

Medical Student Orientation to the Pediatric Ward at Emanuel Children's Hospital

WELCOME!

Welcome to Emanuel! We hope you have a fun and educational experience during your rotation. This manual is a reference for your roles and responsibilities specific to your rotation here. Please see the OHSU handout for additional information on grading, feedback, attendance, professionalism, CLIPP cases, and exams.

WHO CAN HELP?

Dr. John Paisley, Medical Director of Legacy Pediatric Wards; ID/Peds attending.

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Dr. Ann Loeffler, Emanuel Site Medical Director; ID/Peds attending. Manages resident call schedule. Pager 503-938-0960; aloeffle@lhs.org

Dr. Lauren Rose, Pediatric Hospitalist; Co-Director Graduate Medical Education;

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Dr. Ellen Stevenson, Pediatric Hospitalist; Co-Director Graduate Medical Education;

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Angela Cacchioli Graduate Medical Education Coordinator 3-4656; Can help with badges, computer access, parking, PACS access, meal cards, call room issues, scrubs, etc.

Dr. Tracy Bumsted, Medical Student Course Director (503) 494-5982; or page through OHSU operator

Trevor Monteith, Student Coordinator. Office 494-3195, CDRC Rm 2114D, pedstud@ohsu.edu

CALL ROOM

The call room for the senior resident and the intensivist are outside the PICU. The intern and student call rooms are on the fourth floor.

FOOD

Lunches are provided each weekday. Please call Debbie Balchin at x34385 if you do not plan to partake in the cuisine for the month. Also tell her if you have special dietary needs (vegetarian) although there is no guarantee that all needs can be provided here.

Residents and students are given meal tickets for on-call meals. These can be used at the hospital cafeteria which is open M-F 6am-7pm and Saturday during the day, or the Heartbeat Café located in the atrium open 24h/day (this is your only food option in the evenings and on Sundays).

DRESS CODE

Professional Dress. White coats encouraged for students. No open-toe shoes or short skirts. Nametag. No scrubs unless you are on-call of post-call. You will also receive a blue or green lanyard to wear to match your team color.

PERSONAL BELONGINGS

Call rooms are not secure; too many people can access them. Never leave valuables, checkbooks or credit cards in an unlocked place. There are combination lockers on the fourth floor if you would like to use one. Call Angela Cacchioli 3-4656 in the GME office for the combinations. Please do not leave food, etc. in the common charting areas on the ward. There are cabinets for coffee cups, etc. that someone can show you.

BOOKS & RESOURCES

There are several basic texts on the floor next to the charge nurse desk and above the computer in the call room. The Legacy intranet homepage has a links to the library page under "clinical resources." This page then has links to key references (micromedex, Peds in Review, Redbook, teaching sheets etc) as well as a number of journals and OVID search engine. In addition, there are formularies and Harriet Lanes attached to all the nursing carts in the hallways.

MEDICAL STUDENT ROLE / EXPECTATIONS

We expect you to follow 2-4 patients at one time. Discuss with the senior resident which patients you should follow. Ideally, over the course of the rotation, you will have a mix of simple acute patients and more complicated chronic patients. You should get to know your patients and their families well and be invested in their care. When admitting a patient, you should write up a complete history and physical on separate progress note paper (not the resident/hospitalist template). Assessment should include a differential diagnosis with the most likely diagnosis first. Plan should be by problems or systems. When doing admits, don't forget to plot all kids on a growth chart. When you are on call, you do not need to write H & Ps on every patient the team admits but you should try and do them on all of the patients that you will follow. When picking up a patient who you have not admitted, read the history and physical and any progress notes done prior to the day you are seeing them. Look at all orders written in the last 24 hours on your pts as this may help you in your daily assessment and management. See and examine the patients you are following everyday, gathering pertinent information such as vitals, ins and outs, medications (including 24 hour summary of number and types of respiratory treatments), and laboratory and imaging results if known. Present your patients in rounds according to the presentation guidelines found later in this manual. We expect that you will read about your patients' medical problems and will contribute to the discussion about your patients on rounds.

You may accompany patients for procedures, participate when a consultant meets with your patient, join patients for physical therapy, etc. You should take ownership and be the one to follow-up on labs and xrays, call pharmacy when needed, set up follow-up appointments, etc. Coordinate with your team when requesting results and making appointments to avoid multiple phone calls to the same person. You should NOT give major results or inform patients of new diagnoses on your own. You should not order medications, labs, or procedures or call consultants without discussing plans with the team. Ask for clarification if you're not sure that something is appropriate for you to do or tell a family that you will return with one of the supervising doctors if you are unsure if you should be answering their questions.

When you are done using a chart, please place it back in the chart storage outside the patient's room. Once orders are co-signed, turn the order flag to red for it to be taken off by the nurses. Never put a chart with an un-cosigned order flagged back in the storage bin since these orders may inadvertently be carried out without an MD signature/approval, even if it wasn't flagged. The interns, senior resident, NP, or attending should double check all orders. Sign your name legibly or print your name under your signature with "MS3" after your name. When ordering medication for a child, write patient's weight on the order sheet. Always write the medication dose followed by "mg/kg" so everyone can double-check your dose. [ex. Johnny 10 kg: Vancomycin 100 mg IV q 6 hour (10 mg/kg/dose)]. Don't take the hard chart off the unit. (see admissions and discharges below for additional details)

TEAM STRUCTURE

There are two teams, a Blue team and a Green Team. Each team has a hospitalist who supervises the care of pediatric patients admitted to the ward service. One team is lead by a senior resident (R2) from OHSU; the other team has a Pediatric Nurse Practitioner who functions as team facilitator. Each team has a pediatric intern from OHSU, and for most of the year, a family practice resident as well. Family practice interns from Southwest Washington Medical Center and second-year family practice residents from Providence Milwaukee rotate here. For 2 months a year, there will be a family practice intern from Samaritan Health Services in Corvallis as well. OHSU Students (4-5) are split between the 2 teams and are an integral part of the team. There may also be a DO student from Corvallis here for a 2-week block. There is often a 3rd attending as well, who is not on service, but helps with admissions, discharges, general ward work, and can help when the senior is post-call or in clinic.

The Blue team admits ward attending hospitalist patients Mon, Wed, and Fri. The Green team admits ward attending patients Tues, Thurs, and Sat. The Blue team attending takes phone calls about admits on Sun, but these admissions are divided between the two teams for Monday so that the Green team has the bulk of the ward patients (since the Blue team takes admission on Mon). On the days when the team is not admitting ward attending patients, they admit private and subspecialty patients.

ATTENDINGS

This hospital admits children from all over the region. Some private pediatricians have admitting privileges here and will manage their patients with the residents/students. If the patient's primary care provider does not want to or cannot attend, then the patient will go to the WARD service which is covered by the Emanuel staff hospitalists. The hospitalist or moonlighter is not the official attending for any of the children whose private attendings have accepted the patient to their service.

MOONLIGHTERS

When a PL2 is the senior resident, a moonlighting staff doctor is on from about 5:30 pm to 2:00 am and from 1 pm to 2 am on weekends/holidays for backup. In addition, a hospitalist is often in the senior resident role at night. They are here to help with admissions, staff the admissions to the ward team, help with procedures, answer questions, provide second opinions for all pts, etc.

SCHEDULE

CONFERENCES

- Noon Conference: (Monday-Friday 12:15-1:15, Rm 3317, 3rd floor Conference Room)
- Miller Rounds: (Monday 3-4 pm, Rm 3317, 3rd floor Conference Room) except on Memorial Day, Independence Day, and Labor Day. On those weeks, Miller Time will occur on Tuesday 3-4 pm.
- Radiology Rounds (Thursday 10:30-11:00, Rm 3317, 3rd floor Conference Room): with Dr. Paul Marten, pediatric radiologist. If he is not there, page him at 503-938-1035.
- Friday Case Conference (7:30am, MOB West Conf Room): The attendings (often Ellen Stevenson or Lauren Rose) are primarily responsible for choosing the cases which are presented as an unknown or interesting case for general discussion. The senior resident can help choose cases as well. Medical students and residents usually present the case. Coffee and pastries are served.
- Emanuel Pediatric Grand Rounds: (7:30am on the 3rd Tuesday of each month, Lorenzen Conf Center) Residents do not have to prepare for this. Be on time please. Coffee and good pastries are served.

EMANUEL HOLIDAYS

July 4th (Observed on the day that it falls)

Labor Day

Thanksgiving- Thursday and Friday

Christmas Day

New Year's Day

Memorial Day

DAILY SCHEDULE

7:00-7:30am: **Signout** from night team to the day time residents. The senior resident will determine if the entire team should be present during sign-out, or if the medical students and interns should start pre-rounding, and have separate senior-senior and intern-intern sign-out. If sign-out is separate, the senior will then notify medical students or interns of new patients or changes after sign-out. Please see your patients in the mornings by 9:30am. If you see a kid in the morning you think is ready to go, please initiate the discharge paper work and call your resident in order to expedite their discharge. **(Please see Discharge section)**

9:30-11:00am: **Walk Rounds**: Blue Team starts on Infant/Toddler side A, and Green Team starts on side B. Each patient is presented by a medical student or intern. If a medical student is following a patient, they should be the one to present. The presentations are typically more complete the first day that the patient is being presented and more focused on subsequent days. When the volume is high, the presentations will need to be very concise and very pertinent. The senior resident takes a leadership role during rounds with their team (directing which patient to start with, listening and commenting on presentations, suggesting management plans, and teaching when time allows). A hospitalist for each team supervises the presentations and management decisions, and teaches during this time. When time allows, the team rounds at the bedside. These rounds are multidisciplinary. Nurses are included during rounds and should be notified prior to their patient being discussed (a team member can call the RN when the patient before theirs is being discussed—an RN list is at each nursing station). Other key providers (respiratory therapy, social work, case managers) can also be included. Orders can be written during rounds.

11am-12:15: **Work/Subspecialty and Private Patient Rounds/Sign-out**: Work on discharge paperwork for your patients, put notes in charts, and do general ward work. Also, if the team has not yet rounded with private or subspecialty attendings, then this should be done during this time; or your senior will “run the list” with the team and decide who will call the various subspecialty and private attendings to round on their patients. Sign-out should occur before noon conference for anyone who needs to leave for the afternoon.

12:15-1:15: **Noon conference/Lunch.**

1:15 -5:30pm: **Work**: Take care of cross-cover work on your patients from the morning (follow-up on studies, labs, call consults, etc), admit new patients, discharge patients. You may work on CLIPP cases during this time if it is quiet but please check with your team first to see if there are patients to see, labs or xrays to be checked, relevant

literature searches that you can do, or other work to be done first. Always check with your resident and/or ward attending and update them on your patients before leaving for the day.

5:30 Evening signout rounds: Unless you are on call, you will usually go home before sign out and the interns and residents will signout.

EVENING WALK ROUNDS: When you are on call, it is expected that the senior/hospitalist, intern and student will formally do walk rounds with the charge nurse at night, about 10pm or so to review issues with all the children. A lot of questions can be dealt with then, decreasing night phone calls to the intern. Unstable children can be assessed as well, and other calls made or a transfer to the PICU, if needed.

WEEKEND SCHEDULE

On the weekend, the residents on the night before divide the entire census up and see as many patients as possible prior to 9am. They start with sick patients and discharges. Post-call medical students will see a few patients in the morning between 7-9 am; these will be assigned by the senior resident or moonlighter on call with you. Eating disorder patients do not need notes on the weekend. The on-call team in the day can go by and check for changes or discharges on these patients. The weekend call team, including the on-call medical student, arrives at 9am for sign-out. The post-call team should come to the call room as close to this time as possible, briefly update the list, and sign out. The on-call residents will then go around and finish any notes not completed by the night team.

PHONES/PAGERS

Residents and attendings will carry portable phones. Medical students will not carry these phones but will be expected to wear OHSU pagers. Please make sure that your pager number is listed at the top of the teams lists. The portable phones work most of the time on the floor, but are not always reliable on other floors.

The blue team interns carry 3-1151 and 3-1152 and the blue team leader 3-3323. The green team interns carry 3-153 and 3-1154 and the green team leader carries 3-3324. The intern on call always carries the 3-1151 phone at night. Other interns should forward their phone to the 3-1151 phone at night.

The senior resident always carries the 3-1149 phone, and pager, 503-830-4501.

The general admitting phone for ward patients is 3-1150. An attending or senior resident will carry this phone.

Emanuel pagers are text capable at www.arch.com/message. Ask someone to show you the link from the physician intranet.

ELECTRONIC CHART (E-CHART)

We are moving to a paperless chart system slowly. Labs, vitals, many imaging and path reports, some consult notes, etc. are on this system. It has good and bad aspects. Call x55888 for help if the unit secretaries and nurses cannot answer a question.

ADMISSIONS

- Before going to admit a child, pull up from e-chart under Transcriptions any outpatient or ED note available. The ED physician's H and P provides a lot of information. Notes from our pediatrics clinic are in there as well. You can also review labs and x-rays. Also, look for papers sent with the child from another ED or clinic, etc.
- Try to coordinate with the nurses and see if they want to join you when you take the history. They ask a lot of the same questions we do and will usually just listen and fill in what they need. They also need to know some additional information so you might let them have a minute to ask this during the history. The nurses can then begin getting vitals on the child while you continue with your history.
- When you introduce yourself to the parents, let them know that you have spoken with their doctor, reviewed the records from ED's or clinics, etc to get acquainted with the child's problem, but that it's helpful to review the information first hand and make sure that all the details are complete. By explaining this first, they will be more understanding when you ask them to repeat things that they have already said over and over again.
- Provide the parents with the team structure and write the relevant names on their white board:
 - Attending-----Consulting Attending (if applicable)
 - I I
 - Senior Res/NP Resident
 - I I
 - Intern Med student
 - I
 - Med student
- You should write your Admission H+P on regular progress note paper. The standard H&P template should only be used by the intern/resident/hospitalist; it is very confusing if a medical student writes on it. You may also type an H & P. At the time of admission, please put the PCP's name and phone numbers on the chart, both on the H& P form and on the discharge paperwork.
- The goal is to begin evaluation and therapy as soon as possible. We would like to have the basic orders written on a patient within 40 minutes of their arrival. Try to anticipate what will be needed – e.g., bili lights for a baby admitted for jaundice, an IV for severe diarrhea, and MDI or neb for a known asthmatic. Acute hospitalization is a major event for most families and parents expect something to be done soon. The nurse may want to get an iv started, blood drawn, a fluid bolus going, etc. immediately so please let them get started and work around those immediate patient needs.
- NPO status: Think about whether a child needs to be NPO, ex: kid with abscess in arm, kid who aspirated foreign body, kid who needs a sedated MRI and include this in the orders.
- After the initial evaluation by the medical student and intern, the plans should be discussed with the senior resident/NP first and then the attending.

NOTES ON ORDERS

- Preprinted admit orders are available and should be routinely used.
- Make sure the child's weight is on the orders. Usually the nurses have this quickly and it is used to check dosages, etc.
- **Isolation:** Any proved or possible varicella, measles, or SARS cases, must be in the special negative pressure isolation rooms. There is only one true TB/SARS high neg pressure room on the floor on the adolescent side, and any case with possible active pulmonary TB or SARS must be wearing a mask and be admitted into that room immediately. If you are not sure, isolate them, call the on-call infection control coordinator or ID consult, then discuss the diagnosis. SARS masks, N-95, are available when needed as well as a vented hood for those with facial hair. Common isolations: **contact isolation** (gloves as entering the room, gowns if your clothes will touch ANYTHING in the patient's room) for RSV, croup, diarrheal illnesses, varicella, enterovirus in young

children, lice, scabies, primary herpes etc; **droplet isolation** (surgical mask as you enter the room) for influenza, mycoplasma, bacterial meningitis, pertussis, strep; **droplet and contact:** H1N1 influenza (swine flu variant), adenovirus pneumonia in young children, respiratory illness when you're not sure (ie: viral vs. mycoplasma vs. pertussis), meningitis when you're not sure (enterovirus vs. meningococcus) ***** Anytime you touch anything moist: patient's mouth, diaper, wound, blood, CSF etc – you should be wearing gloves. We have laminated isolation signs on the floor which list the organisms and indications on the back. Suspected swine flu cases, require droplet and contact isolation with the door closed to their room. N-95 or PAPR masks should be worn if suctioning, intubating, or otherwise getting close to their secretions. Family members with a cough should wear a mask when they leave the room.

- Monitors/BP checks are often used unnecessarily. Do not use continuous monitors unless really needed for small infants with true apnea risk or for children with rapidly changing O2 needs, etc. Spot checks with vital signs is generally fine, and most children do not need monitors hooked up while awake. Also think about how often each child really needs a BP, often q12 is fine.
- Medication orders: Include exact dosages by weight and total dose; frequency of administration; route of delivery, duration (if known), and specific "prn" criteria. Example: Tylenol 150mg po/pr q4h prn pain/fever (=15mg/kg/dose). Remember there are different strengths for meds, so when you talk to parents find out the correct one. Do NOT write meds in ml, write mg as the parents may have a different formulation than our pharmacy does. Do not put a "decimal point 0" or ".0" after a number because the decimal may not be seen; put mcg for micrograms or spell it out.
- Flag orders using the pull up red plastic tab on the chart door. Med students should NOT put orders back in the cubby without having them cosigned. Tell the nurse about orders that are ASAP or STAT. Non-flagged orders may not be noticed for hours.
- Please check to make sure a code sheet with a proper weight is in the chart.
- Abbreviations can be a problem. You WILL be called to correct these!! No cc, use ml; no U, use Units; etc. a list of these is at each bedside chart.

PICU TRANSFERS

When a patient is deemed to need a higher level of care in the PICU, the child's attending should be notified immediately. The attending or resident should then notify the intensivist or charge nurse about the requested transfer, and a brief summary should be written in the chart about the patient and the reason for transfer. The resident should stay with the patient until they are physically moved to the ICU.

If you are going to picking up a patient who is coming out of the PICU, you can go into the PICU and start reviewing the chart and typing your accept note before the patient is officially on the floor.

DISCHARGES

Discharge planning should be made as early as possible to allow the nursing staff to plan admissions. Discharge paperwork can be started DURING the admission if it is a patient that you expect can go home the same or next day. The nurses must know who is definitely going home by about noon, which is the latest time they can cancel requests for evening nurses. Orders for medication and follow-up appointments should be written for the definite discharges before rounds if possible and immediately after rounds before noon conference otherwise. Ward attendings should be notified as soon as possible about potential discharges. Then they might be able to see and discharge them before rounds. Do not wait until rounds to plan for discharges.

Discharged patients should have follow-up with a clinic physician or a health care provider. When a specific follow-up appointment is made, the time and date should be written on the discharge summary and patient instructions sheet. This will alert the provider if the patient does not keep the appointment.

For common diagnoses (eg. bronchiolitis, croup, etc), teaching sheets from the American Academy of Pediatrics (AAP) can be found on the Legacy intranet by going to "Clinical Resources" and then "Library and Knowledge Base". The teaching sheets are currently located on the bottom right of the page. It is very helpful to print these for patients going home so that they can review them and ask any questions before discharge.

All important information should be communicated on the discharge summary (eg, weight, lab values that need to be checked or that were abnormal, medications and dosage, etc.). Hospital policy is to document in the chart that you personally contacted the PCP who will assume responsibility for the child. For ward patients, the resident or attending will contact the PCP.

Children from our well child clinic (located across the street) or one of the county clinics, are at special risk of not returning. A PCP should be personally notified about the return visit plans; this may be done by phone call or fax from the ward. Please ask the unit secretary to fax the discharge summary to the referring doctor. The fax number can be found in the "Clinics" Book, by asking the family for their doctors "card" or phone number and calling the office, or by an on-line search. Also fax any labs or consults that are pertinent to patient management.

Please write very legibly on all discharge papers. The patient's ongoing care depends on their pediatrician being able to read your writing.

DISCHARGE SUMMARIES

Notes on completing the discharge paperwork and forms:

- The reason for admit is the chief complaint- eg. vomiting
- The final diagnosis is the reason the child was vomiting – the unifying diagnosis for the initial admission (examples: rotavirus gastroenteritis or viral meningitis). There can be no abbreviations on this line, you can never write "SAME" and there is no point in filling it out until the day of discharge.
- Other diagnoses might include underlying diagnoses or other things that made things more complicated (e.g. dehydration, metabolic acidosis, hypoglycemia).
- Procedures performed include IV fluids, IV antibiotics, consults, imaging studies, surgeries, etc. Be as thorough as possible – but neat.
- Hospital course – one line (or one paragraph if typed) about course leading up to admit – then info about the admission.
- Discharge information - be thorough – appts, meds, pending labs, etc.
- If you are generating a typed summary that will be ready THE DAY of discharge, you don't need to do the written summary – but you might like to as a work sheet.

All children in the hospital longer than 48 hours or who have unusual or complicated problems, including any patient admitted to the PICU, should have a formal discharge summary dictated or typed in E-Chart on the day of discharge. Medical students can **not** put a typed summary directly into E-chart. Use the instructions below, save the typed information as a Word document (do not paste it into an e-mail – must be sent as an attachment or it loses all its formatting). Instructions are also found in the black binders on each unit entitled "CLINICS."

To type a dc summary go into E-chart, select "LHS Clinics," then "DC Note," then type /dcpeds and hit F11 to type in a preset DC form. Hit OK then SAVE when finished. Same-day summaries provide for the best memory and most impact on patient care. Please include fax numbers for PCP or any other doctor you want to CC on the summary.

E-Chart does not allow you to save a draft of a dc summary and return to it later. If you wish to start a summary before the patient is ready for discharge (recommended for complex patients), then copy the dc summary template and paste it into a word document. This can then be emailed to yourself since we are unable to save it on the desktops at the workstations. When finalized, it can be emailed to a resident or staff hospitalist for review and then pasted into a DC note in E-Chart. Medical students can help write discharge summaries this way, but they should always be reviewed and finalized with a resident or hospitalist who will be the responsible party for pasting it into E-Chart. Attending email addresses are copied on the back of the hospitalist FAX cover sheets and paper clip any papers you want sent (discharge summaries, CT results, consult notes, etc.)

ASTHMA ACTION PLAN

Every patient who is discharged with the diagnosis of asthma or reactive airways disease is now required to have an "Asthma Action Plan" documented in the record. Follow the above instructions for creating a "DC note." Then type /asthmaplan and hit F11. This will bring up the asthma action plan template. The required elements include a SCHEDULED followup appointment date, time, and name of the provider. If a specific appointment cannot be made with the patient's provider at the time of discharge (for whatever reason), there is a default plan for scheduling a specific slot with the Emanuel pulmonologist on the following Wed at 11am; call pulmonary to confirm 503-459-4540.

MEDICATIONS AND PRESCRIPTIONS

Medication Reconciliation is the system we use for admit (confirming home meds) and discharge prescriptions when they leave. Only residents and attendings can use this system. However, you should double check the MAR (medication list) for all patients that you are following and that they are on both the appropriate medication and dose. Rxpad is the system we use for prescriptions on Echart but can only be used by residents and attendings. You should practice writing prescriptions on a separate piece of paper.

LABORATORY

Most lab results are available in the computer. Other results can be obtained by calling the lab. In general, lab results are immediately available on E-Chart, so check there first. At Legacy, blood cultures are read automatically every 10 min; positive blood and CSF culture are called to the floor and the ordering physician immediately. It is not necessary to call the Legacy Lab for blood or CSF culture results. If you have not heard, they are negative. Most other labs are read by early afternoon so please do not call the micro lab until mid-afternoon because it slows down their work if they need to answer phone calls. If a culture was obtained at an outside laboratory, you will need to call to check on results. Phone numbers for these labs are found in the black "CLINIC" binder on each floor.

Some tests are sent out to Utah by plane Monday - Friday, and they leave our lab about noon. If it is a special test, try to make sure it gets done and sent to our lab by 11 am in case it has to be sent out. Send out results can be queried at x31324- customer service.

RADIOLOGY

Routine studies are kept in radiology and on the PACS system. There are PACS stations in the "fishbowl" (physician workroom) on Infant/Toddler side A, in the PICU, and at one of the computer workstations on Unit 35. We have many radiologists to review films and one pediatric radiologist—Paul Marten, pager 503-938-1035. They are located on the first floor of the hospital across the atrium from the Heart Beat Café.

You will need a sign on for the PACS system unless someone has already logged on. The PACS log-in user name is on your grey card w/ all of your codes given to you at orientation. Your initial password is "begin". You will have access to ALL Legacy hospitals on this. Be sure to select the correct "synapse" for where the study was obtained (Emanuel, Salmon Creek, Mt. Hood, etc.)

If the patient needs a copy of a film for their doctor, it can be made. Contact radiology. Outside films should be kept in the patient's "cubby" (where their blue medical record chart is stored) until they are discharged. Do not leave outside films lying around on the wards or in call rooms. They will disappear, and then the team will waste a lot of time trying to track them down the next morning.

If a patient is admitted to your team and has an outside print film or CD, you can bring it to radiology on the first floor and have them load it into our PACS system. A separate order is necessary to have the film officially read here. In addition, many hospitals have contracted with Legacy to be able to directly electronically transfer films to our PACS system and you can ask radiology if you need this done.

CODES

“Pediatric Codes” are automatically sent by the operators to several pagers at the same time. The team includes the senior, the charge nurse, the PICU doctor, the peds transport team, the “code” anesthesiologist, the RT supervisor, on-call chaplain, a peds PICU RN, an ED nurse and peds IV therapy. The call is set as an alpha pager and the message is put in “Peds code team to _____ location”. It is also called overhead to the code location. The page itself has the same tone as all pages. Remember that the senior resident pager (830-4501) and the intern pager (830-4505) are code pagers, so look at all pages immediately when these pagers goes off.

The hospital policy is that the anesthesiologist or Intensivist run the Peds codes when they arrive, but the most senior pediatric doctor present runs it until they get there. Any emergency involving a child should be called to the operators as a Peds code, since the medicine residents do not respond to this. You should check that all your patients have a code sheet with the appropriate weight in their chart.

There are also occasional mock codes at Emanuel. The team is expected to respond and perform as if it were a real code. If there are too many people present, whether it be a mock code or real code, you may be asked to leave as crowd control can be an issue.

PRESENTATIONS AND NOTES

Three types of presentations:

- New/Full admits (<5 minutes)
- PICU transfers (<5 minutes)
- Daily/Interim presentation (<3 minutes)

The times below are a guide for the ideal situation. When the patient volume is very high or your patient is very straightforward, you may be able to shorten your presentation to one or two minutes. It's good to be prepared to be succinct so that there is sufficient time for longer, more involved discussions of interesting or complicated patients. At the time of admission, there is often more time than during rounds for longer and more complete presentations. You can also present to your resident or attending outside of rounds for practice and teaching.

New/Full Presentation - <5 minutes

Chief Complaint: one-line statement in the patient's (or parent's) own words

History of Present Illness:

Identify pt age, sex, and if applicable any chronic disease/conditions already diagnosed that are important for listener to know with respect to present illness. If there is no previous medical history, can state "previously healthy."

- "3 yr old male with h/o asthma who presents with 1 d h/o SOB and wheezing" leads your reader to a different conclusion than
- "3 yr old male with h/o asthma who presents with 1 d h/o vomiting and diarrhea." In this scenario, the asthma is irrelevant and should simply be included in the PMH section. You, as the historian, know whether the chronic diseases/conditions are important to your presentation since you have heard the entire history, done the physical exam, and reviewed any previous labs/studies **prior to writing your note.**
- Duration of symptoms and qualifiers:
- "3 d h/o NBNB vomiting initially 1-2 x per day, increasing to q feed today and 2 d h/o watery diarrhea q 3-4 hours"
- "Pain" should have qualifiers: quality, quantity, location, alleviating/aggravating factors, timing, setting, and associated symptoms.

Any medications that were tried in the home and what effect they had.

The chronology of visits to PCP or ED and reason for admission and **summarize** the diagnosis given and any medications/labs/studies done for the pt while at these visits, up until the time at which they are sitting in front of you in the hospital room.

Example of an HPI:

"1 yr old male previously healthy with 2 d h/o NBNB vomiting q 2-3 hrs and 1 d h/o watery diarrhea q 15 minutes, decreased activity and only 1 wet diaper in last 24 hrs. Initially taking sips of PO apple juice and pedialyte, now refusing all PO. Whole family sick with V/D x 2 days. ROS negative for fever, rash, RN, cough or abd pain. Pt taken to PCP (Dr. Smith) yesterday, given phenergan PR and tolerated PO w/o emesis and sent home. To Emanuel ED tonight with lethargy, continuing V/D and refusal to take PO. In ED, given 20 ml/kg NS bolus x 2, lytes significant for CO2 of 15, CBC and UA unremarkable, rota pend, **admitted to DCH ward** for rehydration and presumed viral gastroenteritis."

ROS: Be sure to include pertinent positives and negatives. If applicable, you can state "ROS negative except as described in HPI."

Past Medical History (conditions should be in chronological order):

Birth History if pt is young, or if relevant to HPI.

Any chronic diseases, when diagnosed, ongoing treatments for these, names of specialists following pt.

List number and reasons for acute clinic/ED visits over recent past.

Past Surgical History
Name of PCP/Clinic
Immunization Status
Developmental History
Diet

Medications: Include names, dosages, timing

Allergies: Include drug name and what reaction occurred.

Social History: Include who lives in the home, what city they live in, daycare exposure, what grade the child is in if school-age, tobacco exposure (ask, “does anybody smoke?” rather than “does anybody smoke **in the home?**” since most parents think that if they smoke **outside**, their child isn’t getting exposed to smoke), pets, recent travel, social stressors.

Family History: Start by asking if there are any **children** in the family with diseases or conditions they see a doctor for regularly. Ask about childhood deaths in the family. Less important here is Grandmother’s heart disease and Grandfather’s diabetes, unless of course they developed these conditions when they were children.

Physical Exam:

Vital signs: Temp, HR, RR, BP, O2 sat. Weight, Height, OFC (if <2 yr) and %
General, HEENT, Neck, CV, Resp, Abd, GU, Ext, Neuro, Skin

Labs/Studies: List any labs/studies done prior to admission, even if result is pending (and where they were done.)

Assessment: One line summary statement of HPI, PE, labs and most likely diagnosis.

- “3 mon old male with tachypnea, poor feeding, murmur and cardiomegaly on CXR, most likely congenital heart disease.”

If diagnosis is in question, list differential diagnosis in order of most likely to least likely. The assessment allows you to demonstrate your ability to think critically about your patients.

Plan: By problems (pneumonia, pyelonephritis, dehydration) or systems, for example:

FEN/GI (fluids, electrolytes, nutrition, gastrointestinal)

Pulmonary

Cardiovascular

Infectious Disease

Neuro

Heme

Renal

Disposition

Your plan should address abnormalities in PE, labs and studies, and should be based on your assessment above.

Every pt should also have a disposition plan, which simply means what needs to happen in order to discharge the pt.

As many people have specific expectations, ask your senior resident if your plan should be by problems or systems.

New Pt Admitted Overnight or After Rounds the Previous Day (<5 minutes)

This presentation is exactly like the new/full admit presentation above, except that after **labs** and **studies** you incorporate overnight events and any new developments (including changes in PE) since admit before going on to your assessment and plan. You do not need to state two assessments and plans. Most patients will be admitted in the afternoon or evening prior to your presentation in rounds. The idea is to capture how the patient appeared on admit, and then state any changes on your second exam and assessment the morning of your presentation.

New Pts from PICU (a.k.a. PICU Transfers) (<5 minutes)

This presentation can be initially confusing, especially if the patient has had a prolonged PICU course with multiple medical issues. Your job as the historian, is to review the initial History and Physical in the chart, as well as the PICU transfer note (unless the pt has stayed 24-48 hours in the PICU, in which case you can review the daily progress notes.) The key to this presentation is brevity. In essence, PICU transfer presentations should be thought of as an expanded daily presentation such that the **subjective** information is a summary of the PICU course. You can do this by systems if the patient is complicated with multiple systems involved, or simply state a few summary sentences about how and when the pt initially presented, why the pt was transferred to the PICU, and the PICU course. Then, progress to your **objective** data for the last 24 hours and proceed with a daily presentation format. Ideally, you will have already presented these patients to the attending on the day of transfer and a more succinct presentation will be possible.

Daily/Interim Presentation (<3 minutes)

Use this format for patients admitted >24 hours ago. Brevity is important. You may omit the portions of subjective and objective data that do not directly relate to pt's reason for admission or working diagnosis.

Identification: One line statement of name, age, working diagnosis and date of admit.

Subjective:

Yesterday: "Had ____ study or lab which showed ____ result"

Overnight: "Did well" or "Had difficulty due to _____"

Objective:

PE – Vitals (24 hr range and trend of T, HR, RR, BP, O2 sat)

I/O's with UOP calculated as ml/kg/hour

PE pertinent positives and negatives.

Labs – can state which lab obtained and any abnormal values. State which labs are still pending. It is also helpful to report trends (e.g., "the hct today is 24, improved from yesterday when it was 22")

Studies – radiological studies, echocardiograms, EEG, etc.

Medications – list names of medications (and dosages/timing if applicable e.g., albuterol MDI q 4 hr, last given at 0800)

Assessment: One line summary of name, age, working diagnosis, and response to treatment(s). If diagnosis is still in question, continue to state **your** differential from most to least likely. The assessment allows you to demonstrate your ability to think critically about your patients.

Plan: By problems or systems. Should address abnormalities in PE, labs and studies, and should be based on your assessment above. Every pt should have a disposition plan.

General

Early in the rotation, **practice** giving your presentations to fellow students, interns, and the senior resident. This will help your confidence as well as improve your ability to communicate effectively during rounds and on the wards. Later on in the rotation after gaining experience, you may not need full presentation practice. Please speak up if you feel you need more formal presentation practice, or have any questions about the presentation expectations in this handbook.

GRADING SYSTEM: (O)RIME Method

Senior residents and attendings will be asked to evaluate medical students clinical performance according to this system. Below is a detailed discussion of this method.

The RIME method of grading emphasizes a developmental approach and distinguishes between basic and advanced levels of performance for clinical rotations. Such a system is “synthetic” rather than “analytic” and each step represents a synthesis of skills, knowledge, and attitudes that have been practiced from the preclinical years of medical school through residency.

Observer: A student in pre-reporter status, not meaningfully contributing to patient care activities. First- and second-year medical students largely are observers.

Reporter: Student can accurately gather and clearly communicate the clinical facts about a patient. Mastery of this step requires the basic skills to obtain a history and do a physical examination and the basic knowledge of what to look for. The student “reports” the facts, such as, “the pt has had 3 days of increasing shortness of breath and fatigue”, “the heart rate is 100”, “the liver is 3 cm below the costal margin”, “the sodium is 140.” This descriptor emphasizes day-to-day reliability – for instance, being on time, or following up on a patient’s progress. The student at this stage has a sense of responsibility and is achieving consistency in bedside skills in interpersonal relationships with patients. Reporter is minimum passing criterion in the third-year medical student clerkship. An OHSU student consistently at the level of “reporter” would receive a grade of “Satisfactory.” A student not consistently performing at the level of “reporter” by the end of the clerkship would receive a grade of “Marginal” or “Failure” and will be required to remediate the clerkship during their MS4 year.

Interpreter: Making a transition from “reporter” to “interpreter” is an essential and often difficult step in the professional growth of a student. An interpreter can report the facts accurately, and also can “interpret” these facts by thinking critically about the clinical data and formulating a differential diagnosis without prodding. Students at this stage can also advocate or refute diagnostic hypotheses. An interpreter might say, “2 month old male with unrepaired VSD now with a 2 day history of shortness of breath and poor feeding, and an exam significant for respiratory rate of 40, diffuse pulmonary crackles and liver down 3 cm below the costal margin, CXR remarkable for cardiomegaly and diffuse bilateral pulmonary opacification; therefore the pt most likely has congestive heart failure with fluid overload.” An OHSU student who is consistently at the level of “interpreter” would receive a grade of “Near Honors.”

Manager: A student at the “manager” level can not only report and interpret the clinical data, he/she has the knowledge, confidence and judgment to decide on a course of treatment. This level requires higher-level interpersonal skills and involvement in patient care. A manager might say, “2 month old male with unrepaired VSD now with a 2 day history of shortness of breath and poor feeding, and an exam significant for respiratory rate of 40, diffuse pulmonary crackles and liver down 3 cm below the costal margin, CXR remarkable for cardiomegaly and diffuse bilateral pulmonary opacification; therefore the pt most likely has congestive heart failure with fluid overload. I propose we give lasix 1 mg/kg IV x 1 now.” An OHSU student who is consistently functioning at the level of “manager” would receive the grade of “Honors.”

Educator: To be an educator, the trainee must be able to go beyond the basics of reporting, interpreting and managing the patient’s clinical care. An “educator” is a self-directed learner, someone who defines questions to research and searches the literature for evidence on which clinical practice can be based. An “educator” then shares this information with others. This is a senior resident- or attending-level skill. However, students and residents at all levels should strive to be educators.