



**DEPARTMENT OF PEDIATRICS
RESIDENCY PROGRAM
POLICY AND PROCEDURE MANUAL
July 2011**

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

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

PL-1 Year

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

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

PL-2 Year

The goals of the PL-2 year are to:

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

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PL-3 Year

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

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

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

ADMINISTRATION

1. **PHOTOLIBRARY SERVICES** - Photo library services are only for journals that cannot be checked out of the library or found online; please do not take in outside projects or books that can be checked out and copied on the Pediatric Department machine.
2. **MAILBOXES** - Please empty your mailbox at least once a week, more often, if possible. Because of the limited space in the individual mailboxes, they become "overstuffed" and important mail may be wrinkled or folded in the attempt to place more mail in the box. Large packages or boxes will be given to the Pediatric Housestaff office for you to pick up at your convenience.
3. **EMAIL** – Email **MUST** be checked on a regular basis, i.e. not less than once per day.
4. **EQUIPMENT** – The Housestaff Office (Room 3335) has a computer, printer, copier and fax machine available for resident use during regular office hours. There is a large copier/scanner for large copy jobs in the near the service elevators on the third floor; each resident has an individual code for use with this copier. Please see the housestaff office for your code.

SUPERVISION POLICY OF PEDIATRIC RESIDENTS

Ultimately, the patient's attending physician is responsible for ensuring patient safety and quality patient care. Qualified attending physicians are assigned supervisory responsibility for all residents at all times when a resident is on duty. The insurance of qualified faculty is based on appropriate training, and board certification as well as appropriate clinical credentials and privileges.

Attending physicians must understand the importance of enabling the resident to take responsibility for "first decision" making prior to faculty involvement. First decision making by the resident will aid in the maturation of each resident whereas "final decision" making after involvement is the province of the faculty.

All supervising attending physicians are required to be familiar with program specific levels of responsibility and teach residents according to the level that is commensurate with training, education, and demonstrated skill. In addition, the level of supervision for each patient encounter should be individualized based on the critical nature of each patient and the ability and experience of the resident involved.

As per the ACGME requirements, supervision is defined by the following four categories:

Direct Supervision – The supervising physician is physically present with the resident and patient.

Indirect Supervision with direct supervision immediately available – The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide Direct Supervision.

Indirect Supervision with direct supervision available – The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via phone, and is available to provide Direct Supervision.

Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

PGY-1 residents in all clinical settings, including nights and weekends, will be directly supervised or indirectly supervised with direct supervision immediately available. This supervision will be provided by the attending physician in charge of that patient, a senior pediatric resident (PGY2, PGY3), or, in the case of the NICU, a qualified Neonatal Nurse Practitioner (NNP).

PGY-2 residents, for the majority of their clinical experiences, including nights and weekends, will be directly supervised or indirectly supervised with direct supervision immediately available. This supervision will be provided by the attending physician in charge of that patient, a senior pediatric resident (PGY3), or, in the case of the NICU, a qualified Neonatal Nurse Practitioner (NNP). There may be times during nights and weekends in an inpatient or ICU setting, at the discretion of the attending physician, that the PGY-2 receives indirect supervision with direct supervision available.

PGY-3 residents are supervised in a similar fashion to PGY-2 residents, except indirect supervision may be more frequently utilized during their nights and weekends than for a PGY-2.

The following situations, regardless of supervision level, will necessitate immediate communication with and direct supervision of the appropriate attending:

- Transfer of a patient to an ICU setting
- End of life decisions
- Any patient leaving against medical advice (AMA)

The level of supervision of significant procedures by residents will be determined by the attending physician, but will include at a minimum, all key portions of the procedure. During non-supervised portions of the procedure, the faculty member remains available for consultation and/or return to the operating room.

On-call schedules for attending staff will be easily accessible either on-line or through the hospital switchboard.

All members of the healthcare team (attendings, residents, students, nurses, ancillary staff) are expected to wear identification badges displaying their name and respective role. In addition, team members will introduce themselves and their respective role to the patient/family.

Residents are evaluated in their ability to provide supervision in a number of ways:

- a) Daily family-centered rounds, which are led by PGY-2 and PGY-3 residents, occur on all inpatient units. The attending physician is present during these rounds and provides a real-time monitoring of the residents' performances.
- b) Attending faculty complete written evaluations of residents on every rotation. Residents also formally evaluate each other during their rotations. Evaluations for senior residents' include their supervision performance.
- c) All resident documentation, in both the inpatient and outpatients setting, is reviewed daily by the attending. When necessary, immediate feedback is given to the resident by the attending.
- d) Morning Report, which occurs at both Diamond Children's Medical Center and Tucson Medical Center three times per week, provides the opportunity for residents and faculty to discuss new inpatient admissions and problems patients.
- e) Documentation of clinical skills is also assessed by interaction with residents over specific patients, during subspecialty consultations and during problem patient conferences.

This policy is as stated in the Supervision Policy of the Graduate Medical Education Policy and Procedure Manual.

PROMOTION AND ADVANCEMENT POLICY

Promotion and advancement is discussed in Promotion Committee meetings held twice per academic year.

PL-1

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

PL-2

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

PL-3

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

All pediatric resident promotions are in compliance with the UA GME resident promotion policy.

DUTY HOURS AND THE LEARNING AND WORKING ENVIRONMENT POLICY

The Pediatric Residency Program is committed to promoting patient safety and resident well-being in a supportive educational environment. This duty hour policy is based on upon both a solid educational rationale and patient need that includes continuity of care. This policy recognizes that educational goals must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. In addition, it is important to ensure that residents are provided backup support when patient care responsibilities are difficult or prolonged. The following policy outlines the procedures to be used by the Pediatric Residency Program.

- a. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and moonlighting.
- c. Duty periods of PGY 1 pediatric residents must not exceed 16 hours in duration.
- d. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties. At-home call cannot be assigned on these days.
- e. Duty periods of PGY 2 pediatric residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. Adequate sleep facilities will be provided to resident when needed.
 1. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
 2. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
 3. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
 - a. Under those circumstances, the resident must:
 1. appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

2. document, IN WRITING, the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- b. The Pediatric Program Director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
- f. All residents should have 10 hours free of duty between scheduled duty periods. Any exception to this must be documented and the program director notified. Any PGY-2 or PGY-3 resident must have at least 14 hours free of duty after 24 hours of in-house duty.

On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

- a. Residents must not be scheduled for more than 6 consecutive nights of night float.
- b. PGY 2 and PGY 3 residents must be scheduled no more frequently than every third night, for in-house call, averaged over a 4-week period.
- c. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
 - i. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
 - ii. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

Moonlighting

- a. The program director must ensure that moonlighting does not interfere with the residents' learning objectives
- b. Moonlighting, either internal or external, must be counted toward the 80-hour weekly limit on duty hours

Oversight

- a. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service
- b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged
- c. The Chief Residents and Residency Coordinator in the Pediatric Housestaff Office must be informed in advance of any major changes in the call schedule and/or master schedule.

Residents must record duty hours during ALL inpatient and ICU rotations and at least quarterly for all other rotations (as directed by the Housestaff Office). In addition, any duty hour violations must be reported to the Program Director and/or Coordinator immediately.

EXTENSION OF DUTY BEYOND SCHEDULED SHIFT POLICY

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

- a. Under those circumstances, the resident must:
 1. appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
 2. document, IN WRITING, the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- b. The Pediatric Program Director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

QUALITY ASSURANCE AND IMPROVEMENT POLICY

PURPOSE:

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

POLICY:

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

PROCEDURE

1. **Medical Records**

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

2. **Morbidity and Mortality**

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

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

RESIDENT SELECTION POLICY

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

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

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

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

GRADUATED RESPONSIBILITY AND SUPERVISION OF RESIDENTS IN AMBULATORY GENERAL PEDIATRICS

- 1) Residents with 0 to 6 months of training should work with close supervision by the ambulatory attending including thorough discussion and patient examination.
- 2) Residents with 7 to 18 months of training must discuss all patients with the supervising ambulatory attending.
- 3) Residents with greater than 18 months of training should discuss all patients with the supervising ambulatory attending until the attending feels the resident is able to work with increased responsibilities. Then the resident may work independently depending on the type of patient and at the discretion of the attending.
- 4) PL-3s have the added responsibility of teaching and supervising medical students and residents.

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

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

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

CONTINUITY CLINIC GUIDELINES

1. The role of the Continuity Clinics is to provide the resident-physicians an opportunity to develop and maintain long term care relations with a comprehensive group of patients. It is expected that the resident will carry the responsibility of providing primary care for the patients in their Continuity Clinic. This will include:
 - a. providing all routine primary care services
 - b. reviewing the acute primary care services provided by others when the resident-physician is not available
 - c. determining what secondary care services are indicated
 - d. arranging for and coordinating secondary care services
2. Residents are to remember that, except for the situations noted below, that their PRIMARY RESPONSIBILITY ON THE HALF DAY(S) OF THEIR CONTINUITY CLINIC IS TO THE PATIENTS IN THAT CLINIC.
3. Continuity Clinic Scheduling:
 - a. Objective: To have as much continuity as possible in clinic, while adhering to the ACGME requirement.
 - b. Plan
 1. The Day Float resident's Continuity Clinic will be scheduled by the Chief Resident and day/time may vary.
 2. Continuity Clinic for the night residents can be cancelled. If the resident has or plans to cancel other clinics to accommodate away electives, the month clinics may need to be preserved; this will be handled on a resident-by-resident basis based on their individual tally of cancelled clinics.
 3. The Chief residents will provide the call schedule at least 3 months in advance to each of the continuity clinic sites so that the resident clinic schedule can be changed accordingly. The Chief residents may cancel/change (post-call) continuity clinics.
4. The minimum number of patients to be seen (per RRC guidelines) during each clinic:
 - PL-1: 3
 - PL-2: 4
 - PL-3: 5
5. Residents in Continuity Clinic are to see general pediatric clinic patients whenever possible (before, between and after seeing their own patients).
6. Residents must attend a minimum of 36 continuity clinic sessions per year for Pediatric residents and 18 for combined EM/Pediatric resident during each year of residency.
7. Residents will be expected to complete 80% of online modules. A passing score of 80% is required to pass modules.

CODES AND STAT CALLS

FOR CODE CALLS

1. When CODE BLUE is called, there is no distinction between a pediatric and adult code. Therefore, the Pediatric Resident hearing the CODE Beeper must respond to all CODE 5000s.
3. The response CODE cart has both adult and pediatric equipment.
4. Request for the emergency cardiopulmonary resuscitation team can be made by dialing 4-5000, telling the operator "CODE BLUE", and giving the location.

CONFERENCES

Teaching day attendance is mandatory for all housestaff with the exception of those on vacation, ED (if shift ends later than midnight the night prior), or on a night shift. Chief residents will have the final approval of whether any other absence is excused or not. Repercussions of an unexcused absence from teaching session will be as follows:

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

1. Each resident will give talks as follows:

PL2 and Combined PGY 3	PL-3	Combined PGY 4	Combined PGY 5
Problem Patient Talk	Problem Patient Talk, CPC or Topic Talk (as chosen by the resident and approved by the Program Director)	CPC or Topic Talk	Problem Patient Talk

A title must be provided for the monthly departmental conference calendar no later than the 20th day of the month prior. Resident must work with a faculty member in the section pertaining to the topic.

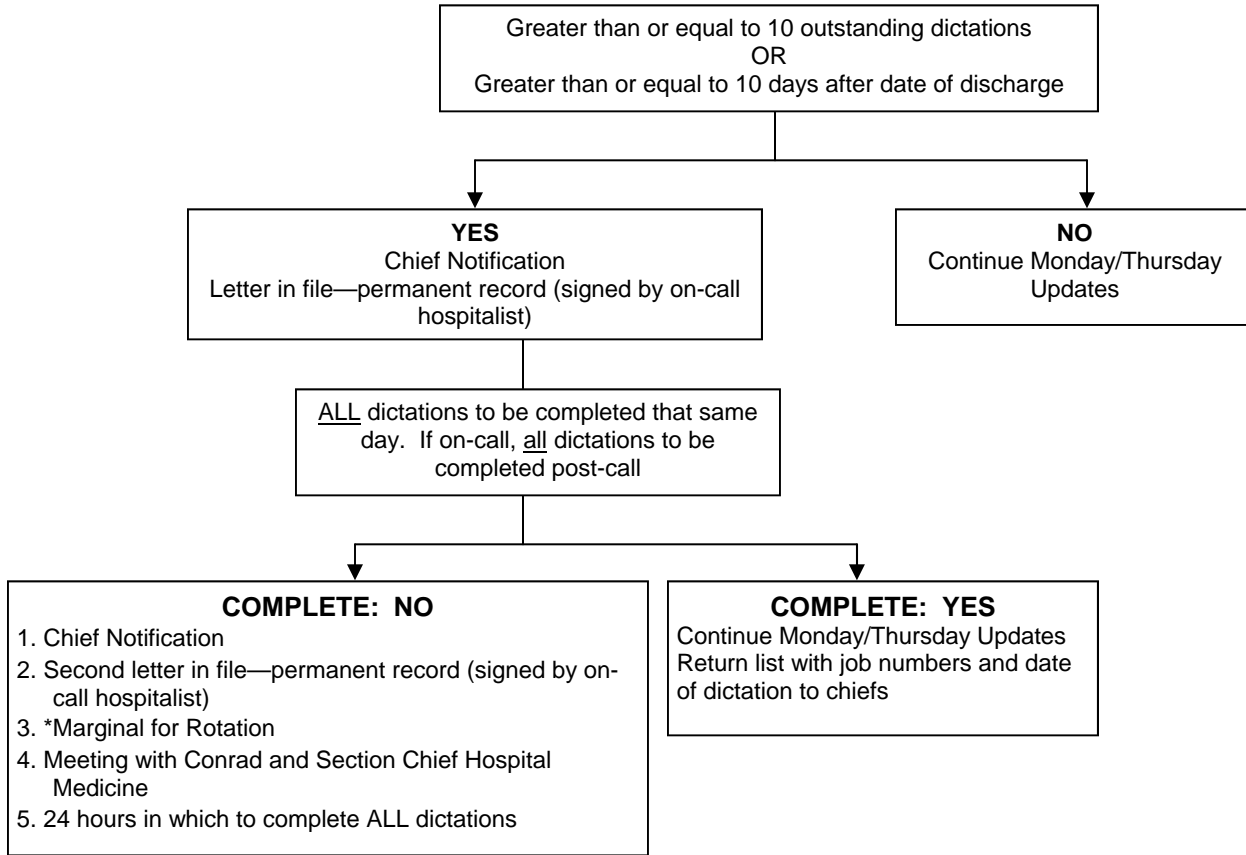
2. Journal Clubs:

- a. The resident journal club is held once per block during teaching day. Each level will have a separate conference, with the following resident leading the presentation:
 - PL1 on nursery rotation
 - PL2 on clinic rotation
 - PL3 on clinic rotation

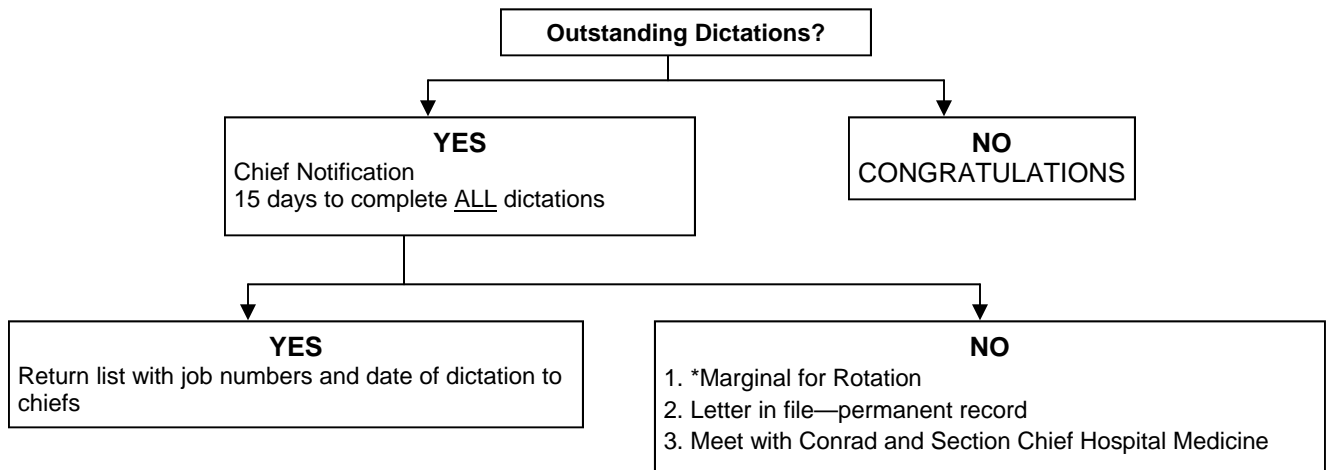
Journal club curriculum is available on the Program's website as well as on New Innovations.

**PEDIATRIC DISCHARGE SUMMARY POLICY
DICTATION POLICY**

Monday	→	†List of dictations due by intern given to intern by admitting hospitalist
Thursday	→	List of dictations due by intern given to intern by admitting hospitalist



**PEDIATRIC DISCHARGE SUMMARY POLICY
END OF INPATIENT ROTATION**



Marginal: Converts to pass if pass subsequent rotation
 Converts to fail if receive <pass on subsequent rotation

Form letters: 2 form letters in file or marginal for rotation
 Meeting with Conrad and Section Chief Hospital medicine

ELECTIVES

- (a) Excluding the adolescent medicine, developmental/behavioral, and intensive care experiences (both NICU and PICU), residents must commit to at least seven months in subspecialty rotations, four of which must be taken at the primary teaching site and/or integrated hospitals.
- (b) Within these seven months, each resident must complete a minimum of four different one-month block rotations taken from the following list of pediatric subspecialties or closely allied specialties:

Allergy/Immunology

Cardiology

Endocrinology

Genetics

Gastroenterology

Hematology/Oncology

Infectious Diseases

Nephrology

Neurology

Pulmonary

Rheumatology

- (c) For the four required block months in different subspecialties from the above list, the inpatient/outpatient mix should reflect the standard of practice for the subspecialty.
- (d) The additional three months may consist of single subspecialties or combinations of specialties from either the list above or the list below. Combinations of subspecialties may be structured as block or longitudinal experiences and, where appropriate, may be combinations of inpatient and outpatient experiences or all outpatient.

Pediatric Anesthesiology

Child Psychiatry

Pediatric Dermatology

Pediatric Ophthalmology

Pediatric Orthopaedics and Sports Medicine

Pediatric Otolaryngology

Pediatric Radiology

Pediatric Surgery

Pediatric Physical Medicine and Rehabilitation

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

(f) Elective Experiences

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

1. Electives offered by this program include:

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

THE CURRICULUM OUTLINES FOR ELECTIVES ARE AVAILABLE ON THE PROGRAM'S WEBSITE.

Reading Elective must be approved by the Program Director and goals and objectives specified prior to the rotation.

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

2. Participation in the International Health elective and in electives not listed above must be approved by the Program Director at least six months in advance. The elective goals, syllabus, bibliography and preceptor/evaluator must be provided.
3. Each senior resident will arrange electives, after discussion with faculty advisor, with the appropriate specialty and notify the Housestaff Office of the elective choices. Discussion with the Program Director is also encouraged.
4. **Residents must have electives set up in advance and must inform the Program Director and Coordinator by date to be determined by Housestaff Office. After that time, the Program Director will assign an elective for that resident. If a resident wishes to change his/her scheduled elective, it must be done at least two months prior to the start of the elective. No changes in elective will be permissible if the elective has been assigned by the Program Director.**
5. Only one call-free elective is guaranteed per year. The call-free electives MAY NOT be "banked" and/or used in any year other than that originally scheduled.
6. With the exception of those who are doing an away elective, **residents on call free elective MUST attend teaching day and may NOT cancel continuity clinics.**

7. Some sections only have one faculty member. If the faculty member is out of town or unavailable during part of your elective, you are required to arrange for an assignment which is to be completed during that faculty member's absence.
8. The Department's position regarding "away" electives is as follows:
 - a. Generally, away electives will be approved if the elective sought is either (1) not available or not acceptable in our program or (2) other unique circumstances as approved by the Program Director.
 - b. All away electives must be approved in writing by the Pediatric Residency Director.
 - c. A houseofficer may take an away elective only during a Call Free month.
 - d. Residents doing a reading elective or an away elective must give a thirty minute talk at teaching day pertaining to what they learned.

PROCEDURE FOR RESIDENT WISHING TO TAKE AN "AWAY" ELECTIVE

- a. A Resident requesting an away elective will present the request to the Pediatric Program Director for review and approval.

A houseofficer may take an away elective only during a Call Free month.
- b. The Pediatric Housestaff Office **must** receive adequate prior notification (minimum four months for electives in the United States) so that the AHSC Contracting Office is able to confirm that a contract is in place for that elective location. For international health electives, it takes many months to arrange a contract and the resident cannot begin his/her away elective until the Affiliation Agreement is completed; therefore, six months' notice is required for international electives.
 1. Resident is responsible for contacting the site at which they wish to rotate. Approval must be obtained from site supervisor and sent directly to Housestaff Program Coordinator.
 2. The following documentation must be provided to Housestaff Program Coordinator no later than three months prior to start date for in-country rotations and at least six months prior for international electives:
 - a. An Outside Rotation Request form (available from Program Coordinator)
 - b. Written permission from Site Supervisor. Must include resident's name, the dates of the rotation, and the name of the rotation.
 - c. Goals and objectives for the rotation (Program Director must be consulted when writing goals and objectives)
 - d. Travel authorization paperwork must be completed with the Housestaff Office no later than 30 days prior to travel.
- c. The Department will reimburse a maximum of \$750.00 toward away elective expenses, plus an additional \$300.00 for an International Health elective. ***This reimbursement will only be provided if all of the above procedures are followed.*** This funding may only be used once during the three-year residency.
- d. The American Academy of Pediatrics Resident Section awards annual scholarships for resident international travel. Applications are encouraged.

EMERGENCY MEDICINE ROTATION

I) OBJECTIVES

1. Demonstrate efficient, thorough history taking skills on critical and non-critical emergency department patients presenting with any illness or injury.
2. Demonstrate physical examination skills in the evaluation of critical and non-critical patients presenting in the emergency department.
3. Demonstrate the ability to identify any life or limb threat.
4. Demonstrate the ability to formulate a differential diagnosis based upon present symptoms and signs.
5. Demonstrate the ability to consider the differential diagnosis from the most serious pathology to the least.
6. Demonstrate the ability to ask, "What is the difference now causing the patient to seek medical attention at this time" rather than earlier or later.
7. View the experience from the patient's perspective. Learn to identify the patient's expectations.
8. Demonstrate the ability to consider alternative or additional diagnoses.
9. Demonstrate the ability to order and interpret appropriate ancillary studies such as lab tests or radiographs simultaneously and as early as possible in the workup of a patient.
10. Demonstrate the ability to institute appropriate therapy.
11. Demonstrate the ability to make decisions concerning the need for patient hospitalization.
12. Demonstrate the ability to obtain adequate patient disposition.
13. Demonstrate the ability to maintain readable, thorough, and complete medical records.
14. Learn the resources available in the emergency department - sexual assault support, alcoholic detoxification centers, social services, and the Regional Poison Center.
15. Learn to develop instant rapport with patients utilizing effective verbal and nonverbal communication skills.
16. Demonstrate procedural skills, including but not limited to anoscopy, arterial puncture, arthrocentesis, minor burn treatment, gastric tube placement, incision and drainage, lumbar puncture, laceration repair, nail excision, nasal packing, peripheral intravenous catheters, and basic wound care.
17. Develop a history and physical examination approach, a working knowledge database, a diagnostic approach, and an initial therapeutic approach to patients presenting with illness or injury as described under the curriculum headings of anesthesia, cardiology, critical care, dermatology, emergency medical services, environmental illness, ethics, general medicine, general surgery, neurology, neurosurgery, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, psychiatry, toxicology, trauma, urology, and wound management.

II) DESCRIPTION OF CLINICAL EXPERIENCE

1. Residents will work eighteen 9-hour shifts throughout the four week block. Eight hours of the shift will be spent picking up new patients. The final one hour of the shift is reserved for charting.

2. For any given shift, residents will sign up for patients in the order they are triaged to their rooms. Any concerns regarding the care of critical patients should be discussed with the attending as early as possible in the patients care.
3. Residents will be the primary caregivers for critical and non-critical patients within the emergency department, and will assist the attending in the management of critical care patients.
4. Residents will be closely supervised. Specifically, they are required to present and review every step of patient care directly to the attending on duty.
5. Residents will perform the initial history and physical examination of critical and non-critical patients, and initiate ancillary studies.
6. Residents will provide needed therapy at the direction of the attending on duty.

III) DESCRIPTION OF DIDACTIC EXPERIENCE

1. The Department of Emergency Medicine based didactic sessions will be conducted on Tuesdays from 0800-1200.
2. Informal lectures will be conducted in the Emergency Department every morning at 0800 by the pediatric emergency care attending. Clinical and bedside teaching will also occur on a case basis.

IV) EVALUATION PROCESS

1. Evaluations will be completed as determined by the department of Pediatric residency program. Feedback forms will be completed by staffing faculty for each resident at the completion of the rotation. Specific areas such as rapport with patients and physicians, integrity, initiative, technical skills, basic medical knowledge, histories and physical examinations" completion of medical records and communication skills will be numerically assessed and recorded. Specific comments made by faculty will be recorded as well.
2. The rotating resident will be allowed to anonymously evaluate any faculty member and staff member. This feedback will be reviewed by the program director and clinical directors in order to improve the rotation and resident experience.

V) FEEDBACK

2. Residents will have informal feedback midway through the block and formal feedback at the end of the block.
3. More frequent evaluation and feedback will be done as needed on an individual basis. Residents performing well will be commended and residents not performing well will be approached during the emergency department rotation for evaluation and feedback.

REQUIRED EVALUATIONS

1. Evaluations are completed by housestaff and faculty at the end of each rotation on the New Innovations® web site. This is accessed at www.new-innov.com/suite. Housestaff complete evaluations on the rotation, faculty and housestaff worked with during the month. All evaluations completed by the residents are completely confidential. Evaluations are available on-line and are to be completed within ten (10) days of the completion of the rotation.
2. All faculty evaluation comments are strictly confidential. A compilation of all scores and comments will be given to each faculty member and the Department Chairman every 12 months without any identification of the respondents.

FLOATING HOLIDAYS

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

VACATION POLICY

1. Each Houseofficer is entitled to 22 working days of paid vacation per year.
2. Vacation blocks are set for the academic year as the first two weeks or last 2 weeks of each block. These dates may not be changed.
3. The Chief Resident will allocate vacation time in accordance with service and individual needs.
4. Vacation time cannot be saved from year to year, nor can it be used prospectively.

PATIENT CARE PROTOCOL

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

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

ADMISSIONS TO DCMC PEDIATRIC FLOOR

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

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

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

ADMISSIONS TO TMC PEDIATRIC FLOOR

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

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

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

ADMISSIONS TO DCMC OR TMC PICU

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

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

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

NOTE: Insurance may dictate which attending to call.

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ADMISSIONS CAP PROTOCOL

CAP MAY CHANGE. PLEASE REFER TO INDIVIDUAL ROTATION POLICY.

TMC Wards

Floor + PICU if floor/special care

Team max: 30

Intern admit: 10

Redistribute in AM at 12

Senior admit: 15

Up to 5 may be transferred off between 4-5 pm

Private attendings may use hospitalists

2 active consults per senior

TMC PICU

ICU only

Team max: 12

DCMC Wards

Diamond 5 (D5) and Diamond 6W (D6W)

Team max: 40

Intern admit: 10

Redistribute in AM at 12

Senior admit: 15 in a 24-hour period and 10 in a 12-hour period

Consults: 2/senior

Transfer off resident service only in rounds

Private attendings may use hospitalists

DCMC PICU

D6N, ICU only

Team max: 24 daytime, 16 nighttime

DCMC NICU

D4N only

Team max: 30

Nursery

Team max: 20

Department of Pediatrics

Arizona Health Sciences Center

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SENIOR NIGHT FLOAT & NIGHT HAWK EXPECTATIONS

Hours: Weekday signout times: 6AM and 5PM
Weekend signout times: 7AM and 7PM

It is imperative that the night float resident be viewed as an integral part of the ward team aiding with the efficiency of rounds, discharges and patient care. Since these shifts are significantly shorter than a 24-30 hour call it is expected that the night float senior & Night Hawk should use their time to contribute to the team. Several expectations are listed below:

1. During PM signout, determine which patients will likely be discharged in the morning and ensure that the patient is ready to go for AM discharge (backsheet completed and ready to finalize, prescriptions signed). The night attending and night float senior should also review the patient list for possible discharges.
2. *Admission:*
 - a. Night Float: actively work with on-call intern to complete admissions (which you alternate with the Night Hawk), and to provide supervision and education.
 - b. Night Hawk: actively work with on-call intern to complete admissions (which you alternate with the Night Float), and to provide supervision and education.
 - c. **Attending must be notified of all admissions and significant events.**
3. *Teams:*
 - a. Night Float: Follow Blue teams patients (except when Blue team seniors is on call, then you follow Red team)
 - b. Night Hawk: Follow Red & H/O patients (except when Red team seniors is on call, then you follow Blue team)
4. Distribute admissions among interns to ensure that each team has a balanced number of patients.
5. Performing nightly walk rounds, which include examining sick patients, updating parents and answering nursing staff questions.
6. Update medications, IVF, respiratory status, labs, etc. on excel sign out sheet.
7. Every night, update Short Stay forms and backsheets. The day teams appreciate this service, since they are often busy.
8. Prior to AM signout:
 - **collect morning labs and vital signs for each patient.** Note these values on the signout sheet that will be given to the daytime seniors.
 - communicate with nurses regarding last minute overnight issues and questions.
 - update the team lists on the dry erase board in the lounge to let daytime attendings and pharmacists know which patients are on the red and blue teams.

Duties may change dependent on the needs of the Pediatric wards.

POLICY RE: PEDIATRIC PATIENTS HOUSED OFF THE PEDIATRIC WARDS

TMC Wards

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

DCMC PICU RESIDENTS' JOB DESCRIPTION

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

General Responsibilities of the 2nd Year PICU Resident:

PATIENT CARE

1. The PICU resident is responsible for admitting and managing the team maximum number of patients.
2. A single resident admission note will outline the history, physical findings, laboratory and radiologic results, an initial assessment and initial plans.
3. Orders will be written by the PICU resident.
4. The Discharge Summary, Off Service note or Transfer Summary is the responsibility of the resident.

CONSULTS/CO-MANAGEMENT

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

ROUNDS

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

TRANSPORTS

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

PICU Night Resident (PL3)

1. The 3rd year PICU Mole is responsible for the care of all pediatric patients in the PICU during their appointed shift.

NIGHTTIME JEOPARDY CALL

1. Jeopardy should be reserved for acute significant illness or family emergency.
2. PL-2s and PL-3s cover all jeopardy for senior residents. The jeopardy resident is on 24-hour call. The mommy call PL-1 may be jeopardized for fellow PL-1.
3. Jeopardy call will be the responsibility of the residents in the general call pool for the month.
4. The resident unable to take call is to determine as early in the day as possible if there is a need to jeopardize someone. This allows for all involved to make appropriate arrangements.
5. The resident unable to take call must contact the resident on jeopardy call directly and then notify the chief resident of the arrangements they have made. The Housestaff office will be notified by the Chief Resident.
6. If the resident unable to take call is a PL-2 or a PL-3 payback to the jeopardized resident will consist of one equivalent call shift.
7. The jeopardy person must be available and respond in a timely manner to any page. If the jeopardy resident is not available, she/he will pay back the jeopardized resident with an equivalent shift.
8. No resident will be jeopardized two nights in a row. If the need for coverage should occur, the Chief Resident will jeopardize another resident at their discretion with payback of one call night to the jeopardized resident from the resident unable to take call.
9. The jeopardy system does not allow for frequent daytime coverage should it become necessary. In the event that frequent daytime coverage is necessary, the Chief Residents will need to create a back-up system utilizing all residents who are in the elective call pool. This will protect the jeopardy resident from missing too much elective time on their rotation during their jeopardy block.
10. If it is perceived by the Chief Residents that the jeopardy system is being abused, a review by the Chief Residents and Program Director will occur. The resident in question will have to present their case to the Grievance Committee (consisting of no less than 5 members of the Housestaff Committee, including the Program Director, Chief Residents, 1 additional attending, and 1 additional resident). If a majority of the committee finds that the resident took jeopardy for an unacceptable reason, he/she will take an additional call and lose golden weekend requests for 4 blocks.
11. All jeopardizing residents will be required to pay back the jeopardized resident (or at least have scheduled a future payback) within 3 months. The pay back date will be at the discretion of the resident who was jeopardized and the chief residents. Failure to comply will result in loss of a golden weekend.

DAYTIME JEOPARDY PAYBACK POLICY

We know that illnesses/emergencies happen suddenly, but please let the chiefs know as soon as possible if you will need coverage the next day. **Jeopardy should be reserved for acute significant illness or family emergency.** Daytime jeopardy payback should be completed within 3 months.

Inpatient Coverage:

- **Interns:**

If an intern is called in to daytime cover wards & NICU then they must payback that intern with one of the following:

1. A Heme/onc weekend shift
2. 2 mommy calls
3. A weekend call shift- equivalent hours covered (ie day = 12 hrs)

- **Seniors:**

If a senior is called in to daytime cover wards, NICU, PICU then they must payback that senior with one of the following:

1. Equivalent hours covered weekend/call shift

You cannot have this make-up day be during the weekday on wards or ICU since you cannot take floaters on these rotations.

Outpatient Coverage:

If a resident is pulled to cover clinic when not on coverage months, they should be paid back with a clinic shift or a mommy call shift.

The payback must be approved by all parties involved + the chiefs.

MATERNITY/PATERNITY LEAVE POLICY

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

MOONLIGHTING POLICY

Purpose

Professional and patient care activities that are external to the educational program are called moonlighting. Moonlighting activities, whether external or internal, may be inconsistent with sufficient time for rest and restoration to promote the residents' educational experience and safe patient care. Therefore, the institution and program directors will closely monitor moonlighting activities as follows:

Policy

1. Internal and external moonlighting must be counted toward the 80-hour weekly limit on duty hours.
2. PGY -1 pediatric residents are not permitted to moonlight.
3. Residency education is a full-time endeavor therefore, the pediatric program director must ensure that moonlighting does not interfere with the integrity of the pediatric residents' training and has the ultimate authority to deny or rescind permission for moonlighting.
4. Pediatric residents are not required to engage in moonlighting.
5. A prospective written statement of permission for moonlighting activities must be obtained from the pediatric program director and be part of the pediatric residents' file. The resident's performance will be monitored for the effect of these activities upon performance. Adverse effects may lead to withdrawal of permission to moonlight.

Possession of a training permit, as required by the college of medicine and issued by the Arizona medical board or by the Arizona board of osteopathic examiners restricts the residents' functions to those conducted as part of an approved postgraduate training program. Thus, professional liability coverage of residents from Arizona state risk management provides coverage only for residency activities. Therefore, residents are responsible for obtaining appropriate licensure and professional liability insurance for any other activities (moonlighting). The state of Arizona, the Arizona board of regents, nor the university of Arizona College of Medicine shall be responsible for any complaints or claims arising out of moonlighting activities.

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MOMMY CALL

Mommy Call will be covered by the PL-2s and PL-3s for the first 3 months; thereafter the interns on clinic, elective and nursery rotations will be responsible for mommy call. Mommy call for seniors will be paired with jeopardy whenever possible.

REQUIRED PROCEDURES AND PROCEDURE CERTIFICATION

1. Each resident is required to document procedures performed on each rotation. These may be logged in New Innovations or at the ACGME website.
2. The list of procedures is based upon the recommendations of the ACGME Pediatric Residency Review Committee.
3. Competency in performing these procedures is required to be recommended for the Pediatric Board examination.

PROCEDURE NOTES: PROTOCOL FOR HOUSESTAFF

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

*ALL PROCEDURES MUST BE DOCUMENTED online at the ACGME website (<https://www.acgme.org/residentdatacollection/>) or on New Innovations (<https://www.new-innov.com/Login/Login.aspx>). **Documentation is REQUIRED for graduation as well as Board certification.***

Specific Procedures/Skills

The Residency Review Committee of the Accreditation Council of Graduate Medical Education has determined that residency programs in pediatrics must provide training in the following skills:

- Basic and advanced life support
- Endotracheal intubation
- Placement of intraosseous and intravenous lines
- Arterial puncture
- Venipuncture
- Umbilical artery and vein catheter placement
- Lumbar puncture
- Bladder catheterization
- Thoracentesis
- Chest tube placement
- Gynecologic evaluation of prepubertal and postpubertal females
- Wound care and suturing of lacerations
- Subcutaneous, intradermal, and intramuscular injections
- Developmental screening

In addition, programs should provide exposure to the following procedures/skills:

- Circumcision
- Conscious sedation
- Tympanometry and audiometry interpretation
- Vision screening
- Hearing screening
- Simple removal of foreign bodies from ears and nose
- Administration of inhalation medications
- Incision and drainage of superficial abscesses
- Suprapubic tap
- Reduction and splinting of simple dislocations
- Pain management

Documentation of your competence in performing procedures is necessary so that you may meet the certification requirements of the American Board of Pediatrics.

PEDIATRIC RESIDENT RESEARCH PROGRAM

GOAL

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

ELIGIBILITY

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

APPLICATION

1. A houseofficer interested in such a project must obtain approval from the Program Director. Final approval/disapproval is the prerogative of the Department Chairman.

SUPPORT

1. It is expected that the Department will have travel funds available for any resident whose research results are selected to be presented at national meetings.

LEAVE OF ABSENCE POLICY INCLUDING SICK LEAVE

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

TMC SCHEDULE OF ROUNDS/CONFERENCES

1. The senior resident will supervise pediatric and non-pediatric housestaff and students assigned to the TMC Wards.
2. MONDAY, THURSDAY, FRIDAY:
 - a. Morning Report is at 8:00 am. It is expected that the Chief Resident will attend, as will all house officers and students. Attendance by other attendings such as associate faculty and hospitalists is encouraged. Exceptions are to be made only for true emergencies.
 - b. Student rounds with the teaching attending will be held at a time mutually agreed upon by the students and the attending, as long as it does not interfere with the other attending times or other commitments which the students may have).
 - c. The Chief Resident may join work rounds several days each week and will also be present for Morning Report. Consultation with the Chief Resident regarding complex/interesting patients is strongly encouraged.
3. Tuesday/Thursday attending rounds are to be held from 11:00 am to 12:00 noon.

PL-2 COVERAGE ROTATION AND PL-3 ELECTIVE/COVERAGE ROTATION POLICY

Responsibilities: To provide daytime help, help out when there are conflicts with continuity clinics and residents having to leave post call, or when clinics are busy. Also to be available for cross-cover needs as specified by the chief resident. Coverage resident must be available by pager or phone at all times.

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

Education: during this rotation, when cross-cover assistance is not needed, the PL2 may attend general pediatric, subspecialty and CRS clinics of their choice as well as pursue any research and/or publication activities of special interest. This time may also be utilized for in-depth reading of the medical literature. The PL3 will attend an elective when cross-coverage is not needed.

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

PL-1 WARD RESPONSIBILITIES

1. The PL-1 is required to take and record a complete and thorough history which includes not only the present illness, but the past history, including family, social, immunization, birth and developmental histories as well as review of systems. The physical exam must be equally as complete. The growth parameters, including height, weight and head circumference must be plotted at this time.
2. Upon completion of the initial work-up, the PL-1 is to formulate his/her provisional diagnosis and appropriate treatment plan. The diagnosis and orders are to be reviewed with his senior resident after the latter has seen the patient as well. A mutual plan will be derived from this meeting and its contents presented to the referring or attending physician. A complete treatment plan is then implemented with input from the resident team and attending physician.
3. A successful relationship between the PL-1 and the attending physician is kept alive by continuous communication between these parties. Prompt notification of the attending physician of changes in the clinical course of the patient and changes in diagnostic or treatment plan must be carried out by the PL-1. The attending physician carries the ultimate responsibility of his patients, and therefore, it is essential that he be informed of any change in the condition of or subsequent course of his patient. These discussions should also include discharge and follow-up plans for the patient. If the patient is on the hospitalist service, the PL-1 should arrange for communication with the patient's primary care doctor (e.g. Family practice, those without admitting privileges, out of town physicians) either by direct discussion or discharge summary, detailing the patient's in-house stay.
4. The PL-1 should be on the ward with his/her patients as much as possible. This places the PL-1 close to his/her patients as well as to the nurses who are likewise involved in the delivery of care to patients. From the ward, the PL-1 can best monitor patients and make proper chart notes. The PL-1 is thus also available to attending physicians who are rounding on their patients. The availability of intern and attending physician to each other is crucial to the program and the training of housestaff in any hospital. It is expected that the PL-1 discuss patients with their attendings at least on a daily basis.
5. The pediatric houseofficer shall respond to any pediatric emergency within the hospital, regardless of whether or not that patient's physician is a member of the pediatric faculty. Following any emergency, the responding houseofficer must write an account of their intervention in the chart.
6. Any critically ill patient on the ward or a patient the PL-1 is uncomfortable with for any reason should be discussed immediately with an upper level resident. If a senior resident is unavailable, an attending should be notified of the PL-1's concerns. If a patient needs transfer to another unit (e.g. NICU, PICU) or another service, a member of the transferring service should write a transfer summary.

WARD ROUNDS

1. Daily work rounds will be made on all patients by the houseofficers. During or after work rounds, a progress note on each patient should be entered in the chart.
2. Formal teaching rounds are to be conducted in a sophisticated manner. Selected patients are to be presented by the PL-1 succinctly and accurately. Rounds are not to be interrupted by telephone calls, side conversations, etc.

CHARTS

1. Charts are to be written utilizing the “problem-oriented” system. The importance of maintaining good records cannot be overemphasized. Habits developed during internship will carry over for many years, and the keeping of thorough and accurate records is just one important example. The record and corresponding signature must be legible. Progress notes should appear daily and be entered immediately after seeing and discussing the patient on rounds or with the attending staff. These notes should depict the hospital course of the patient, the results and interpretation of laboratory data, alterations in diagnosis and treatment, etc. Only matters directly related to the patient should appear in the permanent record.
2. Sick patients and the precarious situations dictate further need for frequent and complete notes. The PL-1 should check each chart before leaving for the day to see if new notes by the attending physician or consultants have been entered.

ORDERS

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

DISCHARGE SUMMARIES

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

Please refer to official discharge policy.

PATIENT DISCHARGE

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

PROCEDURES

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

TEACHING RESPONSIBILITIES

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

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

PATIENT CARE

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

ROUNDS

1. Each morning, after receiving "sign-in" from the night float resident, the PL-2 and PL-3 will review and if clinically necessary examine the new admissions of the previous night, then assemble the ward team for work rounds. The PL-2 and PL-3 resident will lead the discussion of each patient's hospital course and plans for the day and will supervise work rounds on both 3 East and 3 West.

NIGHT RESIDENT

1. The PL-2/3 taking call during weekdays must be present to receive sign out of the ward's patients at 1700. He/she is then responsible for the welfare of all patients on pediatric service.
2. Immediately after sign out, the resident on-call must communicate with the intern on call and discuss questions concerning the pediatric inpatients.

WEEKENDS

1. The PL-2 and/or PL-3 are not expected to round on weekends if not on-call.

CONSULTS

1. When the pediatric team is formally consulted by another service, the initial consult (history, physical, chart note), delegated by the hospitalist, is completed by the ward resident and discussed with the general pediatric attending. Thereafter, the resident follows that patient daily. Orders and daily progress notes are the responsibility of the primary attending service.
2. During the hours of 0800 to 1700 on weekdays, "Pediatric Consults" originating in the emergency room at DCMC shall be handled by the senior resident. The pediatric residents may call the Chief Resident at any time with clinical questions.
3. Orders are the responsibility of the primary attending service unless pediatrics is given permission by said service to write orders or in the event of an emergency. Progress notes on all consults should be concise and address potential problems.

CONFERENCES

1. The PL-2/3 resident at DCMC must attend "Morning Report" at 0830 on Mondays, Thursdays, Fridays. During the conference, he/she will present interesting admissions for discussion with other residents and faculty. The residents should bring pertinent radiographs and slides to this conference.

TEACHING

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

2. The PL-3 should be particularly aware of children admitted to services other than a pediatric service, as they may often afford very interesting teaching opportunities for the students and residents.
3. The PL-3 will research and supply current references to the ward team on selected cases. If time permits they should review and critique the articles with the team.

CONTINUITY CLINIC COVERAGE

1. The coverage resident will cover the ward resident when they have Continuity Clinic.

PL-3 RESIDENT RESPONSIBILITIES ON TMC WARDS

PATIENT CARE

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

ROUNDS

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

PL-3 RESIDENT RESPONSIBILITIES on TMC WARDS

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CONSULTS

At TMC all consults on ward patients must first go through the attending of record. There is a maximum of 2 active consults per senior.

1. When the pediatric team is formally consulted by another service, the initial consult (history, physical, chart note) is completed by the ward resident and discussed with the pediatric attending. Thereafter, the resident follows that patient daily (if approved). Orders and daily progress notes are the responsibility of the primary attending service.
2. Orders are the responsibility of the primary attending service unless pediatrics is given permission by said service to write orders or in the event of an emergency. Progress notes on all consults should be concise and address potential problems.

CONFERENCES

1. At TMC the PL-3 will attend Morning Report at 0800 on Mondays, Thursdays and Fridays.

TEACHING

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

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