**Transplant Rounding Presentations**

Employ the “SOAP” format:

S – Subjective – overnight events and things the patient reports

* Start with a one liner of the patient: “XX year old M/F POD# s/p DDRT/OLT/etc
* Include anything that the team was paged about overnight or major events from the day before that were not discussed yet by the team – can include changes in vitals, abnormal labs, blood transfusions, change in level of care, etc. And what was done to intervene.
* Ask the patient about pain, oral intake and toleration (ie nausea, vomiting, or chose not to eat for some reason), flatus, bowel movements
* *Common pitfalls:*
	+ *Being overly wordy or editorializing. Use* ***concise*** *and* ***precise*** *language*
	+ *Recapping events from several days or results that have already been discussed*
	+ *Forgetting to ask the patient about flatus/bowel movements*
	+ *Using date of surgery rather than post operative day*

O – Objective – the data: vitals, exam, I&Os, labs, imaging. Please present in that order!

* Only include pertinent findings (ie Cr and BUN, don’t need to tell us the Cl-)
* If a patient is in the ICU this is where you would include information about pressors and vent settings
* When reporting drain output also comment on the quality of the output
* *Common pitfalls:*
	+ *“vitals are stable” – the most stable vitals belong to a deceased person, within normal limits is appropriate, our patients tend to have values worth reporting*
	+ *Forgetting to include the exam*
	+ *Not separating out the outputs from different drains/knowing which is which*
	+ *Repeating parts of the subjective again*
	+ *“the read isn’t back” – please give your assessment after looking at the images. Even if you aren’t confident it’s great practice!*
	+ *Presenting the plan, ie “BP is in the 180s should we start nifedipine?”*
	+ *The FK level is never back at the time of rounds, you don’t need to remind us*

A – Assessment – a quick summary statement

P – Plan – broken down by either systems or problem focused. Using a systems approach in your head even for floor patients can help you make sure not to miss anything (neuro, cards, pulm, GI, renal, ID, endo, heme, dispo is a commonly accepted order).

* *Common pitfalls:*
	+ *Repeating data from the above sections*
	+ *“continue to monitor”, “ask XX” – have a definitive plan/rationale*
	+ *overall lack of organization*
	+ *Forgetting the immunosuppression – TIP: put it in the same system as the organ transplant (ie renal for kidney and GI for liver) so you don’t forget.*

Floor Patient Example:

Mr X is a 60 year old male with ESRD 2/2 HTN now POD 3 from a DDRT. Overnight he had a fever of 101.8 for which blood and urine cultures were drawn, a CXR performed, and he was started on vancomycin and zosyn. This morning he reports feeling well, his pain is well controlled, he is on a regular diet and has no nausea or vomiting. He has been passing flatus but has not had a bowel movement.

He is afebrile, and blood pressures have been in the 160-170s over 80-90s. Not tachycardic, satting 100% on room air. On exam he is nontender and non distended, the dressing is intact, and his foley is still in. He made 2L of urine overnight, his drain put out 40mL of serosanguinous fluid. Labs notable for Cr 2.5 down from 3.4, BUN 60 down from 70, Hgb 8.0, stable from 8.2, WBC 6. Blood cultures pending, UA negative, CXR did not show any consolidations. Most recent FK level 6.1.

In summary Mr X is a 60 year old male POD 3 s/p DDRT with immediate graft function doing well except for an isolated fever.

Plan will be to:

Continue his current pain control with Tylenol and tramadol prn.

I would like to start 30 mg daily of nifedipine which was his home medication for his hypertension

His foley can be removed and we will do a void check

Prograf was increased yesterday from 4mg to 5mg for the level of 6.1. We will continue MMF 1000mg bid as well as his prednisone taper.

Follow up blood and urine cultures and monitor for repeat fever. Continue vanc and zosyn for now. Will stop pending gram stain and cultures negative.

Continue sqh for DVT prophylaxis

PT and OT are working with him and recommending home PT. He should be ready for discharge tomorrow.

ICU Patient Example:

Ms Y is a 65 year old female with ESLD 2/2 EtOH now POD 4 from OLT. Her course was notable for HAT on POD 1 requiring take back for aortic jump graft and subsequent bleeding requiring take back on POD 2 for hematoma evacuation. Overnight she required 2 units of pRBC. Nursing reports improvement of blood pressure and lowering of pressors post transfusion. However she has had increasing vent requirements with FiO2 80%.

She has been afebrile, currently requiring levo 0.4 and vaso 0.4 down from a peak of levo 0.1 overnight, to maintain MAP >60. Currently on 80% FiO2, PEEP of 5 and PS 12 to maintain O2 saturation >94%. On exam she follows commands. Her abdomen is distended, the dressing has minimal sanguinous saturation. All 3 JP drains have serosanguinous non bilious output, she has a foley in place with minimal urine output. UOP overnight was 50mL total, the drains put out 525, 475, and 500 cc for a total of 1.5L. Labs are notable for Hgb 8.1 from 6.4, WBC of 3.0, platelets of 45, Cr of 4.1 up from 3.5, BUN of 90, AST 300 down from 410, ALT 270 down from 350, Bilirubin 3.0 up from 2.7, Alk phos 333 unchanged, INR 2.1 down from 2.3. Recent cultures all show no growth to date. US done yesterday afternoon showed patent vasculature with appropriate waveforms.

In summary Ms Y is a 65 year old female POD 4 s/p OLT with take back for aortic jump graft and hematoma evacuation with worsening respiratory status and worsening AKI.

Plan:

Neuro: continue current pain control regimen

Cards: hypotension likely due to hypovolemic/hemorrhagic shock which is improving post transfusions. Wean pressors to maintain MAP > 60.

Pulm: worsening respiratory status, obtain CXR today and repeat ABG later this AM. Pending results can discuss need for intervention. Also send BAL/sputum cultures.

GI: LFTs improving with exception of t bili likely due to recent transfusion. Trend LFTs q12 hrs. Will keep all drains in place for now. Received solumedrol induction, is currently on steroid taper and was started on prograf 2/2 yesterday, we will get the first level today, goal range will be X. Currently NPO without feeding access. Pending pressor requirements can place dobhoff feeding tube and start trickle tube feeds later today.

GU: Worsening AKI with oliguria and uremia in setting of bleeding. Patient will benefit from dialysis. Will coordinate with SICU and nephrology teams.

ID: Send sputum cultures, follow up CXR, can consider starting therapeutic antibiotics based on results. Continue prophylactic abx per protocol.

Endo: on sliding scale insulin prn

Heme: Trend LFTs and coags q12hrs. Hold chemical DVT ppx in setting of recent bleeding and thrombocytopenia.

A **NOT** so good example:

Mr X is our kidney patient who has been struggling with blood pressure and pain. I got multiple calls from nursing overnight and they are really upset because he keeps asking for more pain medication and only wants IV dilaudid and doesn’t want to try the pills and I tried to explain to him why we can’t do that but he won’t listen. So maybe we should get the pain team to see him? And his blood pressure might be in part from his pain but it’s hard to tell so we gave him some prn labetalol last night and it came down a little but not much. We restarted the amlodipine yesterday but it’s not enough so what do we want to add? Otherwise his numbers all look good, Cr is down, made a lot of urine. He’s upset about the foley and wants that out. The diabetes educator tried to work with him yesterday. His fingersticks are high so that needs work. But once we get the blood pressure and sugars ok he could go home maybe as early as tomorrow. Oh and he was on aspirin so do we want to restart that or wait until clinic?

A Better version:

Mr X is a 55 year old male with ESRD 2/2 DM and HTN POD 3 from DDRT whose post operative course has been notable for hard to control blood pressure and fingersticks. This morning he continues to complain of pain, however on questioning states he has not taken any oral pain medication as he feels the IV medications work better. Nursing tried to do patient education overnight however he was not responsive. He is eating a regular diet and having flatus and bowel movements.

He is afebrile, his blood pressures have been in the 180s/90s, HR 90s, satting 100% on RA. On exam he is non distended and tender along the incision site. His foley is in place. He made 3.2L of urine over the last 24hours. Labs notable for Cr 1.7 down from 2.5, BUN 30, Hgb 9.0 from 9.3, fingersticks have ranged from 200-300s.

Mr X is a 55 year old male POD 3 from DDRT with IGF with persistent hypertension and hyperglycemia and poor interactions with the healthcare team.

Plan:

Will re-educate patient again today about the need for oral based pain medication regimens as a requirement for discharge. Will attempt multimodal therapy with Tylenol, oxycodone, and lidocaine patches

Continue home amlodipine 10mg, will add carvedilol 6.25mg bid for hypertension.

Remove foley and void trial

Touch base with endocrinology and diabetes educator about insulin regimen given persistent hyperglycemia

Continue sqh for dvt ppx. He was on a baby aspirin for primary prevention prior to surgery, we will continue to hold this and can consider restarting as an outpatient.

Dispo pending blood pressure and fingerstick control, potentially as early as tomorrow.