

**DEPARTMENT OF PEDIATRICS
POLICY AND PROCEDURE MANUAL
July 2008**



EDUCATIONAL GOALS OF THE UNIVERSITY OF ARIZONA PEDIATRIC RESIDENCY PROGRAM.....	4
ADMINISTRATION SECTIONS	7
SUPERVISION POLICY OF PEDIATRIC RESIDENTS.....	8
PROMOTION AND ADVANCEMENT POLICY	10
DUTY HOURS	11
QUALITY ASSURANCE AND IMPROVEMENT POLICY	13
RESIDENT SELECTION POLICY.....	14
GRADUATED RESPONSIBILITY AND SUPERVISION OF RESIDENTS IN AMBULATORY GENERAL PEDIATRICS	15
THE ROLE OF THE PL-3 IN UMC PEDIATRIC CLINIC	16
CONTINUITY CLINIC GUIDELINES.....	18
COMMON UNITY.....	19
CODES AND STAT CALLS.....	20
CONFERENCES.....	21
DISCHARGE SUMMARIES	23
ELECTIVES	26
RESIDENT WISHING TO TAKE AN OUT-OF-TOWN ELECTIVE.....	28
EMERGENCY MEDICINE ROTATION	29
REQUIRED EVALUATIONS	32
FLOATING HOLIDAY POLICY	32
VACATION POLICY	34
PATIENT CARE PROTOCOL.....	35
ADMISSIONS TO UMC PEDIATRIC FLOOR.....	36
ADMISSIONS TO TMC PEDIATRIC FLOOR	36
ADMISSIONS TO UMC OR TMC PICU	36
ADMISSIONS CAP PROTOCOL.....	38
PEDIATRIC WARD POLICY RE: PEDIATRIC PATIENTS HOUSED OFF THE PEDIATRIC WARDS.....	39
NON-PEDIATRIC RESIDENTS IN THE PEDIATRIC INTENSIVE CARE UNIT	40
PICU RESIDENTS' JOB DESCRIPTION.....	42

POLICY FOR TRANSFERS OUT OF OR INTO INTENSIVE CARE UNITS.....	44
JEOPARDY CALL.....	45
MATERNITY/PATERNITY LEAVE POLICY	46
MOONLIGHTING POLICY	47
UMC AND KINO MOMMY AND NURSERY CALL.....	48
PROCEDURE CERTIFICATION	49
PEDIATRIC RESIDENT RESEARCH PROGRAM	51
LEAVE OF ABSENCE POLICY INCLUDING SICK LEAVE	52
TMC SCHEDULE OF ROUNDS/CONFERENCES	53
PL-2/PL-3 DAY FLOAT ROTATION POLICY	55
PL-1 WARD RESPONSIBILITIES.....	56
PL-2 AND PL-3 RESIDENT RESPONSIBILITIES ON THE UMC WARDS	60
TMC WARD FLOAT AND WEEKEND COVERAGE POLICIES	64
PL-3 RESIDENT RESPONSIBILITIES ON TMC WARDS.....	65

EDUCATIONAL GOALS OF THE UNIVERSITY OF ARIZONA PEDIATRIC RESIDENCY PROGRAM
Includes Summative Letter Policy

The goal of the University of Arizona Department of Pediatrics Residency Training Program is to provide residents with a comprehensive and personally rewarding educational experience that will allow their pursuit of primary care, academic or public health careers. The program aims to combine required rotations with extensive opportunities that allow each resident to pursue his/her interests in-depth. The program, although university based, is a collaborative effort with community pediatricians and aims to provide a variety of patient experiences. The objective is also to teach residents the value of preventive care by working with infants, children and adolescents requiring ambulatory care, as well as the critically and terminally ill.

PL-1 Year

The goals of the PL-1 year are to provide residents the opportunity to

- 1) acquire basic clinical and procedural skills to evaluate, diagnose and treat infants, children and adolescents with diseases that range from the simple to the moderately complex;
- 2) successfully complete general pediatric in-patient and out-patient rotations;
- 3) develop knowledge in and successfully complete adolescent rotation. This knowledge should then be applicable to subsequent patient encounters throughout the residency;
- 4) develop basic skills in assessment of the normal newborn (in the well-baby nurseries) and in evaluation and treatment of the critically ill neonate during the NICU rotation;
- 5) acquire basic knowledge and competence in the evaluation of children with hematologic/oncologic as well as cardiac, pulmonary or other specialty problems during the elective specialty rotation of the PL-1's choice;
- 6) develop basic skills to consult, evaluate and utilize the medical literature;
- 7) develop moderate expertise in teaching medical students and
- 8) develop supervisory skills which allow them to act at the completion of the PL-1 year, as competent PL-2 supervisors of PL-1s and medical students.

PL-2 Year

The goals of the PL-2 year are to:

- 1) increase knowledge and skills related to patient care;
- 2) increase the ability to evaluate and care for patients with more emergent, complex and life-threatening diseases;
- 3) participate in a private practice preceptorship to develop the medical/legal/financial fundamentals of community-based pediatric care;
- 4) develop increased subspecialty expertise during electives;
- 5) augment knowledge of child behavior/development during this required rotation;
- 6) increase knowledge and facility in formal and informal teaching settings (e.g. Morning Report, resident conferences)
- 7) begin to develop skills and knowledge in quality assessment and improvement, risk management and cost effectiveness in medicine.
- 8) at the completion of the PL-2 Year, the resident should be capable of assuming the senior supervisory role for PL-1s and medical students.

PL-3 Year

The goals of the PL-3 year are to provide the resident with the opportunity to:

- 1) assume a senior inpatient and outpatient supervisory role;
- 2) hone clinical and procedural skills;
- 3) increase knowledge of diseases of marked complexity and severity;
- 4) increase expertise in the evaluation and care of acutely ill children in an Emergency Department setting, including those who have incurred severe accidental or non-accidental trauma;
- 5) act as teacher and consultant;
- 6) critically evaluate the medical literature and apply current medical information to patient care concurrent with acquisition of skills required for continuing medical education (CME).
- 7) develop competency in dealing with the patient and family, as well as the community, including medical, legal, financial, and educational organizations/institutions.

- 8) hone skills and increase knowledge in quality assessment and improvement, risk management and cost effectiveness in medicine.

A summative letter is provided each PL-3 resident at the completion of their third year and reviewed in detail with each PL-3.

ADMINISTRATION SECTIONS

1. **PHOTOLIBRARY SERVICES** - Photolibrary services are only for journals that cannot be checked out of the library; please do not take in outside projects or books that can be checked out and copied on the Pediatric Department machine.
2. **MAILBOXES** - Please empty your mailbox at least once a week, more often, if possible. Because of the limited space in the individual mailboxes, they become "overstuffed" and important mail may be wrinkled or folded in the attempt to place more mail in the box. Large packages or boxes will be given to the Pediatric Housestaff office for you to pick up at your convenience.
3. **EMAIL** – Please check email at least once per day.
4. **EQUIPMENT** – The Housestaff Office (Room 3335) has a computer, printer, copier and facsimile machine available for resident use during regular office hours.

SUPERVISION POLICY OF PEDIATRIC RESIDENTS

1. All residents involved in inpatient and outpatient care of pediatric patients have faculty supervision. PL1 residents are directly supervised by senior pediatric residents (PL2 and/or PL3) and by attending pediatric faculty.
2. At least one attending physician is located in each of the pediatric clinics, at UPH Hospital at Kino Campus and at University Medical Center.
3. Interns are directly supervised by full-time faculty of the General Pediatrics Section during their normal nursery experience at University Medical Center.
4. Residents assigned to the neonatal intensive care unit at University Medical Center are under the direct supervision of the attending neonatologist.
5. Interns on the pediatric wards are supervised by senior residents who are supervised by the Chief Residents and attending faculty.
6. Residents assigned to elective, private practice, emergency medicine, CCRS, Subspecialty and adolescent rotations are directly supervised by the attending physicians in these areas.
7. Daily attending rounds are made by the pediatric intensive care unit and ward attending faculty who also monitor the performance of residents.
8. The faculty complete written evaluations of housestaff on every rotation. Housestaff also formally evaluate each other during their rotations.
9. Morning Report also occurs three times per week at University Medical Center and includes a pediatric Chief Resident, faculty and pediatric housestaff. New inpatient admissions and problems patients are discussed with supervisory residents during these sessions. Morning Report also occurs three times per week at Tucson Medical Center and includes a pediatric Chief Resident, attending and associate faculty and pediatric housestaff.
10. Housestaff skills in the performance of procedures are directly monitored by senior residents, attending physicians, NNPs (and registered nurses for IVs only).
11. Documentation of clinical skills is also assessed by interaction with residents over specific patients, during subspecialty consultations and during problem patient conferences.
12. All housestaff have semiannual meetings with their faculty advisors.

13. All residents formally meet with the Residency Program Director at least twice a year for all three years. Frequent informal meetings also occur throughout all three years.

This policy is as stated in the Supervision Policy (issued September 4, 2003, effective October 1, 2003) Graduate Medical Education Policy and Procedure Manual.

PROMOTION AND ADVANCEMENT POLICY

PL-1

Promotion/advancement from the PL-1 to PL-2 year is dependent upon successful completion of the eight goals enumerated for PL-1s (*vide supra*).

PL-2

Promotion/advancement from the PL2 to PL-3 year is dependent upon successful completion of the seven goals enumerated for the PL-2 year (*vide supra*).

PL-3

Successful completion of the PL-3 year and residency program is dependent upon attainment of the education goals and objectives for the PL-3 year.

All pediatric resident promotions are in compliance with the GME resident promotion policy (September 2003)

DUTY HOURS

SOURCE: Department of Pediatrics

Effective Date: July 1, 2008

APPROVAL: _____

Conrad J. Clemens, M.D., M.P.H., Program Director, Pediatrics

Date: July 1, 2008

DISTRIBUTION: Residency Program Residents, Faculty and Staff

Supervision of Residents

- a. All patient care must be supervised by qualified faculty
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultation

Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program
- b. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities
- c. Residents are provided with 1 day (24-hour period) in 7 free from all educational, clinical and administrative responsibilities, averaged over a four-week period, inclusive of call
- d. There must be a duty free interval of at least 10 hours prior to returning to duty
- e. Night Call during the PL-1 year should average every fourth night during in-patient rotations. There is no scheduled overnight call on clinic rotations.
- f. Night Call during the PL-2 year averages every fourth night during in-patient rotations to every fourth-seventh night when on elective. There is one call free month.
- g. Night Call during the PL-3 year ranges from every fourth night on in-patient wards to every fourth-seventh night during electives. There are two call free months.
- h. The Chief Residents and Residency Coordinator in the Pediatric Housestaff Office **MUST** be informed in advance of any major changes in the call schedule and/or master schedule.
- i. Residents must record duty hours on New Innovations at least quarterly and as directed by the housestaff office and, in addition, **NOTIFY THE HOUSESTAFF OFFICE OF ANY DUTY HOUR VIOLATIONS IMMEDIATELY.**

On-Call Activities

- a. In-house call must occur no more frequently than every third night, averaged over a four-week period
- b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities or transfer of patients unless limited by RRC requirements
- c. No new patients may be accepted after 24 continuous hours on duty
- d. At-home call (or pager call) is defined as call taken from outside the assigned institution
 - 1. The frequency of at-home call is not subject to the every third night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period
 - 2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit
 - 3. The program director and the faculty must monitor the demands of at-home call in the program, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Moonlighting

- a. The program director must ensure that moonlighting does not interfere with the residents' learning objectives
- b. Moonlighting that occurs in the primary clinical site must be counted toward the 80-hour weekly limit on duty hours

Oversight

- a. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service
- b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged

QUALITY ASSURANCE AND IMPROVEMENT POLICY

PURPOSE:

In compliance with the Essentials of Accredited Residencies for Graduate Medical Education (ACGME), this policy is set forth by the University of Arizona Pediatric Residency Program to ensure that the Quality Assurance (QA) activities conducted in the clinical practice of pediatrics meet the guidelines.

POLICY:

1. To meet the continuity of care requirement for pediatric residents, the pediatric clinics and inpatient services must have an adequate medical records system that supports resident education and QA activities. This system must be easily accessible during and after hours.
2. There shall be a monthly Morbidity and Mortality (M&M) conference attended by residents and faculty that provides an evaluative overview of the quality of care provided to patients.
3. The pediatric Program Director and pediatric Chief Residents in conjunction with attending pediatric hospitalists will perform regular chart audits to assess quality of care provided to pediatric patients.

PROCEDURE

1. Medical Records

Each pediatric resident will have orientation to the medical records department at the beginning of the intern year. The pediatric Program Director will review resident performance in medical records regularly with assistance from the pediatric program coordinator.

2. Morbidity and Mortality

The Section of Critical Care will, with the pediatric Chief Residents, prepare a monthly M&M conference/review. The time, date and location of the conference will be published in the monthly conference schedule.

3. All residents will receive instruction in medical quality assurance and improvement, and must participate, on request, in departmental, hospital and university quality assurance and improvement activities. A record of these quality assurance improvement activities will be kept in the pediatric residency office.

RESIDENT SELECTION POLICY

The Department of Pediatrics fully adheres to the Resident Selection Policy as enumerated in the University of Arizona College of Medicine Graduate Medical Education Policy and Procedures Manual (adopted Feb. 1999).

First year applicants are chosen from qualified participants in the National Residency Match Program (NRMP).

All residents are appointed when their prior experience and attitudes show the presence of abilities necessary to attain successful completion (with required knowledge and skills) of the residency program.

The Pediatric Residency Program does not discriminate on the basis of sex, race, age, religion, ethnicity, disability, national origin or veteran status.

**GRADUATED RESPONSIBILITY AND SUPERVISION OF RESIDENTS IN
AMBULATORY GENERAL PEDIATRICS**

- 1) Residents with 0 to 6 months of training should work with close supervision by the ambulatory attending including thorough discussion and patient examination.
- 2) Residents with 7 to 18 months of training must thoroughly discuss all patients with the supervising ambulatory attending.
- 3) Residents with 19 to 24 months of training should discuss all patients with the supervising ambulatory attending until the attending feels the resident is able to work with increased responsibilities. Then the resident can work independently with brief discussion with the supervising ambulatory attending.
- 4) Residents with greater than 24 months of training are expected to gain skills in providing independent patient care with brief discussion with the attending. PL-3s have the added responsibility of teaching and supervising medical students and residents.

The supervising ambulatory attending is available as a resource and consultant for residents of all levels of training. The attending will also review all charts and orders.

The attending will meet and evaluate each resident's performance in primary care areas as part of their monthly evaluation. This evaluation will be documented and incorporated into their personal file. If a resident is repeatedly noted to have specific deficits, these issues will be directly addressed by the supervising ambulatory attending.

Privileges may be restricted at any time per the judgement of the supervising attending.

THE ROLE OF THE PL-3 IN UMC PEDIATRIC CLINIC

The PL-3 shares the following responsibilities with the attendings in the clinic:

1. Patient Care: Your primary role is as a supervisor. However, when the clinic is busy you should facilitate smooth movement through the clinic by seeing patients quickly and efficiently.
2. Teaching: You are a source of information to the medical students and you should be available for precepting as well as be cognizant of teaching opportunities in the clinic. PL-1s will also call on your expertise and you should be available to help expedite care of their patients

The following are PL-3 responsibilities:

1. Seriously ill patients: All children who are wheezing, have high fevers, or who may need admission should be followed by the PL-3. Sign up for these patients or assign a PL-1 to see them with your close involvement.
2. Labs: All clinic labs are placed in a box with your name on it. Please review the labs each day (this may be done in conjunction with the PL-2) and give to the ordering providers if no urgent follow-up is needed; otherwise, follow-up yourself if the person who ordered the lab is not available.
3. High Risk Patients: Please keep a file of patients requiring close clinic follow-up. The M.D./P.N.P./M.S. should give you a card with patient information on those children at high risk. You can then remind them to follow-up or do this yourself.
4. Nursery: The PL-3 is part of the nursery team. Your role is similar to that in the clinic both teaching and patient care is your responsibility. You should help the medical students with their newborn exams, emphasizing normal newborn behavior that might not be obvious to the student.
5. Lunch coverage: You should be available by beeper through the lunch break except when Grand Rounds are at TMC. There is also an attending available by beeper at lunch if you have questions.
6. Orientation: Each month everyone should be oriented/re-oriented to clinic. You are responsible for assuring that the medical students and interns are oriented to clinic when they begin.

THE ROLE OF THE PL-3 IN UMC PEDIATRIC CLINIC

July 2006

Page two

7. Evaluations: You are responsible for providing feedback to Dr. Madden regarding medical student evaluations. You are also responsible for giving feedback to the PL-1 and PL-2 at the mid-point of the rotation and at the end of the month evaluation.
8. Journal Club: The PL-3 is responsible for preparing the monthly pediatric residents' journal club with the assistance of Dr. Tom Ball or the program director.

CONTINUITY CLINIC GUIDELINES

1. The role of the Continuity Clinics is to provide the resident-physicians an opportunity to develop and maintain long term care relations with a comprehensive group of patients. It is expected that the resident will carry the responsibility of providing primary care for the patients in their Continuity Clinic. This will include:
 - a. providing all routine primary care services
 - b. reviewing the acute primary care services provided by others when the resident-physician is not available
 - c. determining what secondary care services are indicated
 - d. arranging for and coordinating secondary care services
2. Residents are to remember that, except for the situations noted below, that their PRIMARY RESPONSIBILITY ON THE HALF DAY(S) OF THEIR CONTINUITY CLINIC IS TO THE PATIENTS IN THAT CLINIC.
3. Continuity Clinic Scheduling:
 - a. Objective: To have as much continuity as possible in clinic, while adhering to the ACGME requirement for a 24 hour workday.
 - b. Plan
 1. The Day Float resident's Continuity Clinic will be on Tuesday mornings.
 2. Continuity Clinic for the PL2 TMC Float and PL3 PICU mole can be cancelled. If the resident has or plans to cancel other clinics to accommodate away electives, the mole month clinics may need to be preserved; this will be handled on a resident-by-resident basis based on their individual tally of cancelled clinics.
 3. The Chief residents will provide the call schedule at least 3 months in advance to each of the continuity clinic sites so that the resident clinic schedule can be changed accordingly. The Chief residents may cancel (post-call) continuity clinics
4. The minimum number of patients to be seen (per RRC guidelines) during each clinic:
 - PL-1 – 3
 - PL-2 – 4
 - PL-3 – 5
5. Residents in Continuity Clinic are to see general pediatric clinic patients whenever possible (before, between and after seeing their own patients).
6. Residents must attend a minimum of 36 continuity clinic sessions per year during each year of residency.

COMMON UNITY

The parent education program at Common Unity adds to the educational opportunity for a select group of residents interested in furthering their experience in parent education and in the longitudinal care of a group of teen parents and their children. A pair of pediatric residents conducts a health education session once a month during the regular parent education meeting from 6-8 PM on Thursday evening. The residents are responsible for preparing the talk from a list of health and preventive topics appropriate for teen parents. The residents, teen parents, health educator (Joseph Zimbardo), and supervising pediatrician (Dr. Karen Davenport) will update this list. Dr. Davenport will also serve as a resource to assist residents in the development of their course material. PL-1s through PL-3s are allowed to participate in education talks.

CODES AND STAT CALLS

FOR CODE CALLS

1. When CODE 5000 is called, there is no distinction between a pediatric and adult code. Therefore, the Pediatric Resident hearing the CODE Beeper must respond to all CODE 5000s.
2. For a CODE on the fourth, fifth, or sixth floors, a call may be placed to make sure a child is not involved. For a CODE anywhere else, including the lobby, cafeteria, hallway, x-ray, etc., there should be an in-person response. Resident may elect to respond in-person to CODES on the fourth, fifth or sixth floors especially during off hours as their help may be valuable.
3. The response CODE cart has both adult and pediatric equipment.
4. Request for the emergency cardiopulmonary resuscitation team can be made by dialing 4-5000, telling the operator "CODE 5000", and giving the location.
5. For CODES on the Pediatric Ward, the CODE 5000 does not necessarily need to be activated, as we have physicians and resuscitation carts on the floor. Instead, the Resident on Beeper 2105 is notified and a button near the Unit Clerk's desk is pushed that notifies the PICU.

FOR STAT CALL

1. When you need a STAT response, you should page through the operator or paging system (694-4480) and give the extension to be called, plus "Star 99" (*99). This comes across the beeper as the extension, plus dash 99 (-99).

CONFERENCES

Teaching day attendance is mandatory for all housestaff with the exception of those on vacation or on a mole month. Chief residents will have the final approval of whether an absence is excused or not. Repercussions of an unexcused absence from teaching session will be as follows:

- First absence: jeopardy call/mommy call
- Second absence: in-house call
- Third absence: probation

1. Required Minimum Conference Attendance:

Pediatric Residents

- a. PL-1s: 75% of conference attendance and 4 journal clubs
- b. PL-2s: 65% of conference attendance and 4 journal clubs
- c. PL-3s: 65% of conference attendance and 4 journal clubs.
- d. One out-of-town conference will be supported by the Department of Pediatrics up to a maximum of \$750.00. If this money is used toward an away elective, it cannot be put toward a conference or book fund.
- e. PL-3's must have attended the minimum number of departmental conferences (see above) in order to qualify for funding for his/her extramural conference or book fund.

Combined Emergency Medicine/Pediatric Residents

- a. PGY-1s 75% of conference attendance and 2 journal clubs.
- b. PGY-2s 70% of conference attendance and 2 journal clubs.
- c. PGY-3s 65% of conference attendance and 2 journal clubs.
- d. PGY-4s 65% of conference attendance and 2 journal clubs.
- e. PGY-5s 65% of conference attendance and 2 journal clubs.
- f. One out-of-town conference will be supported by the Department of Pediatrics up to a maximum of \$750 in the PGY-4 or PGY-5 year. This must be discussed with and approved by the Program Director.

2. Each PL-2 and each Combined PGY-3 resident is expected to present a Problem Patient Conference.
3. Each PL-3 and each Combined PGY-4 resident is to present a Problem Patient Conference, as well as a CPC or Special Topic conference. Half the PL-3s will do a CPC and half a Special Topic as chosen by the resident and approved by the Program Director.
4. UMC Pediatric Emergency Conference is held the 2nd Tuesday of each month. Attendance of all interns and residents assigned to the UMC clinic is required and attendance is encouraged of all assigned to the wards and those on elective.
5. Journal Clubs:
 - a. The resident journal club is held once a month during teaching day. It is led by the PL-3 on the 3OPC (UMC Pediatric Clinic) rotation. Dr. Tom Ball or the program director assists and supervises.

- b. The Critical Care Section has a monthly journal club. Check with the Section's office.

Conference Policy
July 2005
Page Two

- c. The Neonatology section has a sectional journal club. Check with the neonatology office for dates
6. Policy for PL-3 department funded conferences:
- Submit requested date to the Pediatric Housestaff Office for approval and attach the brochure. Check jeopardy schedule for possible conflicts.

DISCHARGE SUMMARIES

General

1. Dictation summaries should be done on the day of discharge from the hospital and at the very latest within the week of discharge.
2. If dictations are not completed within one month of discharge, MIS will suspend the Attending Physician's admitting privileges until delinquent charts are dictated.
3. The status of each resident's delinquent dictations is reviewed each week by the Program Director and punitive action if necessary will be taken at that time.
4. Summaries should be brief yet informative (please see example).
5. Directions for the dictation system at UMC and TMC are provided in the orientation packet.

SAMPLE DICTATION (fictitious)

Patient Name: Blow, Joe
Medical Record Number: 0000001

Date of Admission: June 30, 2000
Date of Discharge: July 1, 2000

Attending Physician: Charlotte Breathe-Easy, M.D.
Consultant: Alexander Windy, M.D.

Procedures: None

CC (Chief Complaint):

HPI (History Present Illness): Joe is a 7y/o known asthmatic who presented to a community emergency room on the night of admission with a one day history of shortness of breath and wheezing. Mother at home had been treating him with his albuterol MDI 2 puffs every 3 hours without improvement. The patient had a "cold" per mother that started 2 days prior to admission characterized by clear rhinorrhea, cough, and sore throat. His usual asthma triggers include animal dander and upper respiratory tract infections. There are no smokers at home. He has never been in the PICU or been intubated. This is his third hospitalization for asthma.

Immunizations:

Allergies: PCN (throat tightening)

Family History: Father with asthma; all other family members healthy

Social History: Lives with mother, father, 2y/o brother. They have a pet chinchilla and there is no tobacco use

Review of Systems: Non-Contributory; pertinent positives mentioned in HPI

Physical Examination: Alert, speaking in sentences comfortably, mild respiratory distress

Vital signs: P 86, RR 25, BP 100/63, T 37.8, Pulse ox 88% on room air Wt 30 kg (%), Ht __(%)

Heent: Clear conjunctiva, Clear nasal discharge, TMs clear with good landmarks, oropharynx red without

exudate or petechiae, moist

Neck: Supple with shoddy LAD

Chest: Mild subcostal, supraclavicular retractions, prolonged expiratory phase, mild end expiratory wheezing,

fair air entry bilaterally

CV: RRR without murmur

Abdomen: Benign

Skin: No rashes or lesions noted

Hospital Course by Problems (BRIEF!)

1. Asthma Exacerbation: Most likely secondary to viral URI. Patient initially on 2L O₂ by nasal cannula to maintain saturations above 92%. Patient started on 2mg/kg/day prednisone for 5-day steroid burst. Patient also placed on the asthma protocol with albuterol nebulizer treatments q20 min x 3, then gradually spacing out to q 4 hours prior to discharge. The patient was weaned to room air 12 hours after admission. Upon discharge he is to continue his prednisone burst and albuterol MDI 2 puffs q 4 hours x 24 hours, then space to q6 hours x 48 hours then q6 hours prn. Patient is to double up on the Beclomethasone DS inhaler for the next two weeks. Asthma education was reviews and asthma plan was given to the parents.

2. FEN: Adequate hydration was maintained orally through the hospital stay. No IV fluids were given.

Discharge Diagnosis/Diagnoses:

Discharge Disposition: Patient was discharged home in stable condition with his parents

Discharge Medications:

1. Prednisone 30 mg po bid (=2 mg/kg/day divided bid)
2. Beclomethasone DS inhaler 4 puffs bid x two weeks, then decrease to 2 puffs bid
3. Albuterol MDE with spacer as outlined above
4. Loratidine 20 mg po qd prn allergies

Discharge Instructions:

1. Take the medications as prescribed above
2. Follow up in Pulmonary Clinic in 6-8 weeks
3. Follow up with PCP in 2-3 days, sooner if needed
4. Return to PCP's office or emergency room if symptoms worsen
5. Encourage plenty of fluids and rest

C. Breathe-Easy, M.D.
Attending Physician

Dictated by Kurt Ventilation, M.D.
Pediatric Resident

CC: To Primary Physician and all attending and referring M.D.s

ELECTIVES

1. Electives offered by this program include:

ALLERGY AND IMMUNOLOGY*

Anesthesiology

CARDIOLOGY*

Clinical Pharmacology

Clinical Toxicology

ENDOCRINOLOGY*

Educational Strategies

GASTROENTEROLOGY/NUTRITION*

GENETICS/DYSMORPHOLOGY*

HEMATOLOGY/ONCOLOGY*

INFECTIOUS DISEASES*

International Health

Medical Anthropology Program

NEPHROLOGY*

NEUROLOGY* ▪

Orthopedics/Sports Medicine

Procedures

PULMONARY*

Research

Rural Health/Indian Health Services

- May also be taken as an “away” elective after approval by the Program Director.

THE CURRICULUM OUTLINES FOR ELECTIVES ARE IN THE HOUSESTAFF OFFICE or ON THE PROGRAM’S WEBSITE. Indian Health Service opportunities are listed in a separate folder.

Reading Elective must be approved by with the Program Director.

*At the completion of the residency, each houseofficer must have completed four of the nine electives specified above in **CAPITAL LETTERS**. The FOUR REQUIRED ELECTIVES chosen must each be UNINTERRUPTED ONE-MONTH-LONG blocks.

2. PL1s may choose between Cardiology, Nephrology, Pulmonary, or Infectious Diseases. Participation in the International Health elective and in electives not listed above must be approved by the Program Director at least six months in advance. The elective goals, syllabus, bibliography and preceptor/evaluator must be provided.

3. Each senior resident will arrange electives, after discussion with faculty advisor, with the appropriate specialty and notify the Housestaff Office of the elective choices. Discussion with the Program Director is also encouraged.
4. **Residents should have electives set up for July – December and the information reported to the Housestaff Office by May 1. Electives for January – June should be set up no later than November 1. After that time, the Program Director will assign an elective for that resident. If a resident wishes to change his/her scheduled elective, it must be done at least two months prior to the start of the elective. No changes in elective will be permissible if the elective has been assigned by the Program Director.**
5. The Department's position regarding "away" electives is as follows:
 - a. Generally, away electives will be approved if the elective sought is either (1) not available or not acceptable in our program (e.g. allergy/immunology), or (2) other unusual circumstances.
 - b. All petitions for away electives must first be presented in writing to the Pediatric Residency Director at least three months prior to the expected date of departure.
 - c. A houseofficer may take an away elective only during a No Call month.
6. Some sections only have one faculty member. If the faculty member is out of town or unavailable during part of your elective, you are required to arrange for an assignment which is to be completed during that faculty member's absence.

RESIDENT WISHING TO TAKE AN OUT-OF-TOWN ELECTIVE

1. An “out-of-town” elective is available only during a call free elective month.
2. The procedure is as follows:
 - a. A Resident requesting an out-of-town elective will present the request to the Pediatric Housestaff Office for review and advice.
 - b. The Pediatric Housestaff Office **must**, as with all "away" off-campus electives, receive adequate prior notification so that the AHSC Contracting Office is able to confirm that a contract is in place for that elective location. For international health electives, it takes many months to arrange a contract and the resident cannot begin his/her away elective until the Affiliation Agreement is completed.
 - c. Partial reimbursement for the “away” elective expense is \$750.00 (resident conference reimbursement) plus \$300.00 (for an International Health elective). This reimbursement is available only with prior approval for the elective from the Program Director and proper notification to the Pediatric Housestaff Office prior to the elective.
 - d. The American Academy of Pediatrics Resident Section awards annual scholarships for resident international travel. Applications are encouraged. The forms may be obtained in the Pediatric Housestaff Office.

EMERGENCY MEDICINE ROTATION

Pediatric residents are assigned to Emergency Medicine one month in the PL2 and one month in the PL3 year. The rotation(s) may take place at the University of Arizona, directed by Dr. Dale Woolridge, or as an away rotation (arranged prior to master schedule). The PL3 rotation may take place at the University of Arizona or at another program director-approved site. The purpose of this rotation is to provide a learning experience for pediatric residents in a “receiving point for EMT transport and ambulance traffic and access point for seriously injured and acutely ill pediatric patients” (1996 RRC Pediatric Residency Program Requirements).

Residents must contact Dr. Dale Woolridge (dale@aemrc.arizona.edu) 3-4 weeks prior to the start of rotation for orientation and to establish their specific schedule (UC and ED).

I. CLINICAL COMPONENT

1. Residents will work 14 9-hour shifts throughout the month block. Ten shifts will be in the urgent care, four shifts will be in the Emergent care. Emergency department shifts will be scheduled to coincide with selected faculty duty hours.
2. For any given shift, residents will sign up for patients in a random manner as they are triaged to their rooms. No resident will be required to sign up for critical patients they do not feel capable or comfortable caring for. Any concerns regarding the care of critical patients should be discussed with the attending and senior resident prior on shift.
3. Residents will be the primary caregivers for critical and non-critical patients within the emergency department, and will assist the attending and senior residents in the management of critical care patients.
4. Residents will be closely supervised. Specifically, they are required to present and review every step of patient care directly to the attending on duty.
5. Residents will perform the initial history and physical examination of critical and non-critical patients, and initiate ancillary studies.
6. Residents will provide needed therapy at the direction of the attending on duty.
7. Residents will be used as the pediatric consultant while on shift in the emergency department. In this regard, they will act as the liaison to the pediatric admitting team and assist in the disposition of the pediatric patient.

II. DIDACTIC COMPONENT

1. The Department of Emergency Medicine based didactic sessions will be conducted on Tuesdays from 0800-1200.
2. Informal lectures will be conducted in the Emergency Department every morning at 0800 by the emergency care attending. Clinical and bedside teaching will also occur on a case basis.
3. The rotating resident will actively participate in the combined conference that is conducted on the second Tuesday of each month (0800-0900).

III. ADDITIONAL EDUCATIONAL EXPECTATIONS

1. Residents will utilize this rotation to increase procedural skills – both in the ED and, by special arrangement, with Dr. Nogami et al (Anesthesiology).
2. Residents may also utilize time outside the ED to increase orthopedic expertise (e.g. arrange with Dr. Vincent's office), ENT knowledge (Dr. LaMear's office), etc.
3. Residents should participate in Toxicology rounds when possible.

IV. EVALUATION AND FEEDBACK

1. The department of Pediatrics evaluation form will be completed by appropriate faculty for each resident at the completion of the rotation. Specific areas such as rapport with patients and physicians, integrity, initiative, technical skills, basic medical knowledge, histories and physical examinations" completion of medical records and communication skills will be numerically assessed and recorded. Specific comments made by faculty will be recorded as well.
2. The rotating resident will be allowed to anonymously evaluate any faculty member and staff member. This feedback will be reviewed by the program director and clinical directors in order to improve the rotation and resident experience.
3. Residents will have informal feedback midway through the block and formal feedback at the end of the block. The written evaluation from this rotation will be submitted to your program coordinator and can be reviewed thereafter.
4. More frequent evaluation and feedback will be done as needed on an individual basis. Residents not performing well will be approached during the emergency

department rotation for evaluation and feedback.

REQUIRED EVALUATIONS

1. Evaluations are completed by housestaff and faculty at the end of each rotation on the New Innovations® web site. This is accessed at www.new-innov.com/suite. Housestaff complete evaluations on the rotation, faculty and housestaff worked with during the month. All rotations completed by the residents are completely confidential. Evaluations are available on-line mid-month and are to be completed within seven (7) days of the completion of the rotation.
2. Residents who have delinquent evaluations will have Meal Card funds cancelled if evaluations are delinquent three months or more. All evaluations must have been completed for residents to receive Residency Graduation Certificate at the completion of the residency program.
3. All faculty evaluation comments are strictly confidential. A compilation of all scores and comments will be given to each faculty member and the Department Chairman every 12 months without any identification of the respondents.
4. Individual peer evaluations will remain confidential. They will be summarized anonymously and available for resident review with their advisor on a triennial basis.

FLOATING HOLIDAYS

1. PL1s are entitled to 4 floating holidays per year; PL2s and PL3s are entitled to 5 floating holidays per year. The purpose of floating holidays is to make up for holiday time offered to other University of Arizona employees (e.g. Presidents' Day, July 4th, Labor Day, etc.) that cannot be easily accommodated into a resident's schedule due to their unique situation with regard to call and patient care responsibilities.
2. PL-1s may take their floating holidays during elective, adolescent and clinic months only. Only one day may be taken each during the Adolescent and clinic months; the remaining two days may be taken during the elective month.
3. PL2s and PL3s may take their floating holidays during elective months and during the Behavior/Development month during the PL2 year. No more than two days may be used in any month-long elective, and no more than one in a two-week elective.
4. Floating holidays may not be taken on a continuity clinic day.
5. Any request for a floating holiday must be made 2 weeks in advance of the start of the rotation in which the floating holiday will be taken. Permission must be granted by the supervising attending in writing (email from the attending or with an attending signature) and given to the Chief Residents.
4. The Chief Residents will make every effort to accommodate an intern/resident request for a floating holiday but reserves the right to refuse the request in accordance with service or scheduling needs.
5. Floating holidays cannot be saved from year to year unless an additional floating holiday was provided to make up for a jeopardy call and the resident is unable to use it within the calendar year. Floating holidays cannot be used prospectively.
6. During elective rotations when no vacation is taken, floating holidays and conferences may be taken at any time during that rotation not to exceed two consecutive weeks.
9. Floating holidays may be taken on a day scheduled for night call, however, the resident must still complete the night call duties or switch with another resident.
10. Residents do not need to use floating holidays to attend medical conferences. They may attend medical conferences during any rotation provided that they have arranged proper coverage for day and night responsibilities. Floating holidays should be used for all other absences from clinical sites.

VACATION POLICY

1. Each Houseofficer is entitled to 22 working days of paid vacation per year.
2. Vacation may only be taken at the beginning or end of a segment.
3. The Chief Resident will allocate vacation time in accordance with service and individual needs.
4. Vacation time cannot be saved from year to year, nor can it be used prospectively.
5. Housestaff cannot take more than two consecutive weeks off during any elective. The two consecutive weeks may be all vacation, vacation plus conference/meeting, vacation plus floating holidays.
6. During elective rotations when no vacation is taken, floating holidays and conferences may be taken at any time during that rotation.
7. Each houseofficer should contact the housestaff office immediately prior to commencing vacation (to complete unfinished business).

PATIENT CARE PROTOCOL

In the event that an intern/resident is asked to participate in patient care which he/she believes, in good faith, places the patient at risk and/or engenders liability for him/her, the intern/resident must discuss his/her concern with the senior resident who will accompany the intern/resident in a discussion with the attending physician. If no mutual resolution is reached with the attending physician, then:

1. The intern/resident shall objectively document his/her treatment plan, the fact that the plan was discussed with the attending physician, and the ultimate plan as arrived at by the physician in the patient's medical record;
2. The senior resident shall notify the chief resident on-call;
3. The chief resident on call shall notify the attending physician for a further assessment of the plan for patient care and:
 - a. Direct the intern/resident to comply with the plan if the chief feels that the plan meets the standard of care; or
 - b. Notify the residency director of the perception that the care provided may be below the standard of care.
4. The residency director shall communicate the program's concerns to the attending physician. If the attending physician and the residency director do not come to a mutually agreed upon plan of care, the residency director may remove the resident(s) from the case and/or report the case to the appropriate institutional administrative personnel.
5. In the event that the residency director is unavailable, the chief resident shall notify the institutional program department chairperson.

ADMISSIONS TO UMC PEDIATRIC FLOOR

If a patient's PCP is from **UPH - Kino clinic** or **3OPC**, the senior ward resident should be notified and the case discussed with him or her. The senior ward resident can accept the admission for his or her service attending.

If the patient **does not have a PCP**, the senior ward resident should be notified and the case discussed with him or her. The senior ward resident can accept the admission for his or her service attending.

If the patient's **PCP is from the community**, the PCP must be notified of the admission before the senior resident is called. If that PCP does not want to admit to his or her service then it is the PCP's responsibility to find another attending who will accept the patient (i.e. the PCP needs to call the General Pediatric attending on-call or a Hospitalist). An attending needs to be established prior to notifying the senior pediatric ward resident.

ADMISSIONS TO TMC PEDIATRIC FLOOR

For **ALL admissions** to TMC pediatric floor, an accepting attending needs to be established prior to notifying the senior pediatric ward resident. The senior ward resident cannot accept responsibility for admitting any patient without first establishing an accepting attending.

If a patient's PCP is from **UPH - Kino clinic** or **3OPC** the general pediatric hospitalist should be notified and the patient should be admitted to UMC. **If the patient does not have a PCP**, the Pediatric attending on-call for the TMC ER must be notified of the admission. If that on-call attending does not want to admit to his or her service then it is that attending's responsibility to find another pediatric attending who will accept the patient (i.e. the attending needs to call the Service attending or a Hospitalist).

If the patient's **PCP is from the community**, the PCP must be notified of the admission. If that PCP does not want to admit to his or her service then it is the PCP's responsibility to find another attending who will accept the patient (i.e. the PCP needs to call the General Pediatric attending on-call or a Hospitalist). An attending needs to be established prior to notifying the senior pediatric ward resident.

ADMISSIONS TO UMC OR TMC PICU

For **all admissions to a PICU**, the PICU attending on-call must be notified to accept the patient and arrange any necessary transport. The resident on-call for the PICU cannot accept responsibility for any PICU admission. Potential PICU patients should not be turned away without notifying the pediatric intensivist on-call. "Divert" status can change at any moment.

FOLLOW-UP of any pediatric patient discharged from the ER/UC to 3OPC or UPH - Kino

UPH - Kino clinic and 3OPC have walk-in or call-in appointments available Monday-Friday. If the patient is complicated and you wish to discuss their follow-up care with a pediatric resident, call the UMC operator and ask to speak with the pediatric resident on-call for 3OPC "mommy calls." This resident will then notify the senior resident at 3OPC or Kino clinic the following morning. This phone call should not serve as a consult.

NOTE: Insurance may dictate which attending to call.

ADMISSIONS CAP PROTOCOL

TMC Wards

Floor + PICU if floor/special care

Team max: 30

Intern admit: 10

Redistribute in AM at 12

Senior admit: 15

Transfer off resident service only in rounds

Private attendings may use hospitalists

TMC PICU

ICU only

Team max: 12

UMC Wards

3E, 3W, up to 2 in ED and PICU

Team max: 30 + hem/onc

Intern admit: 10

Redistribute in AM at 12

Senior admit: 15

Consults: 2/senior

Transfer off resident service only in rounds

Private attendings may use hospitalists

UMC PICU

6W, ICU only

Team max: 16

UMC NICU

8W only

Team max: 30

Resident admit: 5

Follow max: 10

Vented max: 6

Nursery

Team max: 20

**PEDIATRIC WARD POLICY RE: PEDIATRIC PATIENTS HOUSED OFF THE
PEDIATRIC WARDS**

UMC Wards

1. Pediatric residents will no longer take care of off-pediatric ward patients.
2. Ward residents will follow a maximum of two ED and PICU patients who are on floor status (including patients admitted to subspecialist attendings):
 - Residents are expected to do a full H&P and write orders in SCM
 - Residents must alert both the ED nurse and resident about the orders
 - Residents must leave their pager # in the ED so they can be called with management questions.
3. Floor status patients in the PICU will be covered by the pediatric or ED resident in the PICU.

TMC Wards

Pediatric residents will cover the pediatric wards and PICU. Off-ward pediatric patients will not be followed by pediatric residents.

NON-PEDIATRIC RESIDENTS IN THE PEDIATRIC INTENSIVE CARE UNIT

PATIENT CARE

1. Non-pediatric residents in the ICU act as junior residents and are supervised by the PL-2 pediatric resident on PICU rotation.
2. Each PICU resident is responsible for admitting and managing a reasonable number of patients.
3. Each admission requires an admission note by this resident outlining the history, physical findings, laboratory and radiologic results, and initial assessment and plan. A second note by the attending is required.
4. Progress notes will be written daily on all PICU patients. The resident will write notes on those patients whom s/he is following.
5. The discharge summaries and off service note are the responsibility of the resident following the patient.

PROCEDURES

1. The non-pediatric PICU resident will be asked to perform procedures needed by his/her patients within their abilities and with the assistance of either the pediatric supervising resident or attending.

ROUNDS

1. The PICU residents will round daily with the PICU team. Each resident will be responsible for presenting all patients they are following.

ON CALL RESPONSIBILITIES DURING THE WEEK

1. The non-pediatric PICU resident will take call covering the PICU as a junior resident about every fourth night. S/he will receive check-out from the other PICU residents around 5:00 p.m.
2. If there is a significant problem with a patient in the PICU, the intensivist on call should be notified. All calls for consults or possible admissions in the ED should go to the pediatric intensivist. The pediatric resident should take the non-pediatric resident in the PICU down to the ER for probable PICU admissions whenever possible. If the ED inadvertently calls the resident, the resident must inform the attending.

3. The PICU resident on call will write admission notes on all patients admitted to the PICU during the call night including those patients on other services, such as trauma, neurosurgery, etc. The ICU attending should review admission note and orders.
4. Post call, the PICU resident will write notes on the patients s/he is following and round with the team.

RESPONSIBILITIES ON THE WEEKEND

1. PICU progress notes and rounding are the responsibility of the on-call and post-call residents. Residents on the ward also assist in writing notes.

TRANSPORTS

1. Non-pediatric residents in the PICU will be involved in transports at the discretion of the transport attending.
2. All calls for transport and possible PICU admissions from outlying clinics should be given to the intensivist.

PICU RESIDENTS' JOB DESCRIPTION

The pediatric residents in the PICU are responsible for managing or assisting in the management of all pediatric patients in the ICU while pursuing educational goals appropriate to the rotation.

General Responsibilities of the 2nd Year PICU Resident:

PATIENT CARE

1. The PICU resident is responsible for admitting and managing the following PICU patients (maximum 8):
 - a. General Pediatrics
 - b. Those belonging to associate pediatric faculty
 - c. Those belonging to all other pediatric sections
2. A single resident admission note will be placed in the chart outlining the history, physical findings, laboratory and radiologic results, an initial assessment and initial plans.
3. Orders will be written by the PICU resident.
4. The Discharge Summary, Off Service note or Transfer Summary is the responsibility of the resident.

CONSULTS/CO-MANAGEMENT

All other PICU patients require a pediatric consult or co-management on arrival. Consults cannot be refused and must be completed in a timely fashion. Surgical services may wish to relinquish control of the patient's management to pediatrics. The PICU attending will supervise the pediatric resident when consults are performed.

ROUNDS

The PICU residents are responsible for presenting all patients during rounds.

TRANSPORTS

1. A PICU attending is the attending for all UMC AIRCARE inter-hospital transports (except trauma) and will be available during the transport by telephone or radio to provide assistance in patient management.
2. Contact Pediatric Intensivist.

NON-BUSY INTERVALS

1. During times when the PICU is not busy, the PICU resident is responsible for the continuation of his/her own educational pursuits as deemed appropriate by the PICU attending. These may include:

PICU Resident Job Description
May 2006
Page two

- a. Directed reading
- b. A special lab exercise
- c. Preparing a critical care topic for presentation
- d. Other (as agreed upon between the PICU attending and resident).

TEACHING ANCILLARY PERSONNEL

The PICU resident may be asked to prepare and present a topic to the nurses and medical students, or other ancillary personnel.

PICU Mole (PL3)

1. The 3rd year PICU Mole is responsible for the care of all pediatric patients in the PICU from 5 p.m. to 7:30 a.m. on nights on duty and is encouraged to attend Morning Report on Monday, Wednesday and Friday.
2. The Continuity Clinic for the PL3 PICU Mole will be moved to Wednesday mornings.
3. **Three 'preplanned' absences (covered by banked call swaps) should be the maximum allowed per Mole rotation.**

POLICY FOR TRANSFERS OUT OF OR INTO INTENSIVE CARE UNITS

1. All patients being transferred to wards or to the regular nursery from the Intensive Care Unit, must have a detailed transfer summary written on the chart at the time of transfer.
2. Transfer orders must include the service and specific attending's name to whom the patient is being transferred.
3. At the time the transfer order is completed, the houseofficer primarily responsible for the patient in the PICU/NICU must personally communicate with the senior houseofficer and attending who will assume responsibility for this patient; the senior houseofficer shall then notify the PL-1.
4. When a patient is transferred from the ward or regular nursery to the Pediatric Intensive Care or the Neonatal Intensive Care, a transfer summary should be written on the chart and direct communication should occur between the transferring and receiving houseofficer and attending.
5. In both instances above, the houseofficer assuming the primary responsibility for the care of this patient will be notified immediately by the Unit Clerk upon arrival of the patient to the floor/unit.
6. At times, when things are extremely busy so that a thorough and complete transfer summary is not practical, a brief note stating the major problems must be written and direct verbal communication made with the resident to assume care. When things settle down, the resident transferring the patient should write a more detailed transfer note.
7. Whenever possible, transfer from intensive care units to the ward or regular nursery, should be accomplished as early in the day as possible.

JEOPARDY CALL

1. Jeopardy should be reserved for only urgent needs, e.g. acute significant illness or family emergency.
2. PL-2s and PL-3s cover all jeopardy. The jeopardy resident is on 24-hour call.
3. Jeopardy call will be the responsibility of the residents in the general call pool for the month.
4. The resident unable to take call is to determine as early in the day as possible if there is a need to jeopardize someone. This allows for all who are involved to make appropriate arrangements.
5. The resident unable to take call must contact the resident on jeopardy call directly and then notify the chief resident of the arrangements they have made. The Housestaff office will be notified by the Chief Resident.
6. If the resident unable to take call is a PL-2 or a PL-3 payback to the jeopardized resident will consist of one call night. Intern payback will be 3 Mommy Calls.
7. The jeopardy person must be available and respond in a timely manner to any page. If the jeopardy resident is not available, she/he will pay back the jeopardized resident with two call nights.
8. No resident will be jeopardized two nights in a row. If this should occur, the Chief Resident will to jeopardize another resident at their discretion with payback of one call night to the jeopardized resident from the resident unable to take call.
9. The jeopardy system does not allow for frequent daytime coverage should it become necessary. In the event that frequent daytime coverage is necessary, the Chief Residents will need to create a back-up system utilizing all residents who are in the elective call pool. This will protect the jeopardy resident from missing too much elective time on their rotation during their jeopardy block.
10. If it is perceived that the jeopardy system is being abused, a review by the Chief Residents and Program Director will occur.

MATERNITY/PATERNITY LEAVE POLICY

1. **OBJECTIVE:** The maternity/paternity leave policy of the Department of Pediatrics supports and facilitates a smooth and positive transition into parenting, within the Department's existing educational, clinical service, and financial constraints. In order to arrange an optimal schedule for parental leave, the resident must notify the Program Director of these needs in writing at least 6 months prior to the onset of leave.
2. **DURATION OF LEAVE:** Assuming a normal pregnancy and delivery, maternity leave will last for a maximum of 8 weeks. Paternity leave will also be 8 weeks in duration. Maternity/paternity leave covers adoption, entitling residents to the same benefits as biological parents.
3. **CATEGORY OF LEAVE CREDITED:** Maternity/paternity leave will consist of 4 weeks derived from vacation time. An additional 4 weeks will be completed as a reading elective to be decided with faculty supervisor. This additional 4 weeks will be taken during the PL-2 or PL-3 call-free month.
4. **BOARD ELIGIBILITY:** The American Board of Pediatrics allows for this circumscribed absence from clinical responsibilities. If additional time away from residency training should be required, arrangements for make-up time to fulfill Board requirements will need to be arranged on an individual basis.
5. **SALARY AND BENEFITS:** The resident's salary and benefits will not be interrupted during the 8 weeks of maternity/paternity leave.
6. **COMPLICATIONS OF PREGNANCY/POSTNATAL PERIOD:** In the event of unforeseen complications during pregnancy or the postnatal period, the resident should contact the Residency Director as soon as possible to allow for individual arrangements. Time made up at the end of residency will be salaried only if the time previously taken is leave without pay.

MOONLIGHTING POLICY

1. Moonlighting is a voluntary activity.
2. Moonlighting must not be scheduled so as to interfere with the Department of Pediatrics obligations. Residents who elect to moonlight cannot exceed the ACGME mandated 80 hour work week by moonlighting (i.e. moonlighting is included in the total hours worked).
3. "Supplemental reimbursed residency time" within the pediatric program is covered by the Department's malpractice insurance; moonlighting outside the program requires separate malpractice coverage.
4. Residents may take paid call on designated units (i.e., NICU, PICU, Wards) after meeting each section's clinical criteria/requirements.
5. Residents must have the Program Director's approval to moonlight.

UMC AND UPH-KINO MOMMY AND NURSERY CALL

Mommy Call

Mommy Call will be covered by the PL-2s and PL-3s for the first 3 months; thereafter the interns on clinic, elective and nursery rotations will be added to the mommy call pool. Mommy call for seniors will be paired with jeopardy whenever possible. Mommy Call will include calls from Juvenile Detention Center.

Nursery Call

All non-emergent afternoon calls will be directed to the nursery intern. Afternoon emergencies and evening nursery calls will be taken by the UMC ward intern. Weekend calls are taken by interns on clinic, elective and nursery. They will check out to the ward intern on-call when they leave.

PROCEDURE CERTIFICATION

1. Each resident is to document procedures performed on each rotation at www.acgme.org.
2. At the end of the third year of pediatric residency, the number of times each procedure was performed will be tabulated and must meet program requirements to allow recommendation for board eligibility.
3. The list of procedures is based upon the recommendations of the Residency Review Committee (RRC), American Board of Pediatrics, and Ambulatory Pediatric Association (APA).
4. A resident who does not complete and document the minimum number of required procedures will **not** be recommended for the Pediatric Board examination

PROCEDURE NOTES: PROTOCOL FOR HOUSESTAFF

1. All procedures performed by housestaff need to be documented on a UMC "Procedure Report". As a guideline, this includes any procedure for which written permission is required. This also includes bedside procedures (such as venipunctures, IV's, ABG's, urethral catheterizations, injections, skin tests) for which written permission is not necessarily required.
2. If an Attending Physician is available, s/he should be notified of the procedure and invited to be present "for the key portions" of the procedures.
3. The Attending should then sign the attestation line at the bottom of the Procedure Report, confirming their participation during the procedure.
4. An Attending Physician's signature is required for billing purposes. If no attending is present, no bill will be generated for the procedure.
5. The Housestaff member should keep a copy of the report for their procedure log.

REQUIRED PROCEDURES

SPECIMEN COLLECTION

- ABG/Arterial Puncture (3)
- venipuncture (10)
- bladder catheterization (3)
- suprapubic tap
- clean catch technique
- lumbar puncture (5)
- thoracentesis

DIAGNOSTIC/SCREENING PROCEDURES

- Peak flow (3)
- Developmental screening test
- Tympanometry
- Pelvic exam/endocervical cultures (8)
- Urinalysis (3)
- Stool occult blood exam
- Pinworm prep
- Scabies prep
- Wood light exam
- KOH prep
- Hematocrit (3)

THERAPEUTIC/TECHNICAL PROCEDURES

- Subq injection (3)
- IM injection (3)
- Intradermal skin test (3)
- Suturing of laceration (3)
- Management of paronychia
- Reduction of nursemaid's elbow
- Abscess aspiration, I and D
- Management of 1st/2nd degree burns
- Management of corneal abrasion
- Gastric lavage
- Foreign body removal
- Inhalation medication administration (2)
- Intubation (<2 months) (5)
- Intubation (>2 months) (5)
- Routine IV placement (10)
- Emergency IV access (CVL, intraosseous) (2)
- UAC
- UVC (3)
- Chest tube placement
- Immobilization of fracture/sprain (3)
- Conscious sedation
- Circumcision

PEDIATRIC RESIDENT RESEARCH PROGRAM

GOAL

1. The Department of Pediatrics has a special support mechanism for residents who wish to become involved in research. The Department's aim is:
 - a. To introduce the resident to research
 - b. To teach techniques of hypothesis formation, data analysis, manuscript preparation, and effective use of presentations at national meetings to demonstrate scientific information.
 - c. To motivate research oriented residents towards a career in academic pediatric medicine.

ELIGIBILITY

1. Any interested pediatric resident can apply for this training which is performed in the 2nd and/or 3rd year of residency. Applicants for this training must be willing to devote a block of 1 or 2 months in the 2nd and/or 3rd year (maximum of four months). Additional time (nights or weekends) may be necessary to complete the project.

APPLICATION

1. Pediatric Department Sections involved in this training program have listed projects. A houseofficer interested in such a project would initiate the primary application process through the Housestaff Committee. This preliminary application only requires a brief statement describing the aims of the project and the anticipated time involved. The Housestaff Committee would then make a recommendation, either positive or negative, to the Research Committee with regards to allowing this person the requested research time. Only after approval by the Housestaff Committee will the Research Committee consider a more detailed proposal. (This provides a safeguard so that residents who are not performing well in the clinical arena do not take time away from their basic pediatric training.) Final approval/disapproval is the prerogative of the Department Chairman.

SUPPORT

1. The estimated cost/person for this research training is \$2000 which is to be used for supplies and/or small equipment requests necessary for project completion. It is expected that the Department will have travel funds available for any resident whose research results are selected to be presented at national meetings.

LEAVE OF ABSENCE POLICY INCLUDING SICK LEAVE

1. Each person accrues 8 hours (1 day) of sick leave per month, or 12 days/year. Documentation of illness may be requested by the Director of the Housestaff program. Duration of missed responsibilities due to illness must be reported to the Housestaff Office.
2. Night call responsibilities missed due to illness must be made up at a later date.
3. If a houseofficer is absent because of personal illness, family emergency or similar circumstances, the houseofficer should notify his/her senior resident, chief resident, supervisory attending and the Residency Director.
4. All requests for leave of absence must be submitted to and approved by the Program Director (see also University of Arizona Graduate Medical Education Policy and Procedure Manual).
5. Leave of absence may affect the completion of the residency program and may affect board eligibility and is determined by the Program Director (as stated in the University of Arizona Graduate Medical Education Policy and Procedure Manual).

TMC SCHEDULE OF ROUNDS/CONFERENCES

1. The PL-3 resident will supervise pediatric and nonpediatric housestaff and students assigned to the TMC Wards. PL-1s on the wards will follow ward patients, Special Care Unit patients, and may join PICU rounds if time allows for educational purposes.
2. MONDAY, TUESDAY, THURSDAY:
 - a. Work rounds will be made separately in the PICU and on the wards.
 - b. Morning Report is at 8:00 am. It is expected that the Chief Resident, and PICU attending will attend as will all house officers and students. Attendance by other attendings such as associate faculty and hospitalists is encouraged. Exceptions are to be made only for true emergencies.
 - c. Student rounds with the teaching attending will be held from 9:00-10:00 AM (or at any other time mutually agreed upon by the students and the attending, as long as it does not interfere with the other attending times or other commitments which the students may have).
 - d. Special Care Unit work rounds will be made with the senior resident during morning work rounds.
 - e. The Chief Resident may join work rounds several days each week and will also be present for Morning Report. Consultation with the Chief Resident regarding complex/interesting patients is strongly encouraged.
3. Tuesday/Thursday attending rounds are to be scheduled by the PL-3 from 11:00 am to 12:00 noon, or whatever 2 days works best for the team.

4. SPECIAL CARE UNIT ROUNDS

- a. On Thursday from 10:00 am to 11:00 am there will be special care patient management rounds with the attending, PL-1 residents involved with the patient, PL-3 resident and ancillary care personnel.

Otherwise, daily rounds for Special Care Unit will be conducted with the Senior Resident.

- b. The ward PL-3 resident must perform consultations on all Special Care Surgery patients. This will usually entail a note twice a week regarding primary care issues and attendance at Special Care rounds to discuss these patients

5. DEPARTMENTAL CONFERENCES

At the beginning of the rotation, the team should devise a system to allow a few residents to attend radiology, resident enrichment, specialty, resident, and other conferences offered throughout the month. There must be at least one resident and intern at TMC at all times unless there is a PICU attending and a ward resident present.

PL-2/PL-3 DAY FLOAT ROTATION POLICY

Objectives: to help during busy times or conflicts with schedules. To minimize needs to pull residents out of elective rotations.

Responsibilities: - to provide daytime help during busy winter seasons, help out when there are conflicts with continuity clinics and residents having to leave post call, or when clinics are busy. Also to be available for cross-cover needs as specified by the chief resident.

Residents are allowed to take floaters as long as there are no conflicts with cross-cover and are approved by the chiefs.

Call Schedule – will have the usual number of nighttime and jeopardy calls.

Education – during this rotation, when cross-cover assistance is not needed, residents may attend general pediatric, subspecialty and CRS clinics of their choice as well as pursue any research and/or publication activities of special interest. This time may also be utilized for in-depth reading of the medical literature.

Rotation – will be for two weeks during the second and third years, opposite to vacation.

PL-1 WARD RESPONSIBILITIES

1. The PL-1 is required to take and record a complete and thorough history which includes not only the present illness, but the past history, including family, social, immunization, birth and developmental histories as well as review of systems. The physical exam must be equally as complete. The growth parameters, including height, weight and head circumference must be plotted at this time.
2. Upon completion of the initial work-up, the PL-1 is to formulate his/her provisional diagnosis and appropriate treatment plan. The diagnosis and orders are to be reviewed with his senior resident after the latter has seen the patient as well. A mutual plan will be derived from this meeting and its contents presented to the referring or attending physician. A complete treatment plan is then implemented with input from the resident team and attending physician.
3. A successful relationship between the PL-1 and the attending physician is kept alive by continuous communication between these parties. Prompt notification of the attending physician of changes in the clinical course of the patient and changes in diagnostic or treatment plan must be carried out by the PL-1. The attending physician carries the ultimate responsibility of his patients, and therefore, it is essential that he be informed of any change in the condition of or subsequent course of his patient. These discussions should also include discharge and follow-up plans for the patient. If the patient is on the hospitalist service, the PL-1 should arrange for communication with the patient's primary care doctor (e.g. Family practice, those without admitting privileges, out of town physicians) either by direct discussion or discharge summary, detailing the patient's in-house stay.
4. The PL-1 should be on the ward with his/her patients as much as possible. This places the PL-1 close to his/her patients as well as to the nurses who are likewise involved in the delivery of care to patients. From the ward, the PL-1 can best monitor patients and make proper chart notes. The PL-1 is thus also available to attending physicians who are rounding on their patients. The availability of intern and attending physician to each other is crucial to the program and the training of housestaff in any hospital. It is expected that the PL-1 discuss patients with their attendings at least on a daily basis.
5. All ward patients at TMC and UMC of associate or full-time faculty are the responsibility of the PL-1, PL-2, and PL-3, unless housestaff availability is limited by the University of Arizona Pediatric Department Head (e.g. during epidemics when admissions exceed the capacity of house officers to administer quality of care). Any patient of a faculty member is open for teaching. However, the ultimate responsibility for care of that patient rests with the attending (i.e., proposals for treatment, consults and suggestions made in work rounds must be cleared with the attending physician).
6. The PL-1 at TMC/UMC must complete the consult request form prior to all consultations on all patients.

7. The pediatric houseofficer shall respond to any pediatric emergency within the hospital, regardless of whether or not that patient's physician is a member of the pediatric faculty. Following any emergency, the responding houseofficer must write an account of their intervention in the chart.

8. Any critically ill patient on the ward or a patient the PL-1 is uncomfortable with for any reason should be discussed immediately with an upper level resident. If a senior resident is unavailable, an attending should be notified of the PL-1's concerns. If a patient needs transfer to another unit (e.g. NICU, PICU) or another service, a member of the transferring service should write a transfer summary.

WARD ROUNDS

1. Daily work and chart rounds will be made on all patients by the houseofficers. These should be completed before attending rounds. During or after work rounds, a progress note on each patient should be entered in the chart. This requires work rounds early enough in the day to be ready for both attending physician and teaching rounds.

2. Work rounds should be completed by 8:30 AM on weekdays. They may start at a time mutually agreeable to the ward team to ensure enough time to complete these rounds.

3. Formal teaching rounds are to be conducted in a sophisticated manner. Selected patients are to be presented by the PL-1 succinctly and accurately. Rounds are not to be interrupted by telephone calls, side conversations, etc. They should start promptly.

CHARTS

1. Charts are to be written utilizing the "problem-oriented" system. The importance of maintaining good records cannot be overemphasized. Habits developed during internship will carry over for many years, and the keeping of thorough and accurate records is just one important example. The record and corresponding signature must be legible. Progress notes should appear daily and be entered immediately after seeing and discussing the patient on rounds or with the attending staff. These notes should depict the hospital course of the patient, the results and interpretation of laboratory data, alterations in diagnosis and treatment, etc. Only matters directly related to the patient should appear in the permanent record. The chart is not a place for a running argument; besides being libelous, they are uniformly unprofessional.

2. Sick patients and the precarious situations dictate further need for frequent and complete notes. The PL-1 should check each chart before leaving for the day to see if new notes by the attending physician or consultants have been entered.

ORDERS

1. Extreme care should be taken to insure that all orders are written legibly or entered into the computer correctly. Orders are to be dated, timed and signed and the chart tagged indicating to the nurses that an order has been written. PL-1s should review written orders with the nurse to insure that complete understanding of the orders will ensue.
2. Telephone or verbal orders are NOT acceptable unless an emergency arises. The PL-1 must sign orders as soon as possible.

DISCHARGE SUMMARIES

1. The PL-1 is responsible for the discharge summary on all his assigned patients. These are to be completed at the time of patient discharge and are to be concise and accurate. A copy of the discharge summary should be forwarded to all consultants involved in that patient's care, along with the PCP.

PATIENT DISCHARGE

1. The PL-1 is to be available to the parents of patients at all times. Prior to discharge, the PL-1 should review with the parents the patient's illness, diagnosis, treatment, medications and follow-up. A note is to appear in the chart recording this conversation. When possible, discharge orders should be written before 11:00 AM on the day of discharge.

PROCEDURES

1. The PL-1 should be the primary caretaker of the patient during his/her hospital stay. This includes all pertinent and necessary procedures. If the PL-1 is unskilled in a particular procedure, he should be taught and or supervised by someone competent in that procedure.
2. The person actually performing the procedure is responsible for the consent from parents, a procedure note, and any lab orders necessary for completion of the procedure.
3. Procedures must be recorded in the Procedure Logger of New Innovations® and the supervisor must be noted at that time. All procedures must have a supervisor to verify completion of the procedure in New Innovations®.

TEACHING RESPONSIBILITIES

1. Third year medical students are a part of the ward team. They will be involved with each admission and will follow a certain number of patients. It is the PL-1's responsibilities to involve the medical students in their admissions by leading by example in history-taking and physical exam skills, as well as supervising the medical students' history-taking and physical exams. When possible, the PL-1 should review the student's H & P with the student in a timely manner.
2. The PL-1 should also complete admission and daily orders with the student who shares their patients in an effort to teach the student about daily patient care.
3. If the PL-1 and medical student have a patient, the PL-1 should try to meet with the students in the morning and discuss the events of the night in an effort to help the student prepare a presentation for morning rounds. The PL-1 may then add any additional information not presented by the medical student. Also, the PL-1 should review the notes written by the students on patients that they have in common and provide any feedback to facilitate improvement.
4. On call nights, if a medical student is on call with the PL-1, the intern should involve the student in all admissions and patient care opportunities throughout the night.

PL-2 AND PL-3 RESIDENT RESPONSIBILITIES ON THE UMC WARDS

Each PL-3 will spend one month with special student and housestaff teaching responsibilities for the in-patient services at UMC, and will work in conjunction with and supervise junior residents. Each PL-2 will spend one month on the in-patient service at UMC working closely with the PL-3 and assuming the responsibilities outlined below.

CALL FREQUENCY

1. The PL-3 will take call at UMC, in rotation every 4th night, with the PL-2 ward resident, the PICU resident, and residents in the general call pool.

PATIENT CARE

1. The PL-3 is primarily responsible for carrying the admission beeper and discussing new admissions with attendings, the ward team and nursing staff. The PL-3 is also responsible for assessing and facilitating bed availability by discussing possible admissions and discharges with the nursing staff, attendings, and interns. These responsibilities may be shared with the PL-2 ward resident in a fair and mutually agreeable manner.
2. The PL-3 will assist the PL-2 in the evaluation and management of all patients admitted to the pediatric service or a pediatric subspecialty service. The PL-3 will also assist the PL-2 in supervising the PL-1 with the admission process. This assistance will be provided in a fair and mutually agreeable manner.
3. The PL-2 and PL-3 are responsible for reviewing the intern's and medical student's admission and progress notes and adding addendums when appropriate.
4. Patient's H&P's and orders are primarily the PL-1's responsibility. When the supervising resident must place orders, s/he must discuss these orders with the PL-1 involved with that particular patient. The PL-2 and PL-3 are responsible for reviewing all orders by the PL-1 or medical student. However, an attending physician must co-sign orders for chemotherapy and digitalis drugs.
5. In the event that an admission note is written by a resident rotating on a subspecialty service or a fellow on that subspecialty service, this note will suffice as the "intern/resident admit note" and the ward intern/resident need only write a brief note of acknowledgment indicating that s/he has reviewed that patient's history, physical exam, diagnosis and desired plans of the attending service.
6. Discharge summaries are the responsibility of the PL-1.

ROUNDS

1. Each morning, after receiving "sign-in" from the on-call resident, the PL-2 and PL-3 will review and if clinically necessary examine the new admissions of the previous night, then assemble the ward team for work rounds. The PL-2 and PL-3 resident will lead the discussion of each patient's hospital course and plans for the day and will supervise work rounds on 3-East and 3-West respectively.
2. Walk rounds are encouraged and patients with interesting physical exam findings should be examined by the ward team members during this time. It is recommended that work rounds begin early, that they be completed by the time of the scheduled morning conference (Morning Report or Radiology Conference).

NIGHT CALL

1. The PL-2/3 taking call during weekdays must be present to receive "sign out" of the ward's patients at 1700. He/she is then responsible for the welfare of all patients on pediatric service.
2. Immediately after "sign out", the resident on-call must communicate with the intern on call and discuss questions concerning the pediatric inpatients. Formal "tuck-in" rounds are not mandatory but do aid in trouble shooting potential problems.

WEEKENDS

1. The PL-2 and/or PL-3 are not expected to round on weekends if not on-call.
2. The post-call ward PL-2/PL-3 and the on-call PL-2/PL-3 will help the on-call PICU resident write notes on the PICU patients at UMC.
3. The post-call PL-2/PL-3 ward resident will sign out to the on-call PL-2/PL3 ward resident either before writing PICU notes. The on-call PL-2/PL-3 will then make informal rounds with the on-call intern and attendings.

CONSULTS

1. Unless the patient is followed by our general pediatrics department (3-OPC or UPH-Kino), all consults on ward patients and patients in the emergency department must first go through the pediatric primary care physician. Following this he/she may contact the resident should they feel it necessary that the resident follow this patient. For consults from the UMC ED please see the attached consultation response plan.
2. When the pediatric team is formally consulted by another service, the initial consult (history, physical, chart note) is completed by the ward resident and discussed with the general pediatric attending. Thereafter, the resident follows that patient daily. Orders and daily progress notes are the responsibility of the primary attending service.

PL-2 and PL-3 RESIDENT RESPONSIBILITIES on the UMC WARDS

July 2006

Page 3

3. During the hours of 0800 to 1700 on weekdays, "Pediatric Consults" originating in the emergency room at UMC shall be handled by the PL-3 resident unless the resident has a prior teaching commitment or continuity clinic, in which case the ward PL-2 will be back-up. If the ward PL-2 is tied up, the clinic PL-3 will be responsible for consults. The pediatric residents may call the Chief Resident at any time with clinical questions.
4. After 1700 during weekdays and during all hours on weekends/holidays, the on-call resident will handle pediatric consults originating from the emergency room. S/he must respond to calls within 5 minutes and see the patient in question when appropriate within 30 minutes.
5. Orders are the responsibility of the primary attending service unless pediatrics is given permission by said service to write orders or in the event of an emergency. Progress notes on all consults should be concise and address potential problems.

CONFERENCES

1. The PL-2/3 resident at UMC must attend "Morning Report" at 0830 on Mondays, Thursdays, Fridays. During the conference, he/she will present interesting admissions for discussion with other residents and faculty. The residents should bring pertinent radiographs and slides to this conference.
2. The PL-3 resident at UMC will arrange attending rounds Tuesday and Thursday from 11:00 am to 12:00 noon.
3. The PL-2 and PL-3 residents at UMC will cover the responsibilities of each UMC ward PL-1 during all "Well Baby and Emergency Series" Conferences so that interns will be able to attend.

TEACHING

1. The PL-3 will be responsible for observing one complete admission history and physical with each student at UMC.
2. It is the responsibility of the PL-3, in conjunction with the Chief Resident, to orient medical students to the service. This includes:
 - a. Orient to location of wards, charts, computers, call-rooms, etc.
 - b. Review important data for History and Physical of pediatric patient
 - c. Review SOAP note format.
 - d. Review presentations for work-rounds.
 - d. Define expectations of the student for day-to-day responsibilities and goals for the rotation.

PL-2 and PL-3 RESIDENT RESPONSIBILITIES on the UMC WARDS

July 2006

Page 4

3. The PL-3 in conjunction with the team of residents will need to provide the chief resident mid-way evaluations of medical students and coordinate final evaluation with team and chief resident.
4. The PL-3 will spend a minimum of two hours per week with the interns and medical students for demonstration of interesting physical findings and discussion of interesting cases. This teaching time should be as interactive as possible.
5. The PL-3 should be particularly aware of children admitted to services other than a pediatric service, as they may often afford very interesting teaching opportunities for the students and residents.
6. The PL-3 will research and supply current references to the ward team on selected cases. If time permits they should review and critique the articles with the team.

CONTINUITY CLINIC COVERAGE

1. The PL-3 will provide coverage for the PL-2 ward resident when they have Continuity Clinic and vice versa.

TMC WARD FLOAT AND WEEKEND COVERAGE POLICIES

WARD FLOAT

Shift hours: 6 PM- 7 AM Monday thru Thursday, 6 PM-8 AM on Friday, and 8 PM to 8 AM on Saturday, and 10 PM to 7 AM on Sunday. The TMC ward float will have one day off per week, and a golden weekend.

- **Responsibilities:** to take admissions on the pediatric floor with the intern. To assist with education and procedures.
- If the PICU is exceptionally busy, and the workload on the floor allows, the float should assist in the PICU. Conversely, if the PICU is slow, and the floor is busy, the senior on call should assist on the floor.
- The float will hold the ward sheets, and be responsible for “tuck in rounds” with the intern.
- If there are more than 36 patients on the floor, the float alone will do all subsequent admissions.
- Continuity clinic will be on Friday morning from 8:30-10:30, and no **new** patients will be scheduled.
- **Three ‘preplanned’ absences (covered by banked call swaps) should be the maximum allowed per Mole rotation.**

WEEKEND COVERAGE

- A. The daytime weekend shifts (0800-2000) will be covered by the following seniors [each will do 1 Saturday and 1 Sunday]:
1. The PL-2 on clinic
 2. The PL-2 on elective
 3. The PL-3 at Kino
 4. One PL-3 on elective

PL-3 RESIDENT RESPONSIBILITIES ON TMC WARDS

Each PL-3 will spend one month with special student and housestaff teaching responsibilities for the in-patient services at TMC, and will work in conjunction with and supervise interns.

CALL FREQUENCY

1. The PL-3 will take call at TMC, in rotation every 4th night, with the PL-2 PICU resident, the subspecialty resident and residents in the general call pool.

PATIENT CARE

1. The PL-3 is primarily responsible for carrying the admission beeper and discussing new admissions with attendings, the ward team and nursing staff. The PL-3 is also responsible for assessing and facilitating bed availability by discussing possible admissions and discharges with the nursing staff, attendings, and interns.
2. The PL-3 will assist the PL-1's in the evaluation and management of all patients admitted to the pediatric service or a pediatric subspecialty service.
3. The PL-3 is responsible for reviewing the intern's and medical student's admission and progress notes and adding addendums when appropriate.
4. Writing patient's H&P's and orders are primarily the PL-1's responsibility. When the supervising resident must write orders, s/he must discuss these orders with the PL-1 involved with that particular patient. The PL-3 is responsible for reviewing all orders written by the PL-1 or medical student. However, an attending physician must co-sign orders for chemotherapy and digitalis drugs.
5. In the event that an admission note is written by a resident rotating on a subspecialty service or a fellow on that subspecialty service, this note will suffice as the "intern/resident admit note" and the ward intern/resident need only write a brief note of acknowledgment indicating that s/he has reviewed that patient's history, physical exam, diagnosis and desired plans of the attending service.
6. Discharge summaries are the responsibility of the PL-1.

TMC SPECIAL CARE/Chronically ill & Complex Patients

1. It is the responsibility of the PL-3 to follow all patients on the pediatric service in Special Care. Daily notes on the Special Care patients will be written by the PL-1's and should be reviewed by the PL-3. It is also the responsibility of the PL-3 at TMC to follow all other (i.e. surgery) special care patients as consults and write notes 2-3 times per week.

PL-3 RESIDENT RESPONSIBILITIES on TMC WARDS

June 2007

Page 2

ROUNDS

1. Each morning, after receiving "sign-in" from the on-call resident, the PL-3 will review and if clinically necessary examine the new admissions of the previous night, then assemble the ward team for work rounds. The PL-3 resident will lead the discussion of each patient's hospital course and plans for the day and will supervise work rounds.
2. Walk rounds are encouraged and patients with interesting physical exam findings should be examined by the ward team members during this time. It is recommended that work rounds begin early, that they be completed by the time of the scheduled morning conference (Morning Report).

NIGHT CALL

1. The PL-2/PL-3 taking call during weekdays must be present to receive "sign out" of the ward's patients at 1700. He/she is then responsible for the welfare of all patients on pediatric service and for all patients in the PICU, but will share responsibility once the "float" resident is present.
2. Immediately after "sign out", the resident on-call must communicate with the intern on call and discuss questions concerning the pediatric inpatients. Formal "tuck-in" rounds are not mandatory but do aid in trouble shooting potential problems. The ward resident on call provides primary or consultative support care for all patients in the PICU when a second resident is not on call in the PICU.

WEEKENDS

1. The PL-3 is not expected to round on weekends if not on-call.
2. The post-call ward PL-2/PL-3 and the on-call PL-2/PL-3 resident write notes on the PICU patients TMC.
3. The post-call PL-2/PL-3 ward resident will sign out to the on-call PL-2/PL3 ward resident either before or after writing PICU notes depending on their preference. The on-call PL-2/PL-3 will then make informal rounds with the on-call intern and attendings.

CONTINUITY CLINIC COVERAGE

1. The PL-3 will provide coverage for the PL-2 PICU resident when they have Continuity Clinic and vice versa.

PL-3 RESIDENT RESPONSIBILITIES on TMC WARDS

June 2007

Page 3

CONSULTS

1. At TMC all consults on ward patients must first go through the pediatric primary care physician. Following this he/she may contact the resident should they feel it necessary that the resident follow this patient.
2. When the pediatric team is formally consulted by another service, the initial consult (history, physical, chart note) is completed by the ward resident and discussed with the general pediatric attending. Thereafter, the resident follows that patient daily. Orders and daily progress notes are the responsibility of the primary attending service.
3. Orders are the responsibility of the primary attending service unless pediatrics is given permission by said service to write orders or in the event of an emergency. Progress notes on all consults should be concise and address potential problems.

CONFERENCES

1. At TMC the PL-3 will attend "Morning Report" at 0800 on Mondays, Thursdays and Fridays.
2. The PL-3 resident at TMC will arrange attending rounds, Tuesday and Thursday 11:00 am – 12:00 noon, or whatever 2 days works best for the team.

TEACHING

1. The PL-3 will be responsible for observing one complete admission history and physical with each student at TMC.
2. It is the responsibility of the PL-3, in conjunction with the Chief Resident, to orient medical students to the in-patient service. This includes:
 - a. Orient to location of wards, charts, computers, call-rooms, etc.
 - b. Review important data for History and Physical of pediatric patient
 - c. Review SOAP note format.
 - d. Review presentations for work-rounds.
 - e. Define expectations of the student for day-to-day responsibilities and goals for the rotation.
3. The PL-3 in conjunction with the team of residents will need to provide the chief resident mid-way evaluations of medical students and coordinate final evaluation with team and chief resident.
4. The PL-3 will spend a minimum of two hours per week with the interns and medical students for demonstration of interesting physical findings and discussion of interesting cases. This teaching time should be as interactive as possible.
5. The PL-3 should be particularly aware of children admitted to services other than a pediatric service, as they may often afford very interesting teaching opportunities for the students and residents.

6. The PL-3 will research and supply current references to the ward team on selected cases. If time permits they should review and critique the articles with the team.