TRANSPLANT SERVICE, GUIDANCE FOR SUDENTS, RESIDENTS AND FELLOWS

February 11, 2019.

GENERAL RULES

* You must always acknowledge receiving the order from the attending or other member of the team by texting back, right after reading it. confirming that you will either do it or you can NOT do it.
* When you send a TEXT with any information to any member of the team you should receive acknowledgment from that member that the message was received. Without such confirmation back , it does not count as a message was passed along. Must try other means of direct communication until message is confirmed to be delivered.
* **You must Always get permission** directly from the attending surgeon before you press S before surgery or take patient back to the OR.
* **Never** take patient to the OR or press Swithout **direct** permission or request from the attending surgeon.
* When you operate on the patient You should:
	+ know entire medical Hx, all results (imaging , labs, etc)
	+ examine the patient personally
	+ check if consent is proper (Tx consent) and properly signed (blood Tx?, high risk donor?)
	+ make sure there is no contraindication to surgery (on exam or results)
	+ know the procedure which will be performed
	+ check donor and recipient blood type
	+ check npo status,
	+ check if blood products are ordered
	+ check if proper antibiotic is ordered (know and review allergy)
	+ check if proper immunosuppression is ordered
	+ check if heparin sc was ordered and given in Preop

if case of kidney or pancreas tx:

* + find out patient ETA to the hospital and which bed was assigned
	+ around time of ETA confirm patient location with Rich/Jesse/Karina or Amanda or Christine
	+ make sure all orders are in
	+ get patient from sky lobby if patient is lost there
	+ **make sure labs are drawn** **FIRST**, then EKG and portable chest X ray is done asap.
	+ When there, Do H and P yourself
	+ Review all labs , chest X ray and EKG yourself, check previous relevant imaging – abd CT etc
	+ check if OR Board called for the patient 90 min before scheduled time of surgery, if no, ask them to do so, if yes
	+ check if PACU nurses called for the patient at least 75 min before the time of surgery, if no ask them to call,
	+ check if patient is in the Preop area 60 min before surgery, if no troubleshoot:
		- call transportation to find out ETA to the PACU,
		- call OR Board first then PACU then pack you ask PACU for permission to bring the patient yourself from the floor to the PACU,
		- let attending know about delay and
		- bringing patient up to PACU using wheelchair (park in the new parking 2nd floor), never use floor bed, do not walk the patient

OTHER RULES

* In progress notes **Always include** the level of tacrolimus and current dose of Prograf (Tacrolimus), Cell Cept (MMF) and steroids. (Attending bill insurance mostly for immunosuppression adjustments and it needs to be documented daily notes)
* Always inform immediately attending surgeon on service about **any major deviations from standard practice** (delays, accidents, unexpected events, plan of treatment which seems to be not right)even when you think you know how to fix it. Keep him posted on the progress of the intervention.

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RESIDENTS RESPOSIBILITY TOWARDS STUDENTS

1. Resident is responsible for guiding a student during rotation.
2. Resident introduce the routine during the service, logistics and expectation
3. Resident assigns OR cases for the student ahead of time so student can be prepared to the case.
4. Resident- assign in-house patients to be presented during rounds- usually the same patient student watched or will watch in the OR
5. Resident send OR /clinic schedule for entire week to the student as well.
6. Resident- shows and allows student to do small bedside procedures
7. Resident send student for procurement.
8. Student - know everything about patient- history, medications, physical exam etc.

STUDENTS RESPOSIBILITY

1. To be prepared for the OR cases will be assisting:
	1. **everything** about the patient (detailed H&P, meds, allergy, imaging)
	2. plan of the operation (what anesthesia, what antibiotics, what other drugs before incision and after the incision, steps of the operation, anatomy involved)
2. To know everything about the patient student presents, be updated with the current symptoms and the plan.
3. To know anti-rejection medications, their main side effects
4. Know main steps of the procedure and all connections being made during kidney, pancreas and liver transplants
5. To know type of sutures, stiches, needles

FELLOWS RESPOSIBILITY

1. Plays resident’s role in guiding students when resident is not present
2. Make sure that a student will go on the procurement.
3. Teach a student at any opportunity.

**WOUND DIAGNOSIS AND TREATMENT AT TRANSPLANT SERVICE**

**Changing dressing routine**

- introduce herself
- ask for permission to check the wound
- prepare new dressing in case you need it, tape as well
- remove a dressing wearing gloves
- inspect the wound for any leak, discharge
- if dry, explain to the patient that she/he does not need a dressing anymore, and it is safe to keep it uncovered so air can penetrate, however if she notice any leak she/he should alarm the nurse immediately to cover it with new dressing.
- if still wet, cover with new dressing, reassure the patient that it is not infection, just normal healing, instruct the patient to alarm nurses if it starts being soak to prevent having her clothes wet.
- alarm the team if you think it is infection.
-remember infection start happening on day 3, usually not before, but if you have any doubts show the wound to resident before alarming the patient.

**Diagnosis**

* redness, pain, fever, **---- very often not present!**
* **any discharge from the wound**--- needs to be investigated for wound infection----- color, smell, **culture swab needs to be sent asap**

If high suspicion visually or swab positive!**--- plan to open the wound-** attending decision

**Wound Treatment**

If high suspicion for infection and/or fluid positive for non skin flora then

1. **Wound needs to be open** and fluid for cultures should be sent if not sent before
2. **Debridement-**
	1. **usually in OR** if deep infection especially between fascia and subcutaneous tissue, wide excision
	2. **consider bedside –** if midline, superficial, well vascularized wound, not much fat
3. **Dressing chance twice a day with local antibiotics**
	1. Sulfamylon (good for G+ and G- and Pseudomonas)
	2. Sulvadine (Good for G+)
	3. Sulvadine with Nystatine (for fungi in addition)
	4. Dakins (for fungi in addition)

**Keep going until wound clean**,

* Healthy, clean granulation tissue,
* Quantitive tissue culture negative,
* if dead tissue- debridement again
1. **Wound vac when would grossly clean:**
	1. After wide excision and debridement in the OR (wall suction)- wound potentially clean
	2. **After confirmation it is clean visually, and quantitive tissue culture negative**

Then home with wound Vac- healing by granulation

**Serous fluid from the wound:**

1. Early- fluid overload (especially if kidney graft DGF)
2. Late- think about wound dehiscence- 1-2 weeks after Sx- non contrast CT (never US)

**Foley placement or re-placement-**

EVERY Foley cath in:

* fresh kidney transplant patient or
* patient with BPH, prostate or urethral problems needs to be placed or replaced by resident or fellow (**not a nurse or student**)

**Every fluid drained by IR- send for:**

- gram stain, culture,

- Creatinine

Never order Gentamycin for kidney tx recipients