ☐ Requiring fitting ☐ Full ☐ Part Length ☐

Bed Rails inspected to ensure mechanically working and secure to side of bed — Yes ☐ No ☐

Section D

Has patient and family Been advised of decision? →

- Has assessment, options and risk been discussed with patient /carer/next of kin — Yes ☐ No ☐
- Does the patient/family insist on the use of bed rails — Yes ☐ No ☐
- Is use of bed rails is against advise — Yes ☐ No ☐
- Does the patient/family refuse the use of bed rails — Yes ☐ No ☐
- Is omission of bed rails is against advise — Yes ☐ No ☐

Assessment completed by Initials: ..... Date: .....

Mobility/Falls/Bed Rails Assessment

History	Mental Status	Eyesight
Has the Patient:	Is the patient:	Is the patients:
Been admitted with a fall? Yes/No	Agitated Yes/No	Everyday activity affected by impaired eyesight? Yes/ No
A History of Recent Fall? Yes/No	Confused Yes/No	
Fallen on the ward? Yes/No		
If yes to any score 1	If yes to any score 1	If yes to any score 1
Refer to physio and OT now Score: ☐	Score: ☐	Score: ☐

Toileting	Transferring (bed-chair) Mobility			
Is the patient:	Unable	0	Immobile	0
In need of especially frequent toileting?	Able to sit with Help of 1 or 2 people	1	Wheelchair dependant	1
Yes/No	Minimal help (verbal/physical)	2	Walks with 1 person	2
If yes to any score 1	Independent	3	Independent	3
Score: ☐	Transferring Score: ☐		Mobility Score: ☐	

Add Transferring and Mobility together = ☐

If this is 3 or 4 score 1 for this section

Score: ☐

Date	History Score	Mental Status Score	Eyesight	Toileting	Transferring and Mobility adapted score	Comments/Actions

Score = 1 Low Risk
Assess and document weekly or if condition changes

Total Assessment Score > or = 2 High Risk
Assess and document every 4 days or if condition changes

Nursing Actions	Date and Initials	Nursing Actions	Date and Initials
Introduce and orientate patient to environment and routine e.g. Meal times		**Carry out all the Low risk actions and**	
Instruct patient in use of nurse call system		Position patient's bed at the top of the ward close to bathroom and nurses station	
Assess lighting level and the need for a night light		Assist and supervise patient to bathroom and initiate regular toilet regime	
Ensure patients are able to reach ALL items they may need e.g. Glasses, walking aids etc.		Record patient's lying and standing blood pressure	
Ensure area is free from obstacles and other hazards		Inform medical staff of falls risk score and document in patients clinical notes	
Frequently re-orientate to surroundings and routines		Discuss patient's management with multidisciplinary team and document	
Check clothing is not causing a hazard and footwear is well fitting		Discuss patient's risk and management with family/carer and document	
Ensure bed is at the right height for the patient		Refer to Physio and Occupational Therapy and document	
Ensure chair is appropriate for the patient height and seating area.			
Provide information leaflet to patient and relatives			
Assess need for supervision to toilet/bathroom			
Carry out bedrails assessment			
Refer to Physio and Occupational Therapy and document			

PRE OPERATIVE CHECKLIST *(To be completed by Ward Staff and checked by Theatre Staff)*	Ward				Theatre		
	Y	N	N/A	Inits	Y	N	N/A
PRE OPERATIVE VERIFICATION AND CONSENT							
Patient alert ☐ Sedated ☐ Confused ☐ Unconscious ☐							
Legible armbands x2							
Patient's details correct *(name, hospital number and DOB)* on both armbands/labels and matches call slip/theatre slip							
Consent form completed correctly							
Operation site marked correctly as per consent form							
CJD risk assessment form (annex J) completed Result: high risk ☐ low risk ☐ unknown ☐							
Patient has fasted From: ..... (date) Food: ..... Hrs Fluid: ..... Hrs							
Allergy status checked Details: ..... None ☐							
Pre Medication given if prescribed							
Relevant drugs omitted Specify:							
Was beta blocker treatment compliant?							
Infection status checked Details: ..... None ☐							
Implantable Electronic Device present If Yes specify:							
Diathermy compatible							
PATIENT PREPARATION	Y	N	N/A	Inits	Y	N	N/A
Patient showered and in appropriate clothes for theatre							
Was compliant hair removal carried out?							
Dialysis fistula							
Tunnelled catheter							
Bladder emptied							
Catheterised							
IV cannula							
Drains insitu							
Dental braces, dental crowns, loose or capped teeth *(please circle)* If Yes specify location:							
Correct tourniquet insitu							
HAVE THE FOLLOWING BEEN REMOVED	Y	N	N/A	Inits	Y	N	N/A
Dentures							
Metal hair accessories including hair beads							
Hearing aid							
Glasses ☐ Lens ☐							
Make-up, nail polish							
Jewellery, body piercing, rings taped/removed from operative side if appropriate. If taped please specify:							
PATIENT COMMUNICATION AND MOBILITY PROBLEMS	Y	N	N/A	Inits	Y	N	N/A
Speech/ Hearing/Vision *(please circle)*:							
Learning Disability							
Has the patient any injuries eg. back, neck, limiting joint conditions, that may affect positioning or other aspects of planned surgery. If Yes detail:							
First language if not English: ..... Is Interpreter required/present Not required ☐							
Compression/Antiembolism stockings							
Intermittent Pneumatic Compression (IPC) Device							

Patient Name: .....

Hospital Number: .....

H&C Number: .....*(or affix label)*

Location: .....

	Ward				Theatre		
	Y	N	N/A	Initls	Y	N	N/A
Drug DVT Prophylaxis prescribed and administered at ..... hrs on ..... (date)							
Bed Accessories requirement (including special pressure relieving mattress) Details: ..... None ☐							
BLOOD RESULTS	Y	N	N/A	Initls	Y	N	N/A
Blood results							
Group and hold ☐ *or* group and cross match ..... units ☐							
Patient Diabetic – if Yes Type: ..... Blood Glucose: ..... at: ..... hrs							
PREGNANCY STATUS *(for menstruating females aged approx 12-55 yrs)*	Y	N	N/A	Initls	Y	N	N/A
Day 1 of LMP: ..... if this date is more than 10 days ago check is ***PATIENT PREGNANT***? Yes ☐ No ☐ Uncertain ☐							
Patient verbally confirms is **NOT** pregnant. Signature of Patient:							
If uncertain pregnancy test required.*(Appropriate test to be used)* *Result*: Positive ☐ Negative ☐							
If patient pregnant Medical staff informed							
DOCUMENTS TO THEATRE WITH PATIENT	Y	N	N/A	Initls	Y	N	N/A
Medical notes ☐ Nursing Notes ☐							
Fluid Balance Chart							
Xrays including scans: hard copy ☐ PACS ☐							
ECG							
Drug Kardex							
Observation chart							
Patient ID labels							
Wound surveillance form							
RELEVANT MEDICAL HISTORY	Y	N	N/A	Initls	Y	N	N/A
Medical History Checked None ☐ List relevant medical history *(If non elective surgery include reason for admission)*							
Care of patient valuables as per Trust policy							
Patient's parent/guardian present if required							
Braden Score: ..... Pressure Damage verified None ☐ If yes specify site:							
Weight: ..... kgs Height: ..... cms							
BASELINE OBSERVATIONS TO BE COMPLETED WITHIN 1-2 HRS PRE-OPERATIVELY							
Temp: ..... Tympanic ☐ Non tympanic ☐ (ward) Temp: ..... Tympanic ☐ Non tympanic ☐ (theatre)	Pulse: ..... BP: ..... Resps:						
Ward staff Signature *(at theatre handover)*: ..... Date: ..... Time: .....hrs Theatre staff Signature: ..... Date: ..... Time: .....hrs							

SPECIAL INVESTIGATIONS *(only record where applicable to your area)*	Ward				Theatre		
	Y	N	N/A	Inits	Y	N	N/A
OPHTHAMOLOGY AND ENT							
Biometry (Ophthalmology)							
Audiogram (ENT)							
Orthoptics							
ORTHOPAEDICS/FRACTURES/ VASCULAR	Y	N	N/A	Inits	Y	N	N/A
Arrangements documented for amputee patients: Incinerated ☐ Buried ☐ Sent as specimen ☐							
Northern Ireland Joint Register (NIJR) consent MPH only							
FRACTURES/EMERGENCY SURGERY	Y	N	N/A	Inits	Y	N	N/A
Skin Injuries None ☐ Details (eg. Bruises, lacerations, blisters):							
Other injuries (please document in medical history) None ☐							
EMERGENCY SURGERY ONLY	Y	N	N/A	Inits	Y	N	N/A
Are relatives contact details in nursing notes? None ☐ If not detail below:							
Spiritual care required None ☐ Comment:							
GENERAL SURGERY/COLORECTAL SURGERY	Y	N	N/A	Inits	Y	N	N/A
Bowel prep							
NEUROSURGERY	Y	N	N/A	Inits	Y	N	N/A
GCS:							
CARDIOLOGY	Y	N	N/A	Inits	Y	N	N/A
Baseline Observations: INR: ..... SpO_2: ..... Warfarin Status:							
MATERNITY SERVICES	Y	N	N/A	Inits	Y	N	N/A
Fetal heart checked							
Palpate abdomen							
OTHER INFORMATION							

If no to any of the items on the pre op checklist, please document reason(s) in the section below

Reason for No	Action Taken (If any)	Initials

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

World Health Organization

Location: .....

Patient Name: .....

Hospital Number: .....

H&C Number: ..... *(or affix label)*

Before induction of anaesthesia ▲▲▲▲▲▲▲ Before skin incision ▲▲▲▲▲▲▲▲▲▲ Before patient leaves operating room

SIGN IN

- ☐ PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ SITE MARKED/NOT APPLICABLE
- ☐ ANAESTHESIA SAFETY CHECK COMPLETED
- ☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING
- ☐ DOES PATIENT HAVE A:
  - KNOWN ALLERGY?
    - ☐ NO
    - ☐ YES
  - DIFFICULT AIRWAY/ASPIRATION RISK?
    - ☐ NO
    - ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE
  - RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
    - ☐ NO
    - ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE
  - ANTICIPATED CRITICAL EVENTS
- ☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT SPECIFIC CONCERNS (INCLUDING ALLERGIES)?
- ☐ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING PRESENCE OF STERILE LABEL AND EXPIRY DATE) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?
- ☐ HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE IV LAST 60 MINUTES?
  - ☐☐ YES
  - ☐☐ NOT APPLICABLE
- ☐ IS ESSENTIAL IMAGING DISPLAYED?
  - ☐☐ YES
  - ☐☐ NOT APPLICABLE

SIGN OUT

- ☐ NURSE VERBALLY CONFIRMS WITH THE TEAM:
- ☐ THE NAME OF THE PROCEDURE RECORDED
- ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT
  - ☐☐ YES
  - ☐☐ NOT APPLICABLE
- ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
- ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT
- THROAT PACK IS:
  - ☐☐ REMOVED
  - ☐☐ NOT APPLICABLE
- ☐☐ TOURNIQUET REMOVED / NOT APPLICABLE

THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

On Behalf of Team

Initials: ..... Time: ..... hrs

On Behalf of Team

Initials: ..... Time: ..... hrs

On Behalf of Team

Initials: ..... Time: ..... hrs

On Return From Recovery

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

	Yes	No	N/A	Time	Initials
Monitoring established: HR ☐ BP ☐ SpO_2 ☐ CVP ☐ EWS ☐					
Hourly urine volumes					
Check lines					
Oxygen prescribed					
Check wound					
Check drains and identify as No 1 and No 2					
IV fluid prescribed					
IV fluids attached and commenced					
IV Dopamine					
Compression stockings in situ					
Stent					
If yes, antibiotic prescribed					
Pain relief prescribed					
Check catheter *(with size)*:					
Check mattress					
Record blood loss					
Record blood sugars					
Check time for next blood					
Ultra sound booked					
Update Braden Score					

Date	Reason for Variances	Action Taken *(if any)*	Initials

Additional Nursing Notes

Date/Time	Notes	Initials

Additional Nursing Notes

Patient Name: ....

Ward: ....

Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials
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Nursing Day 1

Date: .....

	Yes	No	N/A	Time	Initials
Alert and oriented					
EWS *(minimum frequency 2 hourly)*					
Bloods reserved					
Oxygen therapy continues at:					
CVP monitoring continued					
ECG leads in situ					
IV Fluids continue as prescribed					
Wound drain(s) checked					
Hourly urine volumes					
Reserve CSU					
Wound checked and redressed with film dressing					
Tolerating oral fluids					
Tolerating oral medication					
Commencement of oral immunosuppressant drugs					
Commenced on subcutaneous Enoxaparin					
MRSA screen completed					
Personal hygiene attended to					
Catheter care as per policy					
Mouthwashes/oral hygiene offered every 4 hours					
Weight: ..... kgs					
Updated Braden score:					

Pressure areas to be checked BD *(see code below)*	Occiput	Sacrum	Buttocks	Hips	Knees	Heels	Other	Time	Initials
				R	R	R	R		
				L	L	L	L		

Ultra sound scan					
Dialysis					
Refer to Chest Physiotherapist					
Provide patient with Coach					
Reserve CSU					
MSSU					

Post Ward Round Instructions

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Date	Reason for Variances	Action Taken *(if any)*	Initials

Code for pressure area check: ***(refer to CREST guidelines)*** **A** Intact **B** Blanching erthema i.e. skin is red, but blanches under light finger pressure **1** Grade one pressure sore i.e. skin is red but does not blanch under light finger pressure **2** Grade two pressure sore **3** Grade three pressure sore **4** Grade four pressure sore **E** Eschar *(mostly necrotic or sloughy tissue)* **U** Unable to check, reason: .....

Any deterioration in skin condition must be noted in patients notes and care plan adjusted accordingly.

Additional Nursing Notes	Patient Name: .... Ward: .... Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials
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Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 2

Date: .....

	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Blood reserved					
4 hourly EWS					
CVP monitoring					
24 hour fluid balance recorded hourly urine volumes					
Oxygen therapy continued					
Oral medication given					
IV Fluids continue as prescribed					
Wound drain(s) in situ					
Film dressing reapplied					
Personal hygiene attended to					
Updated Braden score:					

Pressure areas to be checked BD *(see code below)*	Occiput	Sacrum	Buttocks	Hips	Knees	Heels	Other	Time	Initials
				R	R	R	R		
				L	L	L	L		

Weight: ..... kgs					
Ultra sound scan					
Dialysis					
Bowel sounds present					
Referred to dietitian					
Advice given on: Mobility Diet Compression stockings Medication					

Post Ward Round Instructions ***(specify changes from Day 1)***

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Date	Reason for Variances	Action Taken *(if any)*	Initials

Code for pressure area check: ***(refer to CREST guidelines)*** **A** Intact **B** Blanching erthema i.e. skin is red, but blanches under light finger pressure **1** Grade one pressure sore i.e. skin is red but does not blanch under light finger pressure **2** Grade two pressure sore **3** Grade three pressure sore **4** Grade four pressure sore **E** Eschar *(mostly necrotic or sloughy tissue)* **U** Unable to check, reason: .....

Any deterioration in skin condition must be noted in patients notes and care plan adjusted accordingly.

Additional Nursing Notes

Patient Name: ....

Ward: ....

Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials

Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 3

Date: .....

	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour fluid balance recorded					
Oxygen discontinued					
Personal hygiene attended to					
Weight (am): ..... kgs					
Updated Braden score:					

Pressure areas to be checked BD *(see code below)*	Occiput	Sacrum	Buttocks	Hips	Knees	Heels	Other	Time	Initials
				R	R	R	R		
				L	L	L	L		

Managing diet					
Wounds checked					
Check bowels moving					
Ultra sound scan					
Refer to Renal Pharmacy					
Renal education informed					
Advice given on: Mobility Diet Compression stockings Medication					
Education leaflets given					
Dialysis					
Social Services required					
Social Services contacted					
Reserve CSU					

Post Ward Round Instructions (specify changes from Day 2)

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Date	Reason for Variances	Action Taken *(if any)*	Initials

Code for pressure area check: *(refer to CREST guidelines)* **A** Intact **B** Blanching erthema i.e. skin is red, but blanches under light finger pressure **1** Grade one pressure sore i.e. skin is red but does not blanch under light finger pressure **2** Grade two pressure sore **3** Grade three pressure sore **4** Grade four pressure sore **E** Eschar *(mostly necrotic or sloughy tissue)* **U** Unable to check, reason: .....

Any deterioration in skin condition must be noted in patients notes and care plan adjusted accordingly.

Additional Nursing Notes

Patient Name: ....

Ward: ....

Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials

Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 4

Date: .....

	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour Fluid balance					
Personal hygiene attended to					
Weight (am): ..... kgs					
Check bowels are moving					
Wounds dry					
Independently mobile					
Managing diet					
Dialysis					
Advice given on: Mobility Diet Compression stockings Medication					
Commence education checklist					
Ultra sound scan					

Post Ward Round Instructions (specify changes from Day 3)

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Date	Reason for Variances	Action Taken *(if any)*	Initials

Additional Nursing Notes

Patient Name: ....

Ward: ....

Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials
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Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 5

Date: .....

	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour fluid balance					
Personal hygiene attended to					
Weight (am): ..... kgs					
Monitor bowel function					
Wounds dry					
Independently mobile					
Managing diet					
Dialysis					
Advice given on: Mobility Diet Compression stockings Medication					
Catheter removed *(TROC)*					
Compression stockings in situ					
Ultra sound scan					
Reserve CSU					

Post Ward Round Instructions (specify changes from Day 4)

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Date	Reason for Variances	Action Taken *(if any)*	Initials

Additional Nursing Notes

Patient Name: ....

Ward: ....

Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials
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Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 6				Date:	
	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour fluid balance					
Personal hygiene attended to					
Weight (am): ..... kgs					
Normal bowel functions					
Wounds dry, no erythema					
Independently mobile					
Managing diet					
Dialysis					
Advice given on: Mobility Diet Compression stockings Medication					
Compression stockings in situ					
Renal Pharmacy					

Post Ward Round Instructions (specify changes from Day 5)

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Date	Reason for Variances	Action Taken (if any)	Initials

Additional Nursing Notes

Patient Name: ....

Ward: ....

Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials
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Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 7	Date:				
	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour fluid balance					
Personal hygiene attended to					
Weight (am): ..... kgs					
Normal bowel functions					
Wounds dry, no erythema					
Independently mobile					
Managing diet					
Dialysis					
Advice given on: Mobility Diet Compression stockings Medication					
Compression stockings in situ					
Renal Pharmacy					
MSSU					
Reserve CSU					

Post Ward Round Instructions (specify changes from Day 6)

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Date	Reason for Variances	Action Taken *(if any)*	Initials

Additional Nursing Notes	Patient Name: .... Ward: .... Hosp No: .... H&C No: .... *(or affix label)*

Date/Time	Notes	Initials

Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 8

Date: .....

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour fluid balance					
Personal hygiene attended to					
Weight (am): ..... kgs					
Normal bowel functions					
Wounds dry, no erythema					
Independently mobile					
Managing diet					
Dialysis					
Advice given on: Mobility Diet Compression stockings Medication					
Compression stockings in situ					
Renal Pharmacy					

Post Ward Round Instructions (specify changes from Day 7)

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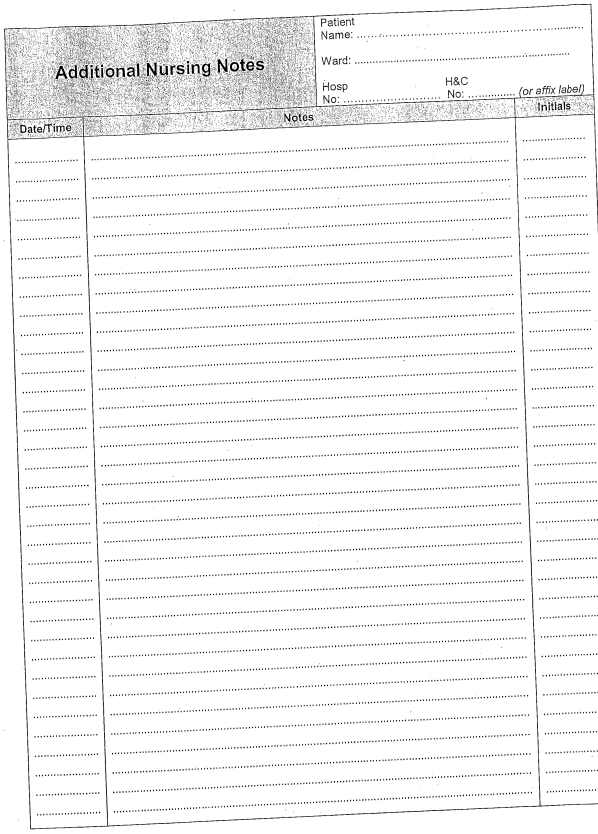
Date	Reason for Variances	Action Taken *(if any)*	Initials



Additional Nursing Notes

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

Date/Time	Notes	Initials

Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 9

Date: .....

	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour fluid balance					
Attended to own personal hygiene					
Weight (am): ..... kgs					
Normal bowel functions					
Wounds dry, no erythema					
Independently mobile					
Managing diet					
Dialysis					
Advice given on: Mobility Diet Compression stockings Medication					
Compression stockings in situ					
Renal Pharmacy					
MSSU					
Reserve CSU					

Post Ward Round Instructions (specify changes from Day 8)

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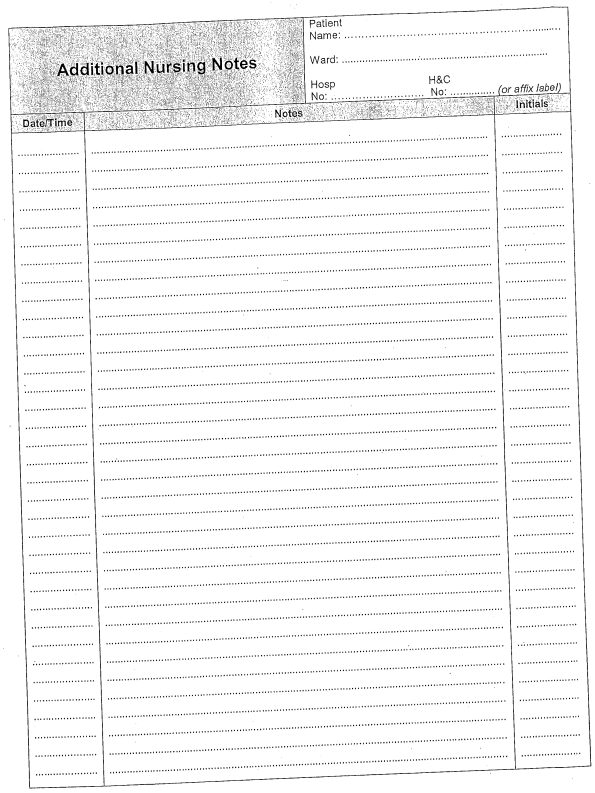
Date	Reason for Variances	Action Taken *(if any)*	Initials



Additional Nursing Notes

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

Date/Time	Notes	Initials
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Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day 10

Date: .....

	Yes	No	N/A	Time	Initials
Asleep as per usual sleep pattern					
Bloods reserved					
4 hourly EWS					
24 hour fluid balance					
Attended to own personal hygiene					
Weight (am): ..... kgs					
Normal bowel functions					
Wounds dry, no erythema					
Independently mobile					
Managing diet					
Dialysis					
Advice given on: Mobility Diet Compression stockings Medication					
Compression stockings in situ					
Renal Pharmacy					

Post Ward Round Instructions (specify changes from Day 9)

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If the Patient remains in hospital after day 10, use the additional nursing day pages on pages 56-61

Date	Reason for Variances	Action Taken *(if any)*	Initials

Additional Nursing Notes

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

Date/Time	Notes	Initials

Additional Nursing Notes

Date/Time	Notes	Initials

Discharge Planning Checklist

EDD: ..... Actual Date of Discharge: ..... Time of Discharge: .....

Please ensure all boxes are ticked and each task is initialled/dated by each registered Nurse completing the task

		Initials	Date
Doctor letter complete and given to patient	Yes ☐ N/A ☐		
Medications Emed update Treatment card	Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐		
Remove Venflon	Yes ☐ N/A ☐		
Remove Femoral Catheter *(see medical notes)*	Yes ☐ N/A ☐		
Patient/Relative information	Yes ☐ N/A ☐		
Diet and Fluids discussed and reinforced	Yes ☐ N/A ☐		
If patient discharged requiring a home mattress • Contact TVN *(only if mattress supplied by Trust* • Contact District Nurse	Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐		
Community Referrals • District Nurse i.e. requires wound dressing • Home help	Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐		
Transport home: Own ☐ Hospital ☐	Yes ☐ N/A ☐		
Dialysis Unit informed/Transplant Co-ordinator informed if applicable	Yes ☐ N/A ☐		
Regular Dialysis transport rebooked *(inform ward clerk in Dialysis Unit ext 33318)*	Yes ☐ N/A ☐		
Arrangements made to attend Transplant Clinic	Yes ☐ N/A ☐		
If patient deceased • Notification of death form posted to GP • GP contacted by phone on 1st working day following patient's death • Patient signed out on (1) ARD (2) PAS	Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐		
Computerised database for discharge updated	Yes ☐ N/A ☐		

Other relevant information: .....

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Discharge Checklist completed by: .....

Post Transplant Care Guidelines

Problem: The patient has the potential to develop post operative complications; i.e. haemorrhage, infection, rejection

Goal: To prevent the risk of post operative complications

Interventions

1. Record and respond to EWS as follows:
   - 15-30 minutes – 4 hours
   - Hourly – 4 hourly
   - 2 hourly – 4 hourly
   - 4 hours – 4 hourly
   - Or as clinically indicated
2. Monitor and report CVP *(Central Venous Pressure)* as above *(normal limits 5-10cmlwater)*
   - If < 5 administer bolus of 0.9% NaCl/Colloid as prescribed by Medical Staff
   - If >10 adjust fluid regime as prescribed by Medical Staff
   - Observe CVP exit site for signs of infection, bleeding and leakage
   - Remove CVP line as per protocol on day 2-3 as instructed by Medical Staff
3. Alternate 0.9% NaCl and 5% dextrose as prescribed by Medical Staff
   - Fluid replacement regime as per Medical Staff
   - Continue with IV fluid replacement regime as prescribed until patient able to tolerate oral fluids
   - Discontinue IV fluid replacement regime as per Medical Staff

Problem: The patient has a urinary catheter in situ

Goal: To monitor urinary output, to prevent infection

Interventions

4. Perform catheter care as appropriate/required
   - Ensure patient's privacy, dignity and respect are maintained at all times
   - Measure and record hourly urometer readings via urometer
   - Ensure catheter tubing not kinked or blocked and allow to drain freely
   - Any reduction in urinary output check for:
     - Kinks in the catheter tubing
     - Catheter is below the level of the bladder
     - The catheter tubing is not blocked by any debris
   - Perform bladder levage if indicated by reduced urinary output and report to Medical Staff
   - Reserve 24 hour urine collection daily for GFR, volume, urinary sodium and urinary creatinin
   - Daily CSU while catheter in situ
   - Catheter removed as per Medical instructions
   - Alternate MSSU once catheter removed
   - If stent in situ ensure antibiotic therapy prescribed

Post Transplant Care Guidelines *(continued)*

Problem: The patient has a surgical wound

Goal: To prevent wound infection and promote wound healing

Interventions

5. Observe wound for signs of serious ooze "pooling"
   Any ooze, signs of infection or observable changes in the wound reserve swab for O+S and report to Medical Staff
   Any ooze noted replace dressing as indicated using aseptic technique
   Observe for signs of haemorrhage
   Ensure allergy status is recorded
   Prior to first Doppler change dressing to IV 3000 if allergic to IV 3000 use alternative transparent dressing
   Wound drain
   Observe and record drain for volume
   Remove drain as instructed by Medical Staff

Problem: The patient is receiving IV/Oral medications

Goal: To ensure the patient receives the prescribed medications

Interventions

6. a) Administer Immunosuppression *(IV or Oral)* as prescribed by medical staff *(refer to local policy/protocol for the administration of immunosuppression)*
   Reserve Immunosuppressant levels on Tuesday/Friday prior to administration of the drug. Report back to Medical Staff the results
   b) Administer pain relief *(IV or Oral)* as prescribed by Medical Staff *(refer to local policy/protocol for the administration of pain relief)*
   c) Administer Anti-coagulation therapy as prescribed by Medical Staff *(refer to local policy/protocol for the administration of Anti-coagulation therapy)*
   d) Administer CMV prophylaxis as prescribed by Medical Staff *(refer to local policy/protocol for the administration of CMV prophylaxis)*
   Administer Oral Anti-fungal mouth care agents as prescribed by Medical Staff *(refer to local policy/protocol for the administration of anti-fungal agents)*

Problem: The patient requires Oxygen Therapy

Goal: To ensure the safe delivery of prescribed Oxygen

Interventions

7. Administer Oxygen Therapy as prescribed on Theatre/Medical notes by Medical Staff *(Document on evaluation as Oxygen requirements alter) (refer to the Trust policy/protocol for the administration of Oxygen Therapy)*
   Discontinue Oxygen as instructed by Medical Staff
   Refer the patient to the Chest Physiotherapist
   Encourage the patient to perform deep breathing and cough exercise
   Provide the "Coach" to allow the patient to perform above
   Assess the signs of fluid overload
   Monitor for signs of chest infection. Reserve any sputum and send to Bacteriology for O+S
   Mobilise the patient as patient condition dictates. Increase mobility as patient improves

Post Transplant Care Guidelines
(continued)

Problem: The patient requires close monitoring of their transplanted kidney function

Goal: To monitor and report daily on the function of the transplanted kidney

Interventions

8. Reserve U+E, CBC as required by Medical Staff

   Reserve U+E, CBC, CRP and GFR daily

   Reserve on Tuesday and Friday the following:

   - Electrolyte Profile
   - Liver profile
   - Bone profile
   - Lipid profile
   - Glucose
   - Magnesium level
   - Immunosuppressant level i.e. Tacrolimus level

   Report to Medical Staff the results of the above

   Increased serum Potassium (K*) may indicate the need for further treatment i.e. Haemodialysis

   Patient to attend for daily Doppler scans of their graft until indicated by the Medical Staff. A member of staff to attend each Doppler scan. Report abnormal findings to the Medical Staff

Nursing Day	Date:			
	Yes	No	N/A	Time	Initials

Post Ward Round Instructions (specify changes from Day)
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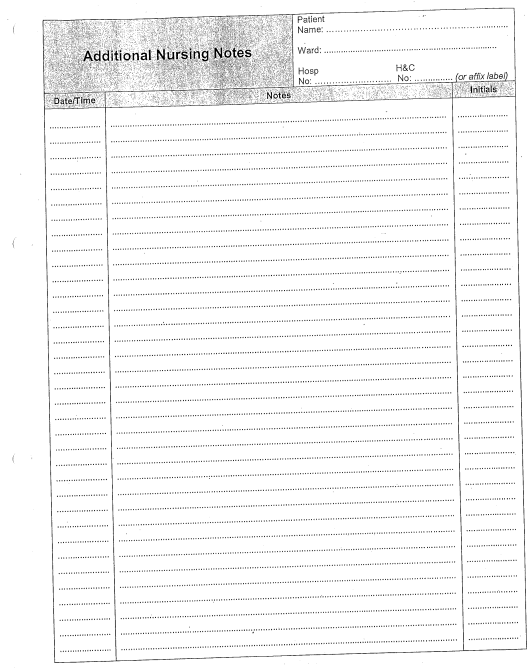
Date	Reason for Variances	Action Taken *(if any)*	Initials



Additional Nursing Notes

Patient Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

Date/Time	Notes	Initials
.....	.....	.....

Additional Nursing Notes

Date/Time	Notes	Initials

Nursing Day	Date:				
	Yes	No	N/A	Time	Initials

Post Ward Round Instructions (specify changes from Day
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Date	Reason for Variances	Action Taken (if any)	Initials

Additional Nursing Notes

Patient
Name: .....

Ward: .....

Hosp No: ..... H&C No: ..... *(or affix label)*

Date/Time	Notes	Initials
.....	.....	.....

Additional Nursing Notes

Date/Time	Notes	Initials

Abbreviations

A/CRF	Acute/Chronic Renal Failure
AKI	Acute Kidney Injury (not ARF)
ANCA	Anti-Neutrophil Cytoplasmic Antibody
APD	Automated Peritoneal Dialysis
AVF	Arterio Venous Fistula
ATN	Acute Tubular Necrosis
BMI	Body Mass Index
BNF	British National Formula
BP	Blood Pressure
BVS	Blood Volume Sensor
Bx	Biopsy
C/O	Complaining Of
CAPD	Continues Ambulatory Peritoneal Dialysis
CBC	Complete Blood Count
CKD	Chronic Kidney Disease (not CRF)
CMV	Cytomegalovirus
Coag	Coagulation
COGW	Change Over Guidewire
CRP	C Reactive Protein
CSU	Catheter Specimen Urine
CTPA	Comp Tomography Pulmonary Angiography
CVP	Central Venous Pressure
EBV	Epstein Barr Virus
ECG	Electrocardiograph
EDD	Estimated Date of Discharge
EPO	Erythropoetin
ERF	Established Renal Failure
ESA	Erythropoetin Stimulating Agents
ESR	Erythrocyte Sedimentation Rate
ESRD	End Stage Renal Disease
EWS	Early Warning Score
FBC (not to be confused with full blood count)	Fluid Balance Chart
FBP	Full Blood Picture
GCS	Glasgow Coma Scale
GFR	Glomerular Filtration Rate
GP	General Practitioner
HD	Haemodialysis
HHD	Home Haemodialysis
HLA	Human Leucocyte Antigen
HR	Heart Rate
HTA	Human Tissue Authority
INR	International Normalised Ratio
IP (not to be confused with Inpatient)	Intra Peritoneal
IV	Intravenous
LDRT	Live Donor Renal Transplant
LFT	Liver Function Test
MRI	Magnetic Resonance Imaging
NSAID	Non Steroidal Anti-Inflammatory Drugs
MUST	Malnutrition Universal Score Tool
NHSBT	National Health Service Blood Transplant
NIKPA	Northern Ireland Kidney Patient Association
NIRRF	Northern Ireland Kidney Research Fund
PCKD	Polycystic Kidney Disease
PD	Peritoneal Dialysis
PEP	Patient Education Programme
PTH	Para Thyroid Hormone
PTS	Patients
Plex	Plasma Exchange
Resps	Respirations

Abbreviations *(continued)*	
RRT	Renal Replacement Therapy
RI	Resistance Index
G&H	Group & Hold
SpO_2	Oxygen Saturation
S/N	Staff Nurse
SLE	Systemic Lupus Erythematosus
GM	Glucose Monitoring
STAT	Stat Dose
STR	Sister
Temp	Temperature
TT	Tissue Typing
TVN	Tissue Viability Nurse
TX (not to be confused with treatment)	Transplant
UF	Ultrafiltration
VCVC	Visual Central Venous Catheter Score
VIP	Visualisation/Inspection