UBC Department of Pediatrics
Year 3
Student Orientation Manual

Academic Year 2013 - 2014

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1. *Program Overview*

**Vancouver Fraser Medical Program (VFMP)**

Paediatrics is an eight week rotation: a four-week inpatient block and four-week outpatient block. Inpatient blocks can be completed at various sites including BC Children’s Hospital, Lion’s Gate Hospital, Royal Columbian Hospital, Surrey Memorial Hospital and Langley Hospital. During the inpatient rotation, students usually are on call 1 in 4.

The outpatient block is comprised of one-to-two weeks experience in various community and subspecialty clinics. The students also have an opportunity to arrange a “designated learning project (DLP)” during their outpatient block. Students require approval from Dr. Mumtaz Virji (mvirji2@cw.bc.ca), Year 3 Clerkship Director, before arranging a DLP.

Students may choose the site for their inpatient block and the preferred outpatient experience. The Department of Pediatrics tries to accommodate all requests as best possible, keeping in mind that student rotations must provide a balanced educational experience in pediatrics.

*BC Children’s Hospital (BCCH)*

BC Children’s Hospital is a tertiary centre where students are exposed to complex patients and healthy patients requiring admission for a specific illness. BCCH is an inpatient rotation where students spend 100% of their time on the wards. At BCCH, students work closely with residents and subspecialist physicians. They work with other health care professionals who closely work with patients, e.g., pharmacists, nutritionists and physiotherapists. This rotation can be very busy.

The student on call is night float, which will increase the educational opportunities for students. CTU morning rounds are family centered – the rounds occur in the rooms of the patients with parents being an integral part of decision-making.

*Lions Gate Hospital (LGH)*

LGH offers a blended community pediatric experience. Students are exposed to a variety of ages and acuity of patients including an 8 – 12 bed Neonatal Intensive Care Unit (NICU) and a 10 – 14 bed Pediatric Ward. On-call is in-house and approximately 1:4. During the on-call hours students will be present at newborn deliveries (32 weeks upward) and see a variety of pediatric consults. When not on call, mornings are usually spent on inpatient rounds, while the afternoons are spent in pediatrician’s offices or in a variety of pediatric clinics (Eating Disorder Clinic, Immunization Clinic and Diabetes Clinic). Most students learning is accomplished with staff preceptors. During their time at LGH, students become part of the pediatric community and play an integral role in patient care.
Royal Columbian Hospital (RCH)

RCH offers a blended pediatric experience with exposure to a wide variety of patients. During the rotation, students interact with patients on the pediatric wards, newborn care and attend outpatient clinics with pediatricians. On the wards, students follow patients with the pediatricians, learning at teaching and neonatal rounds. Calls are in-house, 1:4.

Surrey Memorial Hospital (SMH) -Not available in the fall 2013-

SMH offers exposure to a variety of common pediatric cases with no shortage of patients given the very young population in the area. Inpatient blocks include rounds on the wards and general pediatric teaching clinics with Pediatrics Hospitalist for that week. Inpatient at SMH is busy and students need to be proactive and organized. Students are exposed to multiple deliveries, emergency room and other consults through interactions with the on call Pediatrician. The on call is in house and approximately 1:4.

Langley Hospital (LMH)

LMH is a community hospital serving the needs of children in Langley, White Rock, and parts of Surrey. Students will become exposed to common pediatric complaints though their experiences rounding on the ward and nursery, as well as seeing consults in Emergency. Students will also participate in various outpatient clinics that run at different times of the year, including the Urgent Consult Clinic, Outpatient IV Therapy, and RSV clinic. Students may also attend offices with community pediatricians. Preceptors are enthusiastic and there is a great deal of opportunity for one-on-one teaching. Students are encouraged to function independently within their comfort zone. On call is in-house and approximately 1:4.

Island Medical Program (IMP)

The Pediatric Clerkship rotation at the Victoria General Hospital is an opportunity for medical students to care for children with a variety of acute illnesses, exacerbations and complications of chronic illness from infancy to adolescence; all seen in the hospital and in the ambulatory setting. During the inpatient month, the medical students rotate through an open pediatric ward. Patients are cared for by a designated Most Responsible Pediatricians (MRP). Learning is supported by a pediatric teaching attending (pediatrician of the week), and two to three junior residents in the UBC Family Practice and Royal College Programs. Communication and contact with the Most Responsible Pediatrician (MRP) and On-Call Pediatricians to coordinate patient care is emphasized. The outpatient month rotates the medical student through a variety of pediatric subspecialty clinics. Maintenance of treatment of chronic illness and evaluation of non-acute presentation of pediatric problems in the ambulatory setting is the primary focus.

Northern Medical Program (NMP) Prince George Regional Hospital

PGRH offers community as well as acute hospital-based pediatric care. The Pediatric Ward houses 12 beds including four Pediatric Special Care Unit beds, Level 2B and NICU with 12 beds. The Pediatric floor also houses the Pediatric Ambulatory Clinic and the visiting subspecialty clinics from BCCH. Students split themselves in to two groups of two each. They spend one month each in pediatrics and NICU.
On-Call Shifts are 1:4 over the eight-week rotation. The calls are in-house. During on-call, the students shadow the pediatrician for pediatric and neonatal consults and obstetrical emergencies where the on-call pediatrician is required. Students are expected to do initial assessment, write-up and dictation of consults. They are first on-call for any on-call issues. Often there is a Family Practice resident on call with the pediatrician. During on-call hours students will be present at newborn deliveries and caesarean sections at which the pediatrician is needed will also see a variety of pediatric consults. Students attend to on-call issues from the Pediatric Ward and NICU. When not on call, mornings are usually spent on inpatient rounds, while the afternoons are spent in ambulatory clinics such as a pediatrician’s office, the Child Development Centre, SCAN clinic (Child Abuse and Neglect), immunization clinics, and public health clinics.

During the rotation, students spend one to two hours each with the pediatric support team workers such as a physiotherapist, dietitian, diabetic nurse and social worker. Students are taught with an abridged version of the NRP (Neonatal Resuscitation Program) course during their rotation.

Southern Medical Program (SMP)

Kelowna (KGH)
The SMP program is located in beautiful Kelowna, BC. Students are exposed to acute and chronic pediatric care. The “inpatient” program has students following patients in an “open ward”. Students are expected to round on the patients that they have admitted and review with the appropriate MRP.

Afternoons are comprised of general pediatric clinics or some subspecialty clinics. On call is 1:4 and comprises of deliveries (32 weeks and up) as well as acute pediatric cases needing urgent assessment. The aim of this program is to expose the student to assessment of acute pediatric and neonate patients with the aim of making a plan and following through the a final conclusions (discharge or in some cases transfer out to tertiary centers). Since we are a small center the student will get much hands-on experience in assessment management and interventions (IV, catherization, and intubation).

Kamloops (RIH)
The Pediatric Clerkship rotation at the Royal Inland Hospital is an opportunity for medical students to care for pediatric patients, ranging in age from newborn to late adolescence. Patients are seen both as hospital inpatients and in the ambulatory setting.

During their rotation, medical students are based in the hospital, and work with an “on service” paediatrician, who changes weekly. The on service Paediatrician (and pediatrics team) are responsible for the care of all inpatients, and are available for consultation for acute pediatric cases presenting to both the Emergency Department, and to community clinics. Learning is supported primarily by the on service paediatrician. On call is expected at a frequency of 1 in 4, but does not involve overnight call.

A medical student doing their pediatrics rotation in Kamloops can expect to receive an excellent experience in all aspects of pediatric care. There will be guaranteed plentiful exposure to neonatal/newborn care. The nature of Pediatrics in a smaller center dictates that pediatric cases are on a somewhat ad hoc basis, and learners should expect to supplement their direct patient exposure with the use of online learning opportunities (i.e. CLIPP cases).
2. **Program Objectives**

Pediatrics program objectives have been designed to reflect Can MEDS objectives and are available for viewing on MEDICOL and in academic resources portion of the manual. Students are expected to be aware of the program objectives for Pediatrics.

During the Pediatric clerkship rotation, students are expected to accomplish the following:

- Acquire a basic knowledge of growth and development (physical, physiological and psychosocial) and understand its clinical application from birth through adolescence.
- Develop communication skills that facilitate clinical interaction with infants, children of different ages, adolescents and their families, ensuring that complete, accurate data is obtained.
- Develop skills to take a complete Pediatric history from parents and the child where appropriate.
- Develop competency in the physical examination of infants, children, and adolescents.
- Acquire the knowledge necessary for the diagnosis and initial management of common, acute and chronic illnesses.
- Develop clinical problem-solving skills.
- Acquire an understanding of the influence of family, community and society on child health and disease.
- Develop strategies for health promotion as well as disease and injury prevention.
- Develop the attitudes and professional behaviors appropriate for clinical practice.
3. **Academic Requirements**

- One history and physical written assignment handed on the 2nd Friday of the rotation.
- Three (3) Mini-CEX’s: (1) History, (1) Physical and (1) Newborn to be handed in by the 7th Friday of the rotation.
- Mid-rotation quiz – which is formative and available on Medicol from Monday week 5 to Monday week 6. It will not be available after the deadline. If not completed a notation will be made on End of Clerkship Assessment.
- Complete 20 CLIPP cases
- Safe Medication Order Writing Module – online.

1 **Special Note on Student Roles & Responsibilities**

**SUPERVISION**
Students must be supervised directly or indirectly at all times.

**History & Physical**
Must be completed, reviewed and countersigned by the attending physician or resident within 24 hours of admission.

**Orders**
Orders must be written under appropriate supervision of attending physician or resident. For all orders clerks must sign orders as below:

- Signature
- Printed name
- Year 3, Class 2011
- College of Physician and Surgeons of British Columbia identity number (CPSID)
- Pager or cell #
- Discussed with Dr. ____________________________
- Write the name of resident or attending physician the order was discussed with.

**Procedures**
Clerk may perform procedures under appropriate supervision. (For details please see the Year 3 P&P manual posted on MEDICOL).

Clerks may not discharge a patient from ward in the hospital, from emergency department or outpatient department. Patients can only be discharged once approval has been given by a senior resident or in charge physician.

Clerks cannot sign birth and death certificates, mental health certificates or other medico-legal documents, although they may carry out the task of certifying death.

Prescriptions to be filled outside the hospital cannot be signed by clerks.

In Pediatrics clerks are usually not expected to dictate consultation or discharge letters. They may do so for their own learning purposes with appropriate supervision of the preceptor.
4. **Evaluations and Marks**

Mid-rotation Evaluation (of students)

Midway through the rotation students will have a Mid-rotation evaluation. Any concerns students have about the rotation should be directed to the DSSL and the clerkship director as soon as identified.

Student Evaluation (by preceptor)

Evaluations are available on One45. The preceptor will receive an email reminder to fill out the evaluations. It is the student’s responsibility to make sure the evaluations are done before end of rotation. Students scheduled two weeks or more within a specific discipline or site should ensure an evaluation is completed. If a preceptor you have worked with for one week gives you good feedback, ask him/her to fill out an evaluation (please ask the program assistant to send an evaluation form to the faculty). For students doing emergency medicine, the comments on end of shift evaluations will be transferred to the overall evaluation.

The evaluations form is a major component of the student’s clinical mark. The final End of Clerkship Form is comprised of all the evaluation forms filled out during the clerkship. Students are evaluated on the basis of knowledge, behavior, interpersonal skills, and willingness to accept feedback and make changes accordingly. Students are also evaluated on their skills to perform an appropriate pediatric history and physical examination, their ability to present during the rounds and to effectively interact with the families and team members. Professional behavior throughout the clerkship is a must and any unprofessional behavior will be noted on the End of Clerkship Form.

The comments from the End of Clerkship Assessments will not be transcribed on the MSPR. It is for students’ feedback only.

Faculty/Service Evaluations (by the student)

It is very important for students to evaluate the faculty and services they work with during their eight-week rotation. The feedback received from the students helps us improve the programs. Thus make sure you do fill out the faculty and service evaluation forms. Comments received from students remain anonymous and help the Department make changes to improve the program.

Marks for the Year 3 Pediatric Clerkship**

Marks for the Pediatric clerkship are divided into three components:

1. Clinical marks = 40% to total grade
2. NBME score = 35% of total grade
3. OSCE score = 25% of total grade

*The Clinical mark is based on the End-of-Clerkship assessment score (100%).

**(1) Written History assignment, and (3) Mini-CEX’s: (1) History, (1) Physical and (1) Newborn are formative with no weigh for the Clinical Mark
5. Administrative Matters

Staying in Touch with the Department Office

The primary contact at VFMP is Alejandro Huerta Rodas (ahuertarodas@cw.bc.ca).
Please make sure we have your appropriate contact information.

The Department of Pediatrics usually sends important time-sensitive information via e-mail. Students are expected to answer e-mail within 24-48 hours and to respond to pages within minutes of receiving them; whether paged from the administrative offices or wards.

Dress Code

Students are not expected to wear white coats in Pediatrics, but should be dressed appropriately. Students are required to wear their white coats for OSCE Exams. All clothing should be clean and appropriate for work area. Dress professionally all the time.

Inappropriate pants include jeans (of any kind), sweatpants, exercise pants, shorts of any kind, leggings, spandex or other form-fitting pants.

Inappropriate tops include tank tops, mid-riff, halter tops, sleeveless, sheer, tops with bare shoulders or spaghetti straps.

Footwear should be clean, in good repair and have non-skid soles. Health Care Providers involved in direct patient care should wear shoes with closed toe and a closed heel.

Nails should be short, clean and free of nail polish. Chipped nail polish and false nails can harbor microorganisms. Nail enhancement such as artificial nails, wraps, tips, acrylics and gels should not be worn by health care workers providing direct patient care or handling patient care products.

We deal with people from different cultures and students should be sensitive to the various cultures.

All areas in the hospital are scent free. Please respect these policies. Many of our staff and patients have allergies and asthma.

Identification cards should be worn at all times.

Absences

As per the Policies and Procedures Manual for Students in Year 3, Academic Year 2012-13:

“In extraordinary circumstances, students may have an Unavoidable Absence or request an Anticipated or Negotiated Absence from their clinical education. We expect all students to approach potential absences in a professional manner, and seriously consider implications for their education, their patients and fellow members of the medical team. Therefore, a request for leave will be reviewed, and either approved or not approved.”
For Pediatrics, absences and leaves are managed by the Year 3 Clerkship Director – Dr. Mumtaz Virji (mvirji@cw.bc.ca) or site directors in consultation with the DSSLs.

The following procedures outline the steps that must be taken in the event that a student is considering an Absence, (either Unavoidable, Anticipated, or Negotiated), from their studies.

**Unavoidable Absences: Illness, injury, family emergency or bereavement**

- The student will notify the preceptor responsible for the session being missed (phone or in person) at their earliest opportunity and, when possible, before the start of the session. Do not ask your colleagues to pass on the message to your preceptor. Most of the preceptors are easily reachable.
- The student will contact the appropriate Site Program Assistant via e-mail or phone.
- Upon their return, the student must provide the Site Program Assistant with a Record of Student Absence Form reporting an Unavoidable Absence, which is available on Medicol.

Students should outline what action they propose to take in order to catch up on missed work (if more than two days of rotation have been missed) and how they will fulfill their clinical responsibilities on the on the Record of Student Absence Form.

**Anticipated Absences**

- For medical or dental appointments or religious holidays (for a complete list, please refer to the Year 3 Policies & Procedures Manual on MEDICOL: http://elearning.ubc.ca/connect/logout

- Home page > [MD Undergrad Info] > [Absence Policies and Procedures] for the Absence Policy outline
- For the Absence Forms, click on [Forms] on the top grey ribbon, look for [Absence Forms > Year 3 > VFMP]
  - Students should attempt to book medical or dental appointments for times outside of scheduled clinical duties.
  - Prior to the Anticipated Absence
    1. The student will contact the Year 3 Clerkship Director – Dr Mumtaz Virji -- or the site director in a timely fashion to discuss the potential for an Anticipated Absence.
    2. If the Anticipated Absence is approved by Dr. Virji or site director, the student will complete a Record of Student Absence Form and have Dr. Virji or site director sign it. Student should outline what action they propose to take in order to catch up on missed work (if more than two days) and how they will fulfill their clinical responsibilities on the Record of Student Absence Form.
    3. The student will submit the signed/approved Record of Student Absence Form to the appropriate Departmental site Program Assistant and the Year 3 Program Manager (Dean’s Office).
    4. The student will notify the appropriate preceptor responsible for the session being missed.
**Negotiated Absences**

- Negotiated absences are for academic pursuits of a one-time nature (e.g., commencement exercises, attendance at a scientific meeting to present a paper or accept an award), participation in major varsity team events, participation in major faculty activities or in worthy social endeavors (e.g. planning a fund-raising event, education or other community event), or rare occurrences (e.g., compassionate leave, marriage).

- Please note that Negotiated Absences may or may not be granted and are at the discretion of the Year 3 Clerkship Director – Dr. Mumtaz Virji or the site director.

- Prior to the Negotiated Absence
  
  i. The student will contact the Year 3 Clerkship Director – Dr. Mumtaz Virji or the site director – to discuss the potential for a Negotiated Absence. This should be done at the time of selection of inpatient / outpatient rotations i.e. eight weeks in advance.

  ii. If the Absence is approved by Dr. Virji or the site director, the student will complete a Record of Student Absence Form for Dr. Virji or the site director to sign. The student should outline what action they propose to take in order to catch up on missed work (if more than two days) and how they will fulfill their clinical responsibilities on the Record of Student Absence Form.

  iii. The student will submit the signed/approved Record of Student Absence Form to the appropriate Departmental site Program Assistant and the Year 3 Program Manager (Dean’s Office).

  iv. The student will notify the appropriate preceptor responsible for the session being missed.
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<tr>
<th>BC Children’s Hospital Administrative Office</th>
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| Undergraduate Program Director              | Dr. Mumtaz Virji  
Mvirji2@cw.bc.ca |
| Distributed Site Specific Leader (DSSL)     | Dr. Seemi Roopani  
SRoopani@cw.bc.ca |
| Program Director Year 4                     | Dr. Victoria Atkinson  
Vatkinson@cw.bc.ca |
| Education Coordinator                       | Marion Cárdenas  
MCardenas@cw.bc.ca |
| UG Education Program – Year 3                | Mr. Alejandro Huerta Rodas  
ahuertarodas@cw.bc.ca |
| Education Assistant – Year 4                 | Mr. Dylan King  
Dylan.King@cw.bc.ca |

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<th>Royal Columbian Hospital</th>
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| DSSL                                         | Dr. Mudaffer Al-Mudaffer  
mudaffer@googlemail.com |
| Program Coordinator                         | Ms. Zunaira Saleem  
Zunaira.saleem@fraserhealth.ca |

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<th>Richmond Hospital</th>
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| DSSL                                         | Dr. Erik Swartz  
Erik.swartz@vch.ca |
| Program Assistant                           | Ms. Caroline D’Sa  
Caroline.DSa@vch.ca |

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<th>St. Paul’s Hospital</th>
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| DSSL                                         | Dr. Antoinette Van Den Brekel  
avandenbrekel@telus.net |

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| DSSL                                         | Dr. Rob Humphreys  
rhumphreys@cw.bc.ca |
| Program Assistant                           | Ms. Barbara Shield  
Barbara.Shield@fraserhealth.ca |

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| DSSL                                         | Dr. Glenn Robertson  
grobertson@cw.bc.ca |
| Program Assistant                           | Ms. Sherri Charters  
Sherri.Charters@vch.ca |

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<th>Chilliwack Integrated Clerkship ICC</th>
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| DSSL                                         | Dr. Mark Mackenzie  
Mark.mackenzie@fraserhealth.ca |
| Program Assistant                           | Ms. Sherol Cunningham  
Sherol.Cunningham@fraserhealth.ca |

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<th>Langley Memorial Hospital</th>
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| DSSLS                                        | Dr. Colleen Poole  
cepoole14@hotmail.com |
| DSSL                                         | Dr. Kathryn Ng  
kathrynwng@gmail.com |
| Island Medical Program, Victoria            | DSSL                                                                 | Dr. Jennifer Balfour | jbalfour@uvic.ca |
|--------------------------------------------|                                                                     | Lynne Fischer        | llfisher@uvic.ca |
| Program Manager Y3 & Y4                    | DSSL                                                                 | Lynne Fischer        | llfisher@uvic.ca |
| Program Assistant Y3                       | DSSL                                                                 | Lynne Fischer        | llfisher@uvic.ca |
| Island Medical Program, Cowichan Integrated Clerkship ICC – (Duncan) | DSSL                                                                 | Dr. Maggie Watt      | drmwatt@gmail.com |
| Program Assistant                          | DSSL                                                                 | Ms. Stacey Taylor    | staceyt@uvic.ca |
| Northern Medical Program (NMP)              | DSSL                                                                 | Dr. Vincent Arockiasamy | Vincenta@unbc.ca; Vincent.arockiasamy@northernhealth.ca |
| Program Manager                            | DSSL                                                                 | Ms. Twylla Hamelin   | hamelin@unbc.ca |
| Program Assistant                          | DSSL                                                                 | Denise Marcotte      | Denise.Marcotte@northernhealth.ca |
| NMP - Terrace Integrated Clerkship ICC      | Program Assistant                                                     | Ms. Susan Moldenhauer| moldenh@unbc.ca |
| NMP - Integrated Clerkship ICC (Piece Liard)| Program Assistant                                                     | Ms. Kim Furlong      | kfurlong@unbc.ca |
| Southern Medical Program (SMP)              | Program Assistant                                                     | Ms. Michelle Bandalo | michelle.bandalo@interiorhealth.ca |
| SMP - Kelowna                              | Program Assistant                                                     | Deb Lingel (RIH)     | deb.lingel@interiorhealth.ca |
| SMP - Kamloops                             | Program Assistant                                                     | Deb Lingel (RIH)     | deb.lingel@interiorhealth.ca |
6. **Academic Resources for Students**

The following documents are available from the UBC Pediatrics Website, Undergraduate Program Student Orientation Manual:


6.1 **Pediatric Undergraduate Curriculum**

6.2 **CLIPP Cases**

6.3 **History and Physical Template**

6.5 **ISMP Dangerous Abbreviations**

6.6 **Mini-CEXs**

6.7 **Procedure and Patient Encounter Log**

6.8 **SOAP Notes**

6.9 **Student Marks**

6.10 **Useful Links & Recommended Textbooks**

6.11 **BCCH – CTU Orientation for Medical Students**
Adapted from the Shared Canadian Curriculum (canuc-paeds)

Medical Expert

The student is able to:

Demonstrate proficiency in acquiring a complete and accurate paediatric history with consideration of the child’s age, development, and the family’s cultural, socioeconomic and educational background.

Describe differences between the medical management of paediatric patients versus adult patients.

Recognize an acutely ill child.

Demonstrate an approach (the generation of a differential diagnoses, appropriate initial diagnostic investigations, and management plan) to the following core clinical paediatric presentations:

- Paediatric Health Supervision
- Newborn
- Neonatal Jaundice
- Fever
- Dehydration
- Respiratory Distress/Cough
- Developmental & Behavioral Problems
- Growth Problems
- Inadequately Explained Injury (child abuse)
- Abdominal Pain
- Vomiting
- Diarrhea
- Altered Level of Consciousness
- Seizure/Paroxysmal Event
- Headache
- Murmur
- Rash
- Bruising & Bleeding
- Pallor (anemia)
- Lymphadenopathy
- Limp/Extremity Pain
- Urinary Complaints (polyuria/frequency/dysuria/hematuria)
- Edema
- Sore Ear
- Sore Throat/Sore Mouth
- Sore Eye/Red Eye
Demonstrate physical examination skills that reflect consideration of the clinical presentation as well as the comfort, age, development, and cultural context of the infant, child, or adolescent.

Demonstrate competence with the following paediatric physical examination skills in addition to general physical examination skills:

- Position and immobilize patient for certain physical exam skills
- Measure and interpret height, weight, head circumference (including plotting on growth curve and calculation of BMI)
- Measure and interpret vital signs
- Palpate for fontanelles and suture lines
- Perform red reflex and cover-uncover test
- Perform otoscopy
- Inspect for dysmorphic features
- Elicit primitive reflexes
- Perform infant hip examination
- Assess the lumbosacral spine for abnormalities
- Assess for scoliosis
- Palpate femoral pulses
- Examine external genitalia
- Assess for sexual maturity rating (Tanner staging)

Professional

*The student is able to:*

Demonstrate professional behaviours in practice including: honesty, integrity, commitment, compassion, respect and altruism.

Demonstrate a commitment to perform to the highest standard of care through the acceptance and application of performance feedback.

Recognize and respond to ethical issues encountered in clinical practice.

Fulfill legal obligations as they pertain to paediatric practice (reporting child maltreatment).

Recognize the principles and limits of patient confidentiality as it pertains to paediatrics (age of consent, emancipated minors, disclosure of suicidal/homicidal intent, and disclosure of abuse).

Balance personal and professional responsibilities to ensure personal health, academic achievement, and the highest quality of patient care.

Recognize factors such as fatigue, stress, and competing demands/roles that impact on personal and professional performance. Seek assistance when professional or personal performance is compromised.
**Communicator**

The student is able to:

Demonstrate communication skills that convey respect, integrity, flexibility, sensitivity, empathy, and compassion.

Communicate using open-ended inquiry, listening attentively and verifying for mutual understanding.

Demonstrate a patient-centered and family-centered approach to communication which requires involving the family and patient in shared decision making, and involves gathering information about the patients’ and families’ beliefs, concerns, expectations and illness experience.

Acquire and synthesize relevant information from relevant sources including: family, caregivers, and other health professionals.

Demonstrate organized, complete, informative, legible, and accurate written/electronic information related to clinical encounters (such as: admission histories, progress notes, and discharge summaries).

Demonstrate clear, legible, and accurate ‘doctors orders’ (such as investigations, medication orders and outpatient prescriptions).

Demonstrate organized, complete, informative and accurate information in verbal patient presentations.

Respect patient confidentiality, privacy and autonomy.

Acknowledge/demonstrate the principals of dealing with challenging communication issues including: obtaining informed consent, delivering bad news, disclosing adverse medical events, and addressing anger, confusion, and misunderstanding.

**Collaborator**

The student is able to:

Work effectively, respectfully, and appropriately in an inter-professional healthcare team.

Demonstrate understanding of roles and responsibilities in an inter-professional health care team recognizing their own responsibilities and limits.

Effectively collaborate, consult and/or participate with members of the inter-and intra-professional team to optimize the health of the patient/family.

Effectively work with other health professional to prevent, negotiate, and resolve inter- and intra-professional conflict.
Manager

The student is able to:

Demonstrate priority setting, and time management skills that balance patient care, academic responsibilities, and personal well being.

Employ information technology to maximize patient care.

Demonstrate a rationale approach to finite resource allocation in patient management; apply evidence in cost-effective care.

Develop management plans that demonstrate due attention to discharge planning, and recognition of key community resources to support the family once out of hospital.

Health Advocate

The student is able to:

Engage in advocacy, health promotion and disease prevention with patients and families including: mental health, child maltreatment, healthy active living, safety, and early literacy support.

Identify emerging and ongoing issues for paediatric populations who are potentially vulnerable or marginalized including: First Nations People, new immigrants, disabled children, children with mental health issues, and populations living in poverty.

Identify determinates of health for paediatric populations and the physician’s role and points of influence in these issues.

Identify barriers that prevent children from accessing health care including: financial, cultural, and geographic.

Scholar

The student is able to:


Apply the principals of critical appraisal of the literature to guide evidenced based patient care. Demonstrate integration of new learning into practice.

Demonstrate effective teaching/learning strategies and content that facilitate the learning of others (Peers, patients, families, allied health professionals).
## Clinical Presentation

| Paediatric Health Supervision: newborn, infant, pre-school child, school-aged child, adolescent | Nutrition  
Growth - HC,ht, wt, BMI  
Hypertension  
Health active living  
Mental health  
Normal development  
Immunizations  
Anticipatory guidance  
Injury prevention  
Vision and hearing  
Dental health  
Discipline / Parenting  
Sleep issues  
SIDS  
Crying / colic  
Sexual develop / health  
Adolescent health surveillance (HEADDDS)  
Social-economic / cultural / home / environment |
|---|---|
| Newborn | Birth Trauma  
Depressed newborn  
Prematurity  
Respiratory distress  
Sepsis  
Hypothermia  
Hypoglycemia  
Dysmorphic features  
- Trisomy 21  
- FAS / FASD  
Congenital infections  
SGA  
LGA  
Neonatal abstinence syndrome |
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<td>- Gross motor</td>
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<td>Clinical Presentation</td>
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<td>Specific patterns</td>
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<td><strong>Clinical Presentation</strong></td>
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<td>Periorbital / orbital cellulitis</td>
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<td>Conjonctivitis</td>
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*“Key conditions” are the core conditions that the Paediatric Undergraduate and Clerkship Directors of Canada (PUPDOC) felt are essential for graduating medical students to know. The Key Conditions are neither a differential diagnosis nor a scheme (approach to the clinical presentation). They highlight conditions that may be unique to paediatrics, that are essential, or that are common.*
The following is a list of the available CLIPP Cases in Pediatrics:

1. Prenatal and newborn - Thomas
2. Infant well child (2, 6 and 9 months) - Asia.
3. 3-year-old well-child check - Benjamin.
4. 8-year-old well-child check - Jimmy.
5. 16-year-old girl's health maintenance visit - Betsy.
6. 16-year-old boy's presport physical - Mike.
7. Newborn with respiratory distress - Adam.
8. 6-day-old with jaundice - Meghan.
9. 2-week-old with lethargy - Crimson.
10. 6-month-old with a fever - Holly.
11. 5-year-old with fever and adenopathy - Jason.
12. 10-month-old with a cough – Anna
13. 6-year-old with chronic cough - Sunita.
14. 18-month-old with congestion - Rebecca.
15. 6-week-old with vomiting - John.
16. 7-year-old with abdominal pain and vomiting - Isabella.
17. 3-year-old refusing to walk - Emily.
18. 2-week-old with poor weight gain - Tyler.
19. 16-month-old with first seizure - Ian.
20. 7-year-old with a headache - Nicholas.
21. 6-year-old with a rash - Melanie.
22. 16-year-old girl with abdominal pain - Mandy.
23. 11-year-old girl with lethargy and fever - Sarah.
24. 2-year-old with altered mental status - Matthew.
25. 2-month-old with apnea - Jeremy.
26. 9-week-old not gaining weight - Bobby.
27. 8-year-old with abdominal pain - Jenny.
28. 18-month-old with developmental delay – Anton
29. Infant with hypotonia – Daniel
30. 2-year-old with sickle cell disease - Gerardo.
31. 5-year-old with puffy eyes - Katie.
32. 5-year-old with rash - Lauren
CLIPP log-in information:

Go to http://www.med-u.org/clipp

Click on the "Register" link at the top right of the page

- Registering to use CLIPP (for institutional users)
- Click on ‘Login to Cases’ and the CLIPP login page will open:

Click on 'Register' the top left, type your medical school e-mail address (i.e., Jane.Doe@medicalschool.edu), your first name and your last name. Enter your status in the last field.

- Read the CLIPP Site User Terms and Conditions in the bottom box.
- Click Accept or Decline; then click OK.
- If you clicked Accept, the system immediately will send you a Login and Password (a randomly generated 6-digit number) in two e-mail messages. Be sure to save the login and password for future use.
  
  Your login name cannot be changed. To edit your password, see the instructions for "Changing your password" down below

Logging-in to CLIPP after you register (all users), once you have your Login and Password:

- Go to www.clippcases.org
- Click Go to Cases in the left frame.
- On the Login page, type your Login and Password.
- Click on Login, the Case Selection page opens.
- On the Case Selection page, click the name of the desired case (or click Open case... to the right of the name).
- the case will open
6. 3  History and Physical Template (Guidelines)

**ID**

Name, age, gender, known illnesses and CC: - one word sentence of main concern often using words of parent or child

*e.g. Luke is a 1-year-old previously healthy Caucasian boy presenting with a 2-day history of cough and difficulty breathing*

**Informant**

All sources of information for your history and their reliability

*e.g. History from reliable mother and review of ER records*

**HPI**

The information is the same for any medical problem. A careful and complete description of the presenting problem, with appropriate chronology is key. Always include pertinent positives/negatives and relevant family history or social history items. An important distinction is that much of the history will be observations from a third party (parent/caregiver). Important questions include: mood, activity level, eating pattern, urine output (specific as possible), sleep pattern and a description in the parents word what the problem is, how it has changed, what they have tried to alleviate the symptoms and what they think is causing the child’s illness.

**Allergies**

Allergies and reactions

**Medication**

Any prescription medications, over the counter medications or herbs/supplements

Include doses when known.

**Immunizations**

Ask about receipt of immunizations in every patient; there are standard immunizations given at specific ages. Parents sometimes have the immunization record; if the child has not received immunizations, delicately explore the reasons why. Saying “up to date” is not an appropriate response, try to document what immunizations were given and when. It is important to ask about if any of the immunizations were paid for.
**Past Medical History**

**Birth/Pregnancy History**

*For infants, this component is particularly important.* Often birth/pregnancy history is either relevant to the chief complaint or represents the majority of the PMH. Make sure to include these questions on all infants and any child with a problem that might be related to perinatal/neonatal issues. We usually include this in all children.

Maternal: mother’s age, gravida, para, health problems and medications

Pregnancy: complications, prenatal care/labs/tests

Labour: Duration of membrane rupture and complications

Delivery: Gestational age (at a minimum whether term or premature), Mode (vaginal/C section/forceps/vacuum), Apgars and birth weight

Neonatal: Duration of hospitalization and any events that occurred shortly after birth.

**Medical history**

Any medical problems or hospitalizations with a brief summary and dates

Specifically ask about the last health supervision visit.

**Surgical history**

Any surgeries and dates

**Family history (include genogram)**

Explore any diseases that are in the family (e.g. hypertension, diabetes, or other problems resembling the child’s problem). Also gently explore any miscarriages or childhood deaths in the family. Ask about consanguinity. Family chart should be included.

**Social history**

Ask who lives in the home and whether there are other siblings and the state of the siblings’ health. Explore childcare arrangements—whether it is the family, an in-home setting or center based (larger classrooms). Inquire about what languages are spoken at home. If the child is verbal, directly ask them about school/daycare, friends, and favourite past times/toys, pets and siblings/family members. Identify sources of stress for the parents.

**Diet**

Description of diet: Particularly important in the first year of life or if growth is abnormal.

Comment whether breast feeding or formula feeding (and what type of formula and how much) in infants. Ask about typical diet in older children or about concerns the parents may have.

Important to ask how much milk and how much juice a child is drinking.
**Developmental**

This should be part of every history.

The way you ask the questions will change over time; Start with an open ended question to parents like “tell me what types of things your child is doing now?” Childhood development is often categorized into four domains (social, fine motor, gross motor and language) and screening questions in each domain should be explored. Screening questions should fit age of child.

In older children, make sure to ask about their hobbies, activities, school and friends. Assess academic achievement from parents/patient in older children.

**Review of Systems**

This section is similar to that for adult patients. Remember that preverbal children cannot report many of the symptoms, so parental observation is the main source of information. A sample – remember this is just a sample and you will learn what questions you ask....

- **General:** fever, weight changes (loss or gain), activity, sleep. Any concerns with vision or hearing
- **HEENT:** ear or eye pain or d/c, nasal d/c, sore throat, hoarseness
- **Respiratory:** cough, wheezing, apnea, cyanosis, difficulty breathing
- **Cardiovascular:** murmurs, chest pain, palpitations, syncope, edema
- **Genitourinary:** frequency, dysuria, urine out-put, hematuria, how frequently does the child void
- **Skin:** rashes
- **Neurology:** seizures, loss of consciousness
- **Gastrointestinal:** feeding/appetite, vomiting, diarrhea, constipation, blood in the stool, abdominal pain
- **Musculoskeletal:** joint swelling, pain, tenderness, weakness
- **Psychology:** mood changes, sleep problems
- **Heam/lymph:** bleeding, anemia, jaundice, swollen glands
The approach to the physical examination will vary with the age of the child. There are special manoeuvres that are done at each age.

**General:** Describe the state of alertness, mood and willingness to cooperate with the exam and whether the child is in distress. Common observations to make are is this child well or unwell, toxic or not toxic.

**Vital Signs:**

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Height ______________ % Weight ______________ % OFC ______________ % BMI ______________

**Hydration:** Are there tears? Comment on mucous membranes and skin turgor.

**Head:** For infants and children feel for the fontanelle; comment on the shape of the head

**Eyes:** Note presence of the red reflex in all children; check papillary reaction, lids/conjunctiva

*NB: Fundoscopic exam is difficulty to perform infants but can usually be done in children over 5-6 years of age; (The examination in this age group provides an excellent opportunity to see the optic disc and vessels).*

**Ears:** Check for tenderness of pinna, discharge and gross assessment of hearing. Check TMs bilaterally.

**Nose:** Check for discharge, turbinate color

**Throat:** Check for teeth/caries. Inspect the tongue, buccal mucosal and the posterior pharynx for erythema, enlarged tonsils. Feel for submucous cleft palate in an infant.

**Neck:** Gently palpate neck for masses and assess range of motion (often by observation)

**Lymphatic:** Check LN in neck, axilla and groin.

**Chest:** Observe for signs of respiratory distress (nasal flaring, retractions and grunting). Normal respiratory rate varies with age; percuss for dullness and then auscultate anterior and posterior lung fields (remember the RML) Note the inspiratory: expiratory ratio (I: E ratio). Listen for wheezes and crackles.

**Cardiovascular:** Observe for cyanosis, respiratory distress and hyperdynamic precordium. Palpate the precordium (for thrills); auscultate as in adults—pediatric heart rates are faster than adults thus distinguishing systole and diastole is more difficult. Many children will have benign murmurs (of no medical importance) ---train your ears to hear them! Palpate the peripheral pulses as in adults. (Femoral pulses are particularly important to feel in neonates when screening for coarctation of the aorta).
Abdomen: observe, auscultate and palpate as in adults. Children often have a palpable liver edge...always palpate from the pelvic brim up. Consider a rectal exam if applicable to presenting complaint.

GU: Observe tanner staging if applicable to presenting complaint. In infants examine to ensure testis are descended.

Musculoskeletal: Much of this portion of the examination is observation for tone and strength. In neonates, observe for increased or decreased tone...both are pathological. When children are older and can follow directions, the approach is similar to an adult exam. There are also special manoeuvres to screen for congenital hip dysplasia (Barlow/Ortolani manoeuvres). Look for joint swelling and rashes.

Neurological: Much of this exam is by observation (especially the CN). Observe for facial symmetry, tongue is midline, there is a strong suck. Children have DTR’s just like adults that should be tested. Neonates have primitive reflexes (like an upgoing toe with a Babinski test). If possible observe a child’s gait. Tone and Power can also be mentioned here.

Skin: Look for any rashes, birthmarks etc.

Investigations
List all the investigations done with dates and indicate abnormal results. List all the investigations that are pending.

Impression
In 2 to 3 sentences, provide a summary of the patient with main findings. *(1 year old previously healthy Caucasian boy presented to ER with complaint of cough and increased work of breathing. Neither Chest x-ray nor the physical exam showed any focality and the NPW is pending. He has been admitted for likely RSV bronchiolitis and is currently stable on 3 L of oxygen).*

Problem List
- List all of the acute and chronic problems using patient descriptions *(cough, fever, difficulty breathing)*. Do not to list diagnosis as the problem i.e. asthma, pneumonia etc.
- List a differential diagnosis for each problem with reasons for and against each diagnosis.
- This list should be in order of significance. There may be problems that were elicited in history which were not part of the presenting symptoms.

Plan
- List all investigations that will need to be followed or need to be done (with reasoning).
- Discuss the management of problems in this patient.
- Write the medications used and the supportive treatment being given.
- Discuss the possible subspecialty and other consults to be done. Make sure to write the question you need to be answered by the subspecialty.
- Plan may be discussed with each problem also.
# 6.5 Dangerous Abbreviations, Symbols and Dose Designations

**Do Not Use**

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medication information.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Intended Meaning</th>
<th>Problem</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>unit</td>
<td>Mistaken for “0” (zero), “4” (four), or cc.</td>
<td>Use “unit”.</td>
</tr>
<tr>
<td>IU</td>
<td>international unit</td>
<td>Mistaken for “IV” (intravenous) or “10” (ten).</td>
<td>Use “unit”.</td>
</tr>
<tr>
<td>Abbreviations for drug names</td>
<td>Misinterpreted because of similar abbreviations for multiple drugs; e.g., MS, MSO₄ (morphine sulphate), MgSO₄ (magnesium sulphate) may be confused for one another.</td>
<td>Do not abbreviate drug names.</td>
<td></td>
</tr>
<tr>
<td>QD, QOD</td>
<td>Every day, Every other day</td>
<td>QD and QOD have been mistaken for each other, or as ‘qid’. The Q has also been misinterpreted as “2” (two).</td>
<td>Use “daily” and “every other day”.</td>
</tr>
<tr>
<td>OD</td>
<td>Every day</td>
<td>Mistaken for “right eye” (OD = oculus dexter).</td>
<td>Use “daily”.</td>
</tr>
<tr>
<td>OS, OD, OU</td>
<td>Left eye, right eye, both eyes</td>
<td>May be confused with one another.</td>
<td>Use “left eye”, “right eye” or “both eyes”.</td>
</tr>
<tr>
<td>D/C</td>
<td>Discharge</td>
<td>Interpreted as “discontinue whatever medications follow” (typically discharge medications).</td>
<td>Use “discharge”.</td>
</tr>
<tr>
<td>cc</td>
<td>cubic centimetre</td>
<td>Mistaken for “u” (units).</td>
<td>Use “mL” or “millilitre”.</td>
</tr>
<tr>
<td>αg</td>
<td>microgram</td>
<td>Mistaken for “mg” (milligram) resulting in one thousand-fold overdose.</td>
<td>Use “mcg”.</td>
</tr>
<tr>
<td>Symbol</td>
<td>Intended Meaning</td>
<td>Potential Problem</td>
<td>Correction</td>
</tr>
<tr>
<td>@</td>
<td>at</td>
<td>Mistaken for “2” (two) or “5” (five).</td>
<td>Use “at”.</td>
</tr>
<tr>
<td>&gt;</td>
<td>Greater than</td>
<td>Mistaken for “7” (seven) or the letter “L”. Confused with each other.</td>
<td>Use “greater than”/“more than” or “less than”/“lower than”.</td>
</tr>
<tr>
<td>&lt;</td>
<td>Less than</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose Designation</td>
<td>Intended Meaning</td>
<td>Potential Problem</td>
<td>Correction</td>
</tr>
<tr>
<td>Trailing zero</td>
<td>X.0 mg</td>
<td>Decimal point is overlooked resulting in 10-fold dose error.</td>
<td>Never use a zero by itself after a decimal point. Use “X mg”.</td>
</tr>
<tr>
<td>Lack of leading zero</td>
<td>.X mg</td>
<td>Decimal point is overlooked resulting in 10-fold dose error.</td>
<td>Always use a zero before a decimal point. Use “0.X mg”.</td>
</tr>
</tbody>
</table>

Adapted from ISMP’s List of Error-Prone Abbreviations, Symbols, and Dose Designations 2006

Report actual and potential medication errors to ISMP Canada via the web at https://www.ismp-canada.org/err_report.htm or by calling 1-866-54-ISMPC. ISMP Canada guarantees confidentiality of information received and respects the reporter’s wishes as to the level of detail included in publications.

Permission is granted to reproduce material for internal communications with proper attribution. Download from: www.ismp-canada.org/dangerousabbreviations.htm
6.6 MINI-CLINICAL EXAMINATIONS

The Mini Clinical Examination or Mini CEX

- 10 – 20 minute exercise
- Designed to observe a trainee performing a specific task with a patient and then to provide immediate feedback to the trainee for the purpose of improvement in clinical skills
- Observer can be a faculty member, or a resident/fellow

Objectives

1. To observe a trainee performing the task.
2. To enhance the objective clinical evaluation method of a trainee.
3. To provide instant feedback for the benefit of a trainee.

Method

- Each trainee will be required to hand in a total of 5 Mini CEX forms by the designated due date
- The trainee may select the time/place/patient/observer and the evaluations can be performed at any stage through the rotation
- The Mini-CEX forms will not be factored into the overall clinical mark
- Each trainee is required to hand in one each of:
  1. Focused History
  2. Focused Physical Exam
  3. Focused normal Newborn examination.

* These are a must do requirement for the Year 3 Pediatric Clerkship
FOCUSED HISTORY Mini CEX – Year 3 Pediatric Clerkship – UBC Pediatrics

Student Name: ___________________________ Date: ___________________________

Clinical Problem: __________________________________________________________

Observer Name: ___________________________ Observer Signature: ___________________________

The important purpose of completing this Mini-CEX is for the student to be observed performing a focused history and providing feedback at the time of completing the task.

<table>
<thead>
<tr>
<th>Introduces self (identifying as Medical Student and role)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Begins with open ended questions</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Uses close ended questions when appropriate to clarify and to obtain additional details.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Directs questions to the child when appropriate</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Uses words that are easily understood (avoids medical jargon)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Listens attentively to patient / parent</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Takes history in logical organized fashion</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elicits salient information from patient/parent, no serious omissions required</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>At all times displays elements of professionalism, such as integrity, respect, compassion and empathy</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Closes interview appropriately: summary, parents concerns</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Overall Assessment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>PASS</th>
<th>FAIL</th>
</tr>
</thead>
</table>

One thing to improve: __________________________________________________________________________

One thing to change: __________________________________________________________________________

GRADING CRITERIA:

1 = Does not meet expectations * 3. = Meets expectations: Most students
2 = Requires improvement * 4 = Exceeds expectations (Exceptional student)

Note: * require comments.
The important purpose of completing this Mini-CEX is for the student to be observed performing a focused history and providing **FEEDBACK** at the time of completing the task.

<table>
<thead>
<tr>
<th>Task Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduces self (identifying as Medical Student and role)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriately positions, covers and respects the patient throughout the examination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At all times displays elements of professionalism, such as integrity, respect, compassion and empathy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is flexible in conducting the examination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washes hands</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments on vitals, growth parameters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carries out the appropriate elements of system examined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carries out examination maneuvers correctly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correctly comments on appropriate positive and negative findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall Assessment</strong></td>
<td>PASS</td>
<td>FAIL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**One thing to improve:**

____________________________________________________________________________________

**One thing to change:**

____________________________________________________________________________________

**GRADING CRITERIA:**

1 = Does not meet expectations * 3 = Meets expectations: Most students

2 = Requires improvement * 4 = Exceeds expectations (Exceptional student)

Note: * require comments.
MINI CLINICAL EXAMINATION

POWER POINT CASE PRESENTATION

STUDENT NAME: __________________________ DATE: ___________

CLINICAL CASE: __________________________

PRESENTED AT: __________________________

Student should be provided an assessment of their overall performance as indicated below. Guidelines for assessment are provided on the second page of this form. The written feedback provided to the student is the most important part of this assessment.

**Only the most exceptional presentations should be give an “exceeds expectations”.**

**GUIDELINES:**

1. Provides clear learning objectives at the beginning of the presentation     Yes ☐     No ☐

2. Quality of case presented

3. Information presented is accurate; demonstrates a depth of knowledge about the topic being presented

4. Limits the number of points per slide to 3 to 5; each point should be clear and concise; use of pictures and illustrations where appropriate

5. Presents in a timely and efficient manner

6. Clear, audible, and confident speaking style demonstrating the ability to engage and involve the audience

7. Summarizes case and brings closure, highlights take-home learning points, and provides references

8. Ability to answer questions

**OVERALL PERFORMANCE:**

<table>
<thead>
<tr>
<th>DOES NOT MEET EXPECTATIONS</th>
<th>REQUIRES IMPROVEMENT</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor / Faculty Name:</td>
<td>_____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preceptor / Faculty Signature:</td>
<td>_____________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student Signature: __________________________
6.7 Procedure Logs and Patient Encounters

**Procedure logs include**

1. MDI plus aero chamber inhalation
2. Measure newborns head circumference (HC), length (Lt), weight (Wt) and plot on appropriate charts
3. Measure other age groups HC, Height and Wt and plot on appropriate charts.
4. Newborn complete exam
5. Pediatric blood collection
6. Pediatric injections administer SC, IM, IV push agents, intradermal PPD
7. Pediatric intravenous insertion
8. Pediatric position oximeter attachment.
9. Pediatric vital signs – BP/P/RR.Temp (all ages)
10. Pediatric vital signs – newborn
11. Otoscope exam

**Patient encounters include**

1. Abdominal pain
2. Anticipatory guidance for all ages
   (newborn/infant/toddler/adolescent)
3. APNEA /ALTE
4. Behaviour disorder
5. Child Abuse
6. Dehydration
7. Developmental delay
8. Eczema
9. Failure to thrive
10. Febrile seizure
11. Fever
12. Headache
13. Hypotonic infant
14. Ingestion (acute)
15. Jaundice – neonatal
16. Lethargic infant
17. Obese
18. Otitis / pharyngitis
19. Respiratory distress
20. Urinary tract infection
21. Vomiting

(Patient encounter can be either a real patient or a simulated patient i.e. CLIPP case).
Progress Notes (SOAP Notes)

Remember, CHARTS ARE LEGAL DOCUMENTS; be careful what you write. Plans should be discussed with the resident or attending before writing in the chart.

Here are a few guidelines you should follow when writing in the chart:

1. Start your note immediately after the last note, so it will be in chronological order.
2. Make sure to write the date and time when note is written.
3. Add an addendum if the patient’s condition suddenly changes during your shift or if significant information becomes available which is relevant for patient care.
4. Do not leave blank lines in between text.
5. If you make a mistake, simply cross out the word with a single horizontal line, write “error” and initial it. Do not scribble out a mistake.
6. Always sign your notes after your printed name and include your pager number and ID number.

Progress notes for admitted patients should be written in a SOAP format.

- **S – Subjective**
- **O – Objective**
- **A – Assessment**
- **P – Plan**

**S (Subjective):**

- Information provided by parents / patients about their condition.
  - Get details of the symptoms the patient was admitted with and if symptoms have improved. Example: if the child was admitted with diarrhea – has he had any more loose stools, change in number of stools, colour etc.
  - Is the patient eating better. With an infant you might want to quantify the amount of milk / fluids taken as per mother.
  - Passing urine stools.
O (Objective):

- The information gathered from the physical examination and from the tests.
  - Begin with weight (if new weight available), vitals. If febrile, maximum temperature in last 24 hours.
  - Total input and output – especially in a child admitted with dehydration or with a renal problem. Also important in children not gaining adequate weight due to any reason.
  - Physical examination conducted on that day. Include all pertinent positives and negatives.
  - New laboratory results and other tests done with results i.e, renal ultrasound – normal. Also mention tests already done with pending results.

A (Assessment):

- Assessment of the patient – what you consider the problems with the patient, with the most relevant problem listed first.
- It is also the summary of how the patient is doing and what has changed from previous day.

P (Plan):

- Identify the plans for the patient according to each problem.
- Some people like to merge assessment and plan together.
- The most significant problem should be mentioned first.
- This section should include all the medications, lab tests to be ordered and to be followed, consults to be asked.
- It is very important to write the plan after the rounds as most of the decisions are made in the rounds.
6.9 Student Marks

Marks are based on 3 components:

1. Clinical 40%:
   - End of clerkship assessment scores – 100%
   - History and physical written assignment
   - One History Mini-CEX
   - One Physical Mini-CEX
   - One Newborn Mini-CEX

2. OSCE 25%:
   - Five station OSCE, which will include one history, one physical examination, one counseling session plus two other stations. These stations may be an x-ray, picture or critical thinking of information provided. You will not receive any feedback in any of the stations.
   b. You will have about 1 minute to read the question on the door.
      Then, you will have 10 minutes to complete the station; there will be a warning call to wrap-up at the 8 minute mark.
   c. The other stations which include x-rays, pictures etc, you will have 10 minutes for the station.
   d. You are expected to be appropriately dressed and have a white coat on. You are expected to bring your own stethoscope to the exam.
   e. Any other necessary equipment will be provided.

3. NBME 35%:
   a. One hundred multiple choice questions.
   b. Time allotted: two hours and fifty minutes to complete.
6.10 Useful Links & Recommended Textbooks

Useful Links
2. Pediatrics in Review – www.pedsinreview.org (can access it through UBC library website)
3. CLIPP cases – www.clippcases.org
5. Learn Pediatrics website – www.learnpediatrics.com webpage with physical examination videos done by local UBC faculty. The webpage has been developed by UBC residents and medical students.
6. LUMBAR PUNCTURE TECHNIQUE SPECIFIC FOR PEDIATRICS -- http://www.medicalvideos.us/videos-624-Pediatric-Lumbar-puncture


Recommended Textbooks
1. Nelson Essentials of Pediatrics
   – Richard Behrman/Robert M. Kliegman
2. Rudolph’s Fundamentals of Pediatrics
   – Abraham Rudolph/Robert Kamei/Kim Overby
3. Blue prints Pediatrics
   – Bradley Marino/Katie Fine/Julia Mcmillan
4. Pediatric Clerkship Guide
   – Jerold C. Woodhead
   (you will be assigned a copy of the Pediatric Clerkship on first day of your Pediatric rotation and it must be returned on the day of NBME)
5. NMS series - Pediatrics
   – Paul H. Dworkin/Paula Algranati
Welcome to your rotation on the Clinical Teaching Units! We hope that you will have a great experience. The information provided below is to help you settle in to the ward and to help ensure you have a positive learning experience.

The goals for your month are:

1. Recognize the clinical presentation and course of common pediatric conditions
2. Become comfortable caring for pediatric patients and their families
3. Learn history taking, physical examination, and communication skills
4. Learn how to make clinical decisions based on evidence
5. Function effectively in a team setting

The Wards

Patients admitted to CTU are admitted either to the Green Team or the Blue Team. Each team manages up to an average of 16 patients at any one time.

The Green Team will manage patients on 3M and 3F. In addition to General Pediatrics patients, the team will look after subspecialty patients from Infectious Disease, Gastroenterology, Nephrology, Endocrine and Metabolics.

The Blue Team will manage patients on 3M and 3R. In addition to General Pediatrics patients, the team will look after subspecialty patients from Cardiology, Hematology, Rheumatology, and Neurology. Usually there will be a maximum of two patients from each subspecialty service at any one time in order to promote a diversity of diagnoses.
The Teams

The teams are comprised of:

**Supervising Pediatrician:**
Patients will be admitted under either the Blue or Green Team supervising pediatrician. The supervising pediatrician’s role is to support the team. He or she will accompany ward rounds. They will provide bedside teaching. They will meet with the senior resident on a daily basis to review all patients. They will provide an evaluation for all the members of the team at the end of the rotation.

**Senior Resident:**
The senior resident (3rd or 4th year pediatric resident) is the team leader and must have a detailed knowledge of all patients on the service. The senior resident will run the ward rounds and will be responsible for arranging and supporting all academic rounds. The senior resident will be organizing all admissions to the team.

**Junior Resident:**
The junior resident (1st or 2nd year pediatric resident) – 2 to 3 per team – will be responsible for directly managing all patients on the team under the direction of the senior resident, supervising pediatrician. The junior residents each manage ~ 6-8 patients and co-manage these with the medical students. All patients admitted to the team will have an assigned junior resident.

**Medical Students:**
Each of you should carry ~ 4 patients. You are expected to co-manage your patients with the junior resident assigned to that patient. Please discuss all aspects of your patients’ care with the junior resident. If you receive information from investigations or consultants, please ensure this is communicated to the junior resident in a timely fashion.

**Your Role on the Team:**
You are a critical member of the team and very often the team member your patient and their family see the most.

**Morning Handover**

Handover is at 0730 sharp! Please be on time. All patients on the team should be assigned a medical student (except very complicated and chronic patients with multiple issues that are not acute). It is the responsibility of the medical students and junior residents to divide the patients amongst you evenly to ensure all patients are seen by a medical student every day. On occasion, one student may have more or less patients depending on the timing of discharges and admissions. Strive to maintain continuity with your patients that you have admitted.
Preparing for Rounds

There will be approximately 15-30 minutes of spare time between morning handover and the start of rounds. The time is variable depending on the duration of morning handover and rounds start time agreed upon by the CTU Senior/Attending. In the traditional inpatient rounding model, this was the time when medical students and residents would run around gathering information from nursing flow sheets and examining patients. In our new model (discussed below), this is no longer necessary, but should still be used to optimize patient care. This can be an excellent time for you to gather your thoughts and understanding of your patients, review details you may have forgotten and touch base with your junior residents about patients you’re co-following.

During this time, please also prepare the rounding cart and gathering the relevant rounding materials. This include: finding and inserting all of the team’s patient charts on to the cart; setting up the team’s iPad to view labs and imaging.

Ward Rounds

Rounds format will vary slightly depending on the preference of your team, but we are striving towards a common model of practice, described below:

- Ward rounds will start between 8:30-9:00am.
  - CTU Green typically starts on 3F and CTU Blue typically starts on 3M.
  - The general sequence of which patient to see is: ready for discharge > new/sick patients > stable/known patients
  - Your CTU Senior will provide more definitive directions as to which patient the team will see first.
- Rounds are done at the bedside and involve the family. A typical bedside round takes the following structure:
  - Junior resident/MSI taking care of patient: Presents patients history/reason for being in hospital
  - Review of vital signs and ins/outs from the nursing flow sheet.
  - Review of new investigations.
  - Junior resident/MSI taking care of patient: Relevant physical exam of patient.
  - Junior resident/MSI taking care of patient: Summary of issues and plans for the day.
  - Junior resident / MSI not taking care of patient writes down the orders and flags them for the nurse.

- **NOTES on Ward Rounds:**
  - This is an excellent learning experience in medical communication. Communicating information concisely and efficiently is a key skill in medicine and the resident’s will help you with this. New admissions need to be presented to the team in more detail than a patient known to the team but should not be presented word for word from your admission history and physical. On call you presented in detail to the resident you were working with. At morning rounds, your job is to present the pertinent aspects of the history and physical so that your team gets a good impression of the child you admitted and what the plan was. Again this takes practice but is a skill well worth learning.
Notes

You are responsible to write a complete history and physical note including your impression and plan for each patient you admit. You are also responsible for writing a progress note (SOAP format) on each of your patients. Do not write this note before morning rounds as plans often change during rounds and pertinent investigations and consults for the day are often not back. Do not write this note during morning rounds as this is the time for learning from other patients. Notes should be written by 1500 to ensure that the junior resident’s have a chance to review your note and make any amendments they see fit. On straight forward patients, junior residents may co-sign your note. On complex patients, junior residents may write an additional note. Please remember that medical documentation is an extremely important part of our jobs. Make sure your notes are clear, legible and being co-signed. Friday notes should detail the plan for the weekend. As a courtesy to the on- call team, who does not know your patient, all anticipated weekend discharges should have discharge paperwork and plans completed by Friday.

Orders

You may and should write orders in the chart. Please make sure your orders are written according to safe prescribing hospital practice (see back of order sheet for details). Ensure your order is checked and co-signed by a resident. X-rays ordered need to be ordered on the blue order pages and have a yellow radiology requisition filled out. Consults ordered need to be ordered on the blue order pages and have a pink edged consult requisition filled out. On your consult, make your question to the consulting service clear and include your name and pager number. Either yourself or the junior resident will call the consulting service. If you call the service and discuss the consult, please document on the requisition that the service is aware.

Discharge Summaries /Dictations

Each patient discharged from the ward has a sheet filled out which briefly summarizes their hospital stay. This is your responsibility. As most discharges are anticipated the day before, strive to have your patient’s discharge paperwork ready the night before to aid in a quick discharge in the morning. This is extremely helpful for bed issues in the hospital. You are not responsible for dictated summaries. These are the responsibility of the junior resident. We are a large institution and it is important that we effectively communicate with the medical community following our patients outside of the hospital. Family physicians/ Pediatricians who regularly follow the children we have admitted should be called to be made aware of the admission and the discharge plan.
**Evening Handover**

Evening handover is at 1800 every day except Friday when it is at 1700. This is meant to highlight to the covering team who your patient is and what issues they might expect to have arise overnight. Ensure the patient list is updated to reflect current patient status and any concerns. If you have completed your work you are not required to stay till handover, it will be a good idea to stay couple of times during your rotation to learn how to handover patients.

**Admissions**

The majority of children admitted to the CTU will present initially to the ER. The pediatric ER physician generally decides if a child requires admission and will contact the senior resident. On occasions, patients may be transferred directly from the PICU, another ward, or another hospital. The senior resident is responsible for the initial evaluation and when required may write holding orders before a complete assessment is undertaken. The senior resident will call either you or a junior resident to take a full history and physical. You will be responsible to present your admission to the junior or senior resident. The plan will be reviewed and teaching around the case will be done. If at any time during your admission, you are worried about your patient’s status, please call the senior resident immediately.

**Call**

When on call you will be first call on the ward for issues with your team’s patients and you will be called by the senior resident to participate in admissions from the ER. Please answer your pager promptly. All ward calls must be discussed with the junior resident with whom you are on call. If the situation permits, you are expected to attend to the ward first, assess the situation, come up with a plan and then call the junior resident to review the call. If the situation seems urgent, page the junior resident to attend with you. The resident’s are always happy to hear about ward issues that you have been called about and it is important for safety and continuity that they are made aware of all calls.
**Teaching Rounds**

Bedside teaching will be arranged by the supervising pediatrician or the teaching fellow. You will receive an email letting you know when you are scheduled.

**Monday**

- **0730** Morning Handover
- **0900** Ward Rounds
- **1400** Nephrology Teaching 3M Conference Room
- **1800** Evening Handover

**Tuesday**

- **0730** Morning Handover
- **0900** Ward Rounds
- **1230-1600** Resident Academic Half Day (3D16) (students to report to attending for admissions/ward concerns)
- **1800** Evening Handover

**Wednesday**

- **0730** Morning Handover
- **0745-0815** Resident Morning Report
- **0900** Ward Rounds
- **1600** Subspecialty teaching
- **1800** Evening handover

**Thursday**

- **0730** Morning Handover
- **1130-1200** Cardiology Teaching Rounds (Blue Team)
- **1030** Nephrology Teaching Rounds (Green Team) (3F Conference Rm)
- **1230-1600** Medical Student Academic Half Day (3D16) (CTUMSI’s to return to ward at 1600)
- **1800** Evening Handover
Friday

0730    Morning Handover
0830-0930 Grand Rounds (Chan Center)
0930    Ward Rounds
1200-1300 Advances in Pediatrics (3D16, lunch provided)
1700    Evening Handover

Saturday, Sunday, Holidays

0845    Morning Handover (post-call team to assist in morning rounds)

Frequently Asked Questions:

1. How do I find out what medications my patient is on or when they receive their medications?

   The best place to find that info is on the MAR (medical administration record). Each nurse will have their own clipboard containing the MAR for the patients they are following that day. The nurse for each patient changes each shift, but is always listed on the white board. These clipboards are usually located in the med room and contain information regarding which medications, what dose and when. It’s a great place to find out whether or not your asthmatic patient needs the prn Ventolin’s you ordered and when they last received a Ventolin.

2. Where do I sleep when I am on call?

   The call rooms are located in the back of the Resident Lounge on the 2nd floor of the Children’s building. You can access the lounge with your ID badge. The rooms are assigned – please refer to the Undergraduate Coordinator for access codes. Lockers will be located here. Please don’t leave valuables unattended here!

   Please make sure to close the door properly, thefts have occurred previously. Safety is everyone’s responsibility.

3. How do I use the phone?

   - Calling within the hospital: dial the 4-digit local number
   - Calling outside the hospital: dial 9 first
   - Paging: dial 410 followed by the 4-digit pager number, enter the 4-digit local of the phone you are at and wait for your call to be returned. Do not use the telephone you paged someone to as the person answering the page will get a busy signal.
• Calling long distance: ask the unit clerk for a “special” number

• Hospital Paging: 2161, you can ask them for any local or to page someone directly

• Faxing: ask the unit clerk

Questions:

Dr. Mumtaz Virji
Undergraduate Program Director
Pager # 604-877-2813
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* Developmental Rounds third Thursday each month
Since July 2009, Pediatric residents have been covering CTU call schedule with a night float system. This means that 1 team covers Day shifts (7am-7pm) and another team covers nights. The feedback from the residents have been very positive so far, resulting in improved continuity of care of the patients, increased patient safety and a better learning opportunity for residents. Residents are being able to attend all daily/weekly teaching rounds and this means the whole team is present on the ward and available throughout the week.

Starting April 2010, medical students doing CTU at BCCH will be adopting the night float system. The purpose is to provide similar positive effects as with the residents found. The plan is for students to have 5 night calls, one Saturday 24 hours call and one Sunday day call. Due to orientation and exams it will not be possible to have all students do the above; there will be some adjustments for a couple of students per rotation.

Details:
1. Handover times 18:00 – 07:30, Sunday night through Thursday night (same as residents).
2. CTU night team responsibilities include:
   a. To shadow the residents and work alongside with them.
   b. Admissions overnight
   c. Active management of patients overnight (with residents) with appropriate documentation in patients’ charts reflecting this management.
   d. Preparation of discharge instructions and prescriptions
3. Students doing night float must get an evaluation form filled out by their senior resident (the one they work most with, in most cases that is 5 nights).
4. At any time when dealing with a problem, if you are unsure or concerned about the patient, page the resident immediately. Always inform the resident of any problems – small or big.

This is a big change, the clerkship director (Dr. Mumtaz Virji) will closely monitor this new model and would appreciate any feedback the students have. You will be receiving a survey form at the end of your CTU rotation; this will help us make the final decision about night float (remember this is work in progress).

If you have any concerns at anytime, please feel free to contact Dr. Mumtaz Virji, her email address is mvirji2@cw.bc.ca

September 2013