Maine Medical Center
Maine Transplant Program
Policies and Procedures
Living Donor Multidisciplinary Patient Management Policy

Purpose
To describe the multidisciplinary care of living kidney donors throughout the evaluation, donation, and discharge phases of living donation.

Policy
It is the Policy of Maine Transplant Program to provide and document comprehensive multidisciplinary care and patient management through all phases of living donation. Multidisciplinary care involves a team approach to patient management through the use of standardized protocols and clinical practices, as well as defined roles and responsibilities in the patient management process.

Living Donor Care Phases:

Evaluation Phase: begins with the first presentation by the potential donor to the transplant program and continues until the time the donor enters the OR for the donation surgery. During this phase, the donor completes extensive screening, education, informed consent, and a comprehensive evaluation. All members of the multidisciplinary team participate in this phase of care.

Donation Phase: begins from the time the donor enters for the OR for donation surgery until the donor is discharged from the inpatient surgery stay. During this phase, the donor completes his/her donation surgery, and receives active post donation care from the multidisciplinary team including the Independent Living Donor Advocate.

Discharge Phase: begins with the donor's admission to the hospital and continues through to his/her discharge from the inpatient stay. During this phase, the donor will be admitted to the hospital, complete surgical consents, pre surgical testing and assessment, complete donation surgery, and receive active post donation care from the multidisciplinary team, including the Independent Living Donor Advocate.

Donor Management during the Evaluation Phase:

The *Transplant Nephrologist* leads the team in evaluating and caring for the living donor during this phase. S/he provides clinical direction, comprehensive patient assessment including history, patient education, and recommendations for additional testing and evaluation.

The *Transplant Surgeon* provides surgical assessment, patient education, and completes the informed consent for transplant surgery. S/he outlines the surgical approach, and any special considerations for the surgical process including recommendations to anesthesia. S/he reviews all elements of the surgical process pre and post donation with the donor including side effects, expected outcomes, and alternatives.

The *RN Living Donor Coordinator* plays a pivotal role in coordinating the evaluation of the living donor. S/he provides intensive education regarding living donation, obtains informed consent for evaluation, and reviews multiple sources of information with the donor including SRTR outcomes. The RN Clinical orders and reviews all of the evaluation testing for the living donor per standard protocol, and presents the patient for consideration at the Transplant Candidate Review Committee. S/he arranges all needed per operative testing, and acts as the point person for the pre donation process.

The *Transplant Social Worker* is an expert in the psychosocial evaluation and care of the living donor. S/he provides comprehensive assessment, referral to psychiatry as needed (all non-directed donors and any donors with history of mental health concerns), and care recommendations to the living donor team. S/he participates in the donor selection process, and is a voice in determining the psychosocial suitability of the donor for living donation and identifying and/or addressing any concerns regarding coercion or ambivalence.

The *Transplant Pharmacist*, as part of the donor evaluation process, provides a review of donor medications and any drug interactions that may need to be considered prior to surgery; she also provides an assessment of the donor's ability to understand their medication regimen if applicable.

The *Transplant Nutritionist* reviews the donor's nutritional status and may make recommendations regarding diet or lifestyle changes to either become eligible for donation, or improve or maintain health status during the donation process.

The *Transplant Financial Coordinator* meets with the living donor during the evaluation process to review financial needs pre and post donation, and facilitate any available financial assistance through the NLDAC, NKR, or other sources.

The *Independent Living Donor Advocate* plays a critical role in the Evaluation Phase by assessing the donor understanding of all aspects of the donation process, and his/her willingness to donate free of coercion. S/he acts as an advocate for the living donor, and assures that the donation evaluation phase does not proceed if the donor appears to have any hesitation or expresses any concern about coercion.

Patient Management during the Donation Phase:

The *Transplant Nephrologist* leads the team in caring for the patient during this phase. S/he leads the clinical care plan during the inpatient transplant stay, provides bedside patient care, and advises all multidisciplinary team members on daily care issues. The *Transplant Nephrologist*, in collaboration with the multidisciplinary team, directs the patient discharge plan and follow -up after donation surgery.

The *Transplant Surgeon* provides pre surgical assessment, and leads the surgical team during the ABO verification and donation surgical procedure. S/he also obtains patient consent for the procedure and educates the patient regarding risks/benefits, alternatives, side effects, and anticipated outcomes. The Transplant Surgeon continues patient follow up and monitoring during the inpatient stay and leads the surgical follow up portion of the discharge plan.

The *Transplant Nurse Practitioner* oversees the day to day care of the donor immediately following surgery up to the date of discharge. S/he develops and monitors the care plan, orders needed services and testing, and coordinates team member involvement. The *Nurse Practitioner* provides bedside care, education, and support, and leads development of the discharge plan.

The *Transplant Social Worker* provides psychosocial assessment and support immediately following surgery up to the point of and after discharge. In collaboration with the hospital *Care Management Social Worker,* the Transplant Social Worker assesses patient needs for support and resources during and following the hospital stay, and facilitates needed services.

The *Care Management Social Worker* focuses on a timely and successful discharge for the donor and addresses any service or support needs that will facilitate a positive post discharge outcome. On occasion and depending on the timing of the donation (example: weekend or holiday), the *Care Management Social Worker* may provide the psychosocial assessment in lieu of the *Transplant Social Worker*. In these cases, the *Care*

Management Social Worker will document the assessment and communicate any needed follow up to the *Transplant Social Worker*.
The *Transplant Pharmacist* is a key member of the donation team during and following the donation surgery. S/he oversees the patient medication plan, addresses side effects and drug interactions, and advises the *Surgeon* and *Nephrologist* on any needed pharmaceutical interventions, including pain medications post discharge. The *Transplant Pharmacist* provides patient education regarding medications, and develops and implements the medication discharge plan.

The *Transplant Nutritionist* provides comprehensive assessment and consultation to the donor and transplant team following surgery and prior to discharge. S/he develops a nutritional plan for the donor while in the hospital, as well as a plan to be implemented following discharge. Any special nutritional needs or support are addressed, as well as a plan for nutrition services follow up if needed.

The *Independent Living Donor Advocate* continues to provide advocacy and support for the living donor throughout the Donation Phase. S/he meets with the donor bedside during the inpatient donation stay, and offers any needed support prior to and after discharge as appropriate.

The *RN Living Donor Coordinator* provides ongoing support, education, and coordination of care for the donor during this phase. S/he meets with the donor following surgery and throughout the brief hospital stay to assess his/her needs, provide education, and discuss the post donation follow up plan and requirements.

Patient Management during the Discharge Phase:

The *Transplant Nephrologist* leads the team in caring for the patient during this phase which begins upon admission for the donation. S/he leads the clinical care plan during the inpatient transplant stay, provides bedside patient care, and advises all multidisciplinary team members on daily care issues. The *Transplant Nephrologist*, in collaboration with the multidisciplinary team, directs the patient discharge plan and follow -up after donation surgery.

The *Transplant Surgeon* provides pre surgical assessment following admission for the donation surgery. S/he also obtains patient consent for the procedure and educates the patient regarding risks/benefits, alternatives, side effects, and anticipated outcomes. The Transplant Surgeon continues patient follow up and monitoring during the inpatient stay and leads the surgical follow up portion of the discharge plan.

The *Transplant Nurse Practitioner* completes an admission assessment prior to the living donor surgery. S/he oversees the day to day care of the donor while in the hospital up until discharge. S/he develops and monitors the care plan, orders needed services and testing, and coordinates team member involvement. The *Nurse Practitioner* provides bedside care, education, and support, and leads development of the discharge plan.

The *Transplant Social Worker* provides psychosocial assessment and support during the inpatient stay and up to the point of discharge. In collaboration with the hospital *Care Management Social Worker,* the Transplant Social Worker assesses patient needs for support and resources during and following the hospital stay, and facilitates needed services.

The *Care Management Social Worker* focuses on a timely and successful discharge for the donor and addresses any service or support needs that will facilitate a positive post discharge outcome. On occasion and depending on the timing of the donation (example: weekend or holiday), the *Care Management Social Worker* may provide the psychosocial assessment in lieu of the *Transplant Social Worker*. In these cases, the *Care Management Social Worker* will document the assessment and communicate any needed follow up to the *Transplant Social Worker*.

The *Transplant Pharmacist* is a key member of the donation team up to, during and following the donation surgery. S/he oversees the patient medication plan, addresses side effects and drug interactions, and advises the *Surgeon* and *Nephrologist* on any needed pharmaceutical interventions, including pain medications post discharge. The *Transplant Pharmacist* provides patient education regarding medications, and develops and implements the medication discharge plan.

The *Transplant Nutritionist* provides comprehensive assessment and consultation to the donor and transplant team during the donor's hospital stay. S/he develops a nutritional plan for the donor while in the hospital, as well as a plan to be implemented following discharge. Any special nutritional needs or support are addressed, as well as a plan for nutrition services follow up if needed.

The *Independent Living Donor Advocate* continues to provide advocacy and support for the living donor throughout the Donation and Discharge Phases. S/he meets with the donor bedside during the inpatient donation stay, and offers any needed support prior to and after discharge as appropriate.

The *RN Living Donor Coordinator* provides ongoing support, education, and coordination of care for the donor during this phase. S/he meets with the donor throughout the brief hospital stay to assess his/her needs, provide education, and discuss the post donation follow up plan and requirements.

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References: Centers for Medicare and Medicaid Services, 2019 Organ Transplant Program Interpretive Guidelines 482.90