

Transplant Pre-op Check List

The goal is to have the patient prepared for the OR within 1 hour of arrival.

Assume the OR is going ahead unless you hear otherwise! The physicians will phone if they have an update in regards to time. Do not call for OR time.

The Physician key to the pre-transplant office is kept in the 5A narcotic cupboard. The BCTS are kept on the shelf marked activated♥.

Nursing

Prior to patient arrival prepare the patient room/lounge with the following:

- IV D5W TKVO – use macrodrip and extension tubing set
- 10 mg Vitamin K (mix in a mini-bag) Vitamin K is kept in the fridge.
- Containers for urine C&S and urinalysis
- Scale, BP cuff, and dinamap

On Most occasions the patient will arrive with a support person(s). This is usually a very emotional / stressful time for both the patient and the family. Pastoral care can be called to see. This is usually very helpful!

- Ensure the chest X-ray has been done. The patient usually stops at X-ray before coming to the unit. If it is not completed call for it to be done STAT.

Note on the requisition:

Exam required: CXR PA-Lateral

Relevant History: For transplant

Tentative Diagnosis: For heart transplant

- Ensure the lab and IVT are called STAT.
- If patient has AICD – place patient on telemetry. The pacemaker clinic or EP physician will turn off AICD function.

- Have the patient change into hospital gown.
- Inquire when the last food or drink was and if the patient is taking anticoagulation.
- Call the physician to inform him/her that patient has arrived. They may give verbal orders over the phone.
 - Note on the orders:
 - CMV status: Donor and Recipient
 - √ CMV negative blood products if CMV recipient and donor are negative.
 - If on anticoagulation – physician may request FFP prior to OR. Ask whether patient needs a repeat INR and who to inform if INR is greater than 1.5
 - Antibiotic coverage – physician to choose Cefazolin or Clindamycin
- Get height, weight and vital signs. Record on clinical record. The weight must also be recorded on the admission orders.
- Do a mini nursing assessment. (Important areas to focus: brief medical history, medications, breath sounds, last food/drink, location of emergency contact person). If time permits complete assessment as per standards.
- Connect IV D5W and give vitamin K if ordered.
- Collect and send urine specimens to the lab.
- Assess patient's anxiety. Administer ativan PRN (Ensure consent signed. This is usually done before admission – found in brown folder in the front of BCTS chart)
- Give pre-medications as ordered.
- Assist if necessary for pre-op shower. Use Chlorhexidine scrub.
- Print off blood work results. Notify physician of any abnormalities.
- Complete pre-op checklist.