OBJECTIVE

To provide travel support on a case by case basis to all patients requiring Renal Replacement Therapy in the Bay of Plenty District Health Board (BOPDHB) area, who are currently listed on the Renal Transplant Register.

BACKGROUND

Patients, listed on the National Transplant Register can be called upon at any time, day or night, to attend Auckland hospital for a potential kidney transplant.

Patients accepted onto the transplant list are required to have a plan in place to transport themselves to Auckland at short notice, and for consequent follow up appointments.

Since they can be called in at any time, they can experience problems with their planned transport. Any delay in getting to Auckland may potentially put them at risk of not getting a transplant.

The Peritoneal Dialysis (PD) nurses can identify those patients who may need transport assistance. The Renal Clinical Nurse Manager (CNM) can also be used as a contact person.

STANDARDS TO BE MET

STEP	ACTION	RATIONALE
Patient Presentation to BOPDHB and Transport to Auckland Hospital		
1	• Renal patient who has received a call to attend Auckland Hospital for a potential kidney transplant presents at either the Tauranga or Whakatane Emergency Department (ED). • The Duty Nurse Manager is contacted and will book a DHB vehicle and driver to take the patient, and a support person if present, immediately to Auckland hospital.	• This patient will not be processed through the emergency department, but will wait for contact with the duty manager. • To avoid any delay in getting to Auckland hospital, and potentially not having a Kidney Transplant.
Post-transplantation Patient Transfer to BOPDHB		
2	• The Auckland Transplant team will contact the BOPDHB Duty Nurse Manager to arrange retrieval. • The BOPDHB Duty Nurse Manager will arrange retrieval as per inter-hospital transfer standards.	•
Post-Transplant Care / Follow Up		
3	• The patient returns to the care of the Midland Renal Service. • Scheduled follow up appointments are to be notified at time of appointing to the CNM of BOPDHB Renal Service.	• Most of these appointments are planned and are therefore predictable. • As follow up care is individualised, there may be slight variations in the length of scheduled appointments.

STEP	ACTION	RATIONALE
	• Transplant patients are then reviewed in the Waikato transplant clinic weekly for approximately 26 weeks. • After 26 weeks the patient will then be reviewed fortnightly for approximately 1 year post transplant. • Following this the patient will be reviewed in their domiciliary hospital on a monthly basis.	• The Clinical Nurse Manger of BOP Renal Service will arrange transportation to Waikato for follow up appointments.

REFERENCES

- KHA-CARI Guideline: KHA-CARI adaptation of the KDIGO Clinical Practice Guideline for the Care of Kidney Transplant Recipients. Asian Pacific Society of Nephrology, 17 (2012) 204 – 214.
- Auckland Renal Transplant Group post follow up plan.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.4.1 Patient Transfers
- Bay of Plenty District Health Board policy 6.4.1 protocol 2 Patient Transfer – Interhospital Standards
- Bay of Plenty District Health Board policy 6.4.1 protocol 3 Patient Transfer – Road Standards (To and From Another Hospital)
- Bay of Plenty District Health Board policy 1.3.2 Patient Transport and Accommodation Assistance
- Bay of Plenty District Health Board National Travel Assistance (NTA) Working Manual