



**DEPARTMENT OF PEDIATRICS  
POLICY AND PROCEDURE MANUAL  
July 2009**

THE UNIVERSITY OF  
**ARIZONA**<sup>®</sup>  
COLLEGE OF MEDICINE

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**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.

## Educational Goals

July 2009

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### 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

1. **PHOTOLIBRARY SERVICES** - Photolibrary services are only for journals that cannot be checked out of the library or found online; 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** – Email **MUST** be checked on a regular basis, i.e. not less than once per day.
4. **EQUIPMENT** – The Housestaff Office (Room 3335) has a computer, printer, copier and fax machine available for resident use during regular office hours. There is a large copier/scanner for large copy jobs in the near the service elevators on the third floor; each resident has an individual code for use with this copier. Please see the housestaff office for your code.

### **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 or NNP.
5. Interns on the pediatric wards are supervised by senior residents who are supervised by 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 of the Graduate Medical Education Policy and Procedure Manual.

Department of Pediatrics  
Arizona Health Sciences Center  
July 2005

## 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 UA GME resident promotion policy.

## DUTY HOURS

**SOURCE:** Department of Pediatrics

**Effective Date:** July 1, 2009

**APPROVAL:**

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

**Date:** July 1, 2009

**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 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.

Department of Pediatrics  
Arizona Health Sciences Center  
July 2009

## **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.

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 discuss all patients with the supervising ambulatory attending.
- 3) Residents with greater than 18 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 may work independently depending on the type of patient and at the discretion of the attending.
- 4) 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.

## 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 night float resident 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/change (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 for Pediatric residents and 18 for combined EM/Pediatric resident during each year of residency.

## **CODES AND STAT CALLS**

### **FOR CODE CALLS**

1. When CODE BLUE 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.
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 BLUE", and giving the location.

**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 any other 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. Each resident will give talks as follows:

PL2 and Combined PGY 3	PL-3	Combined PGY 4	Combined PGY 5
Problem Patient Talk	Problem Patient Talk AND CPC or Topic Talk (Half will do a CPC and half a Special Topic as chosen by the resident and approved by the Program Director)	CPC or Topic Talk	Problem Patient Talk

2. UMC Pediatric Emergency Conference is held the 2<sup>nd</sup> Tuesday of each block. 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.
3. Journal Clubs:
  - a. The resident journal club is held once per block during teaching day. It is led by the PL-3 on the Kino outpatient clinic rotation. Dr. Tom Ball or the program director assists and supervises.

## **DISCHARGE SUMMARIES**

### General

1. Dictation summaries should be done on the day of discharge from the hospital and at the very latest within 5 days 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.

## ELECTIVES

(a) Excluding the adolescent medicine, developmental/behavioral, and intensive care experiences (both NICU and PICU), residents must commit to at least seven months in subspecialty rotations, four of which must be taken at the primary teaching site and/or integrated hospitals.

(b) Within these seven months, each resident must complete a minimum of four different one-month block rotations taken from the following list of pediatric subspecialties or closely allied specialties:

*Allergy/Immunology*  
*Cardiology*  
*Endocrinology*  
*Genetics*  
*Gastroenterology*  
*Pediatrics 28*  
*Hematology/Oncology*  
*Infectious Diseases*  
*Nephrology*  
*Neurology*  
*Pulmonary*  
*Rheumatology*

(c) For the four required block months in different subspecialties from the above list, the inpatient/outpatient mix should reflect the standard of practice for the subspecialty.

(d) The additional three months may consist of single subspecialties or combinations of specialties from either the list above or the list below. Combinations of subspecialties may be structured as block or longitudinal experiences and, where appropriate, may be combinations of inpatient and outpatient experiences or all outpatient.

Pediatric Anesthesiology  
Child Psychiatry  
Pediatric Dermatology  
Pediatric Ophthalmology  
Pediatric Orthopaedics and Sports Medicine  
Pediatric Otolaryngology  
Pediatric Radiology  
Pediatric Surgery  
Pediatric Physical Medicine and Rehabilitation

(e) During the three years of training, no more than three block months, or its equivalent, may be spent by a resident in any one of these subspecialties. Subspecialty research electives that involve no clinical activities need not be counted as one of these three block months.

(f) Elective Experiences

Electives should be designed to enrich the educational experience of residents in conformity with their needs, interests, and/or future professional plans. Electives must be well-constructed, purposeful, and effective learning experiences, with written goals and objectives. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor.

1. Electives offered by this program include:

<b>ALLERGY/IMMUNOLOGY*</b>	Anesthesiology
<b>CARDIOLOGY*</b>	Clinical Pharmacology
Clinical Toxicology	<b>ENDOCRINOLOGY*</b>
Educational Strategies	<b>GASTROENTEROLOGY/NUTRITION*</b>
<b>GENETICS/DYSMORPHOLOGY*</b>	<b>HEMATOLOGY/ONCOLOGY*</b>
<b>INFECTIOUS DISEASES*</b>	International Health
<b>NEPHROLOGY*</b>	<b>NEUROLOGY* ▪</b>
Orthopedics/Sports Medicine	Procedures
<b>PULMONARY*</b>	Research
Rural Health/Indian Health Services	

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 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, Endocrinology, 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 must have electives set up for July – December and the information reported to the Housestaff Office by May 1. Electives for January – June must 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 or (2) other unique circumstances as approved by the Program Director.
  - b. All away electives must be approved in writing by the Pediatric Residency Director at least four months prior to the expected date of departure.
  - c. A houseofficer may take an away elective only during a Call Free 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 "AWAY" ELECTIVE

1. An away elective is available only during a call free elective month. Generally, away electives will be approved if the elective sought is either (1) not available or not acceptable in our program or (2) other unique circumstances as approved by the Program Director.
2. The procedure is as follows:
  - a. A Resident requesting an away elective will present the request to the Pediatric Program Director for review and approval.

A houseofficer may take an away elective only during a Call Free month.
  - b. The Pediatric Housestaff Office **must** receive adequate prior notification (minimum four months for electives in the United States) 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; therefore, six months' notice is required for international electives.
  - 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. **THIS FUNDING MAY ONLY BE USED ONCE DURING THE THREE-YEAR RESIDENCY.**
  - c. The American Academy of Pediatrics Resident Section awards annual scholarships for resident international travel. Applications are encouraged.

## EMERGENCY MEDICINE ROTATION

Pediatric residents are assigned to Emergency Medicine for two weeks in the PL1 year, one month in the PL2 and one month in the PL3 year. The rotation(s) must take place at the University of Arizona. 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).

**Resident schedules will be released approximately one month prior to the rotation. Therefore, residents must contact Dr. Dale Woolridge ([dale@aemrc.arizona.edu](mailto:dale@aemrc.arizona.edu)) 5-6 weeks prior to the start of rotation for scheduling issues and 3-4 weeks prior for orientation .**

### I. CLINICAL COMPONENT

1. Residents will work 18 9-hour shifts throughout the month block. All shifts will be in the North POD of the ED that houses the pediatric emergency department. 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. For purpose of patient safety, 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 medicine 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](http://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 ten (10) 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 biannual 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, nursery 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 and/or nursery block.* Resident must find their own coverage during clinic and/or nursery rotations. The chief residents MUST be notified of any floating holidays.
3. PL2s and PL3s may take their floating holidays during elective or clinic 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 block.* Resident must find their own coverage during clinic rotations. The chief residents MUST be notified of any floating holidays.
4. Floating holidays *may not* be taken on a continuity clinic day or teaching 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.
6. 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.
7. 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.
8. 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.

### 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.**

Department of Pediatrics  
Arizona Health Sciences Center  
May 2007

### 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

## Night Float Policy

### **PL3 Rotations:**

- 1) UMC-W Senior: Senior will take only two overnight calls during the segment. They will also have two weeks where they work Monday-Sunday days and will have two Golden Weekends.
- 2) TMC-W Senior: They will work days Monday-Friday on the wards. In addition, they will have two overnight calls and one weekend days on the wards.
- 4) Vacation/Night Float: This rotation will have 10 shifts over a 2-week period.

### **PL2 Rotations:**

- 1) UMC-W Senior: Senior will take only two overnight calls during the segment. They will also have two weeks where they work Monday-Sunday days and will have two Golden Weekends.
- 2) Behavior/Development: Will now have q4 call in the TMC-PICU.

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

**UMC Wards**

1. Senior residents will follow a maximum of two ED or PICU patients who are admitted on floor status (including patients admitted to subspecialist attendings). Pediatric residents **will not** take care of off-pediatric ward patients.
  - a. Residents are expected to do a full H&P and write orders in SCM
  - b. Residents must alert both the ED nurse and resident about the orders
  - c. Residents must leave their pager # in the ED so they can be called with management questions.
2. Floor status patients in the PICU will be covered by the pediatric or ED resident in the PICU.
3. Patients transferred to floor status who remain in the PICU will be covered by the PICU resident until the patient is moved to the floor.

**TMC Wards**

4. Senior residents will follow a maximum of two ED or PICU patients who are admitted on floor status (including patients admitted to subspecialist attendings). Pediatric residents **will not** take care of off-pediatric ward patients.
  - a. Residents are expected to do a full H&P and write orders in SCM
  - b. Residents must alert both the ED nurse and resident about the orders
  - c. Residents must leave their pager # in the ED so they can be called with management questions.

## **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 team maximum of 16 PICU patients.
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.

#### **PICU Mole (PL3)**

1. The 3rd year PICU Mole is responsible for the care of all pediatric patients in the PICU during their appointed shift.
2. The Continuity Clinic for the PL3 PICU Mole can be cancelled or moved to Wednesday morning.
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 dictated or 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 dictated or 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. 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 for senior residents. The jeopardy resident is on 24-hour call. The mommy call PL-1 may be jeopardized for fellow PL-1.
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 equivalent call shift.
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 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 12 weeks derived from vacation time. An additional 12 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.

Department of Pediatrics  
Arizona Health Sciences Center  
July 2006

## **UMC AND UPH-KINO MOMMY 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 responsible for mommy call. Mommy call for seniors will be paired with jeopardy whenever possible.

### PROCEDURE CERTIFICATION

1. Each resident is required to document procedures performed on each rotation. These may be logged in New Innovations or at the ACGME website.
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 at the discretion of the Program Director.

### PROCEDURE NOTES: PROTOCOL FOR HOUSESTAFF

1. All procedures performed by housestaff need to be documented on a 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 Program Director. 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 senior resident will supervise pediatric and nonpediatric housestaff and students assigned to the TMC Wards.
2. MONDAY, THURSDAY, FRIDAY:
  - a. Morning Report is at 8:00 am. It is expected that the Chief Resident 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.
  - b. Student rounds with the teaching attending will be held at a 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).
  - c. 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 held from 11:00 am to 12:00 noon.

**Department of Pediatrics**

Arizona Health Sciences Center

July 2009

**PL-2 COVERAGE ROTATION AND PL-3 ELECTIVE/COVERAGE 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.

**Call Schedule:** The PL2 will have q4 in-house call in the TMC PICU. The PL3 will have the usual number of nighttime and jeopardy calls.

**Education:** during this rotation, when cross-cover assistance is not needed, the PL2 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. The PL3 will attend an elective when cross-coverage is not needed.

**Rotation:** The coverage rotation will be for four weeks during the second year. The elective/coverage rotation will be for four weeks during the third year.

### **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. 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.
6. 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 rounds will be made on all patients by the houseofficers. During or after work rounds, a progress note on each patient should be entered in the chart.
2. 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.

## 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. 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 most admissions and should follow a minimum of 2 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.

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

### 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-2 and PL-3 are responsible for reviewing the intern's and medical student's admission and progress notes and adding addendums when appropriate.
3. 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.
4. 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.
5. Discharge summaries are the responsibility of the PL-1.

### ROUNDS

1. Each morning, after receiving "sign-in" from the night float 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 both 3 East and 3 West.

### NIGHT FLOAT

1. The PL-2/3 taking call during weekdays must be present to receive "sign out" of the ward's patients at 1800. 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 and aid in troubleshooting potential problems.

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

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### 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.
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.

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

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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.
  - 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.

### 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, 8 PM to 8 AM on Saturday, and 8 PM to 7 AM on Sunday. The TMC ward float will have one day off per week, and two golden weekends.

- **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.
- Continuity clinic may be cancelled or scheduled on Friday morning from 8:30-10:30. 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**

#### **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.
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.
7. Discharge summaries are the responsibility of the PL-1.

#### **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.
1. Walk rounds are encouraged and patients with interesting physical exam findings should be examined by the ward team members during this time.

## PL-3 RESIDENT RESPONSIBILITIES on TMC WARDS

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### CONSULTS

At TMC all consults on ward patients must first go through the attending of record.

1. 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 pediatric attending. Thereafter, the resident follows that patient daily (if approved). Orders and daily progress notes are the responsibility of the primary attending service.
2. 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

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.

### TEACHING

The PL-3 will be responsible for observing one complete admission history and physical with each student at TMC.

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.