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. Phone: 413-1161; Pager: (503) 796-5655; jpaisley@lhs.org
Dr. Ann Loeffler, Emanuel Site Medical Director; ID/Peds attending. Pager 503-938-0960; aloeffle@lhs.org
Dr. Lauren Rose, Pediatric Hospitalist; Director Graduate Medical Education; Pager: 503-938-0954; lrose@lhs.org
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, Pediatrics 1 Clerkship Director (503) 494-5982; or page through OHSU operator
Rob Bogacz, Student Coordinator. Office 494-3195, CDRC Rm 2114D

CALL ROOM
The call room for the residents are outside the PICU. The 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.

Meals can be purchased 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 or 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 link 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
Assessment should include a differential diagnosis with the most likely diagnosis first. Plan should be by problems or systems. When doing admissions, 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 whom 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 (provided it doesn’t interfere with other major responsibilities). 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 uncosigned 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 three teams, a Blue team, a Green team, and a Gold team. Each team has a hospitalist who supervises the care of pediatric patients admitted to the ward service. For most of the year, the Blue team is the teaching team and is lead by a senior resident (R2) from OHSU, and has 2-3 pediatric and family practice interns on it; the Green team has a Pediatric Nurse Practitioner who works directly with an attending. For the winter months, there will be more interns on rotation here, and some will work on the Green team. The Blue and Green teams admit hospitalist patients, as well as subspeciality patients, and patients with private attendings every day. The Gold attending decides which team will accept every admission.

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 hospitalist or moonlighting staff doctor is here from 5:30 until at least 2am; and from 1 pm to 2 am on weekends/holidays for backup. In addition, a hospitalist or moonlighter 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)*
- **Radiology Rounds**: *(Thursday 11:30-12:00, Rm 3317, 3rd floor Conference Room)*: with Dr. Paul Marten, pediatric radiologist.
- **Friday Case Conference**: *(7:30am, MOB West Conf Room)*: The attendings (often 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)*

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. 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—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 you 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 sign out.

EVENING WALK ROUNDS: When you are on call, it is expected that the senior/hospitalist, intern and student will 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
If you are not on-call or post-call you have the day off. On the weekend, the student and residents on the night before should be ready at 8am to give sign-out to the day time team on all of the patients. The residents will look through all of the vitals and labs for the patients and see at least the sick patients, if not all of the patients if time allows. Note writing is de-prioritized on the weekend. As the medical student you should pick a couple of patients to look in on that morning and be prepared to give updates to the team. The on-call team will pair up with one of the 2 attendings to help with their work if no admissions are on the floor. As the medical student, admissions are a priority on the weekend since you will generally get the most learning from those experiences.

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 team list.

At night, the intern on call always carries the 3-1151 phone. The senior resident always carries the 3-1149 phone, and pager, 503-830-4501.

Emanuel pagers are text capable at [www.arch.com/message](http://www.arch.com/message).

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, open e-chart under Transcriptions any outpatient or ED note available. The ED physician’s H and P and provides a lot of information. Notes from our pediatric 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:
  Attendings--------------Consulting Attending (if applicable)
  | Senior Res/NP
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.

DISCHARGE SUMMARIES
A resident or attending will complete a formal typed or dictated discharge summary on all patients on the day of discharge. We do not ask medical students to do these summaries.

If you would like to help with the discharge paperwork, you can help fill out the “Discharge Instructions” form, or the “Discharge Summary” form which can be used by the resident or student as a template for their typed summary.

• 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.

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. This will be completed by the attending or resident. Every asthmatic needs a followup appt made before discharge, which is something you can assist with. 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 –see call room bulletin board for details.

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 “CLINICS” 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, or brought to radiology to have it scanned into our PACS system. 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. 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.
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.

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 or HPI depending on your style, 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. 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.”

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.”

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.