



POLICY & PROCEDURE MANUAL

2017-2018

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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 care for patients with more emergent, complex and life-threatening diseases;
- 3) develop increased subspecialty expertise during electives;
- 4) augment knowledge of child behavior/development during this required rotation;
- 5) increase knowledge and facility in formal and informal teaching settings (e.g. Morning Report, resident conferences)
- 6) begin to develop skills and knowledge in quality assessment and improvement, risk management and cost effectiveness in medicine.
- 7) 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.

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 (located in the AHSC library) 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** – All residents are issued an official, secured University-based email address for all official University correspondence as well as secure, patient-related correspondence. **This email account MUST be checked on a daily basis (at minimum).**
4. **NEW INNOVATIONS** – New Innovations must be checked and evaluations, duty hours, and other requirements as addressed in this manual be completed in a timely fashion.
5. **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. Please see the housestaff office for the 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 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 must remain available for consultation.

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

All members of the healthcare team (attending, residents, students, nurses, ancillary staff) must 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 resident performance.
- 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 outpatient 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 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.

f) Standard Clinical Observations occur as part of the evaluation process.

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 Clinical Competency 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.

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.

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 electronic evaluations (available on New Innovations) must be completed in order to advance to the next level of training.

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 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. 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.
- d. Duty periods of pediatric residents 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 8:00 p.m. and 6:00 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 (4) 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 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.
- c. All residents should have 10 hours and must have 8 hours free of duty between scheduled duty periods. Any exception to this must be documented and the program director notified. All residents 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. 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 Education Office must be informed in advance of any major changes in the call schedule and/or master schedule.

Residents must record duty hours in New Innovations during ALL rotations. Hours **MUST** be recorded after each shift. 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 Common Program Requirements, this policy is set forth by the University of Arizona Pediatric Residency Program to ensure that the Quality Improvement (QI) 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 regularly scheduled Morbidity and Mortality (M&M) conference attended by residents and faculty that provides an evaluative overview of the quality of care provided to patients.

PROCEDURE

1. Medical Records

Each pediatric resident will have orientation to the electronic health records at the beginning of the intern year.

2. Morbidity and Mortality

The Division of Hospital Medicine and Outreach will, with the pediatric Chief Residents and residents involved with the case, prepare a regularly scheduled 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 and supervised by the Associate Program Director.

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 (found at http://medicine.arizona.edu/sites/default/files/form_pdf/eligibility_selection_policy.pdf).

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, veteran status or any other applicable legally protected status.

GRADUATED RESPONSIBILITY AND SUPERVISION OF RESIDENTS IN AMBULATORY 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, 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. Resident Continuity Clinics 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 cancels 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. Pediatric residents must attend a minimum of 36 continuity clinic sessions per year; combined EM/Pediatric residents must attend continuity clinic while on Pediatric rotations. Residents on any core rotation must complete 4 sessions during any 4-week block. Only residents on vacation,

nights, or call-free Away elective rotations may cancel continuity clinics.

7. Residents will be expected to complete assigned continuity clinic curriculum.

BUMC CODES AND STAT CALLS

FOR CODE CALLS

1. When CODE BLUE is called, there may be no distinction between a pediatric and adult code. Therefore, the Pediatric Residents hearing the CODE Beeper must respond to all CODE 5000s.
2. Request for the emergency cardiopulmonary resuscitation team can be made by dialing 4-5000, telling the operator "CODE BLUE", giving the approximate age and location.
3. In the event a patient is unstable and rapidly decompensating, but not in arrest, activate the rapid response team by calling ###. Provide the operator with the patient's (approximate) age and location.
4. The wards senior pager (2105) is the only in-house first responder physician pager. As such, all pediatric codes will be texted to this pager. The wards senior who is carrying the pager is responsible to respond immediately to all code pages.

CONFERENCES

The Pediatric conference calendar is updated continuously and is available at <http://peds.arizona.edu/physicians/calendar>.

1. On time attendance at all educational conferences is an expected component of professional behavior. Tardiness to any such session must be explained by written communication to the Program Director.
2. **Teaching Day.** Teaching day attendance is expected 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. Residents may miss teaching day for other educational activities, if approved by the Chief Resident in advance. For other absences, the Chief residents will have the final approval of whether or not an absence is excused. Excused absences are not to exceed 20% of total teaching day attendance. Failure to approve an absence with the Chief Residents in advance, or falling below the 80% attendance minimum will result in the following actions:
 1. First unexcused absence: one extra jeopardy call/mommy call shift
 2. Second unexcused absence: one extra in-house call
 3. Third unexcused absence: probation
3. **CPC.** All PL3s will give a CPC with the assistance of the PL2.
1. **Morning Report:** Morning Report is held on Monday, Thursday and Friday in the Pediatric Boardroom (room 3303), and Tuesday in the resident lounge (room 3505). All residents at BUMC are expected to attend Morning Report, including residents on Elective, Pathway and Research/QI rotations (unless scheduled for an off-site clinic).
2. **Journal Club:** The resident journal club is held once per block. Residents will be responsible for giving Journal Club. Journal club curriculum is available in the Google drive.
3. **Grand Rounds:** held the second and fourth Thursdays from noon-1:00 pm in room 8403 (check calendar for room changes). All residents at BUMC are expected to attend Grand Rounds, including residents on Elective, Pathway and Research/QI rotations.
4. **M & M.** Held monthly in the Pediatric boardroom (check conference calendar). During the second year each resident will be responsible for finding an appropriate case, identifying a faculty mentor, and presenting the case with the assistance of a third year. The schedule will be determined by the chief residents and will be rotation-dependent. Guidelines and timeline provided by the chiefs MUST be followed.

WARD DISCHARGE SUMMARY POLICY

Discharge summaries should be done in lieu of the daily note (completed on day of discharge). If a progress note is done instead of a discharge summary, a summary must be completed within 24 hours.

Resident Policy:

- At 48 hours past due date: Notification by Hospital Medicine Admin Assistant (chiefs also notified). Residents must complete the outstanding summary within 24 hours.
- If not completed within 24 hours, a warning letter is sent to the resident and is temporarily placed in the resident's file. The resident must complete the outstanding summary within 24 hours. If completed within 24 hours, the warning letter is removed from the resident's file.
- If not completed within 24 hours of the warning letter, a marginal pass is given for the rotation (if the grade was going to be a pass) and a permanent letter is placed in the resident's file.

Keep the following in mind: The attending will receive a "courtesy" notice, an "impending suspension" notice, and/or eventual suspension should work not be completed in a timely fashion as noted above.

OUTPATIENT CHART COMPLETION POLICY

In the interest of providing excellent care to our patients and attaining a high level of professionalism, timely chart completion is imperative.

- It is expected that all residents complete notes from all outpatient clinical encounters (to include both outpatient clinic rotations and continuity clinic) within 24 hours.
 - It is best to complete the notes immediately after the patient encounter or immediately following the half-day clinic session but we understand that this is not always possible.
- In unusual circumstances we understand that a note might not be completed for 48 hours after the patient encounter and, while not preferred, this is acceptable. It is, however, unacceptable to take longer than 48 hours to complete clinic notes.
 - The reasons for this are many including the fact that the clinic notes are an important means of communicating to the other physicians including your fellow colleagues what has occurred during a clinic encounter. This information may pertain to a follow-up visit, senior resident tasks, or mommy call.
 - Also, if notes are not completed promptly the possibility of omitting important details increases.
 - If the note is not complete by 48 hours, the attending which staffed the patient will contact the chiefs (uazpeds@gmail.com)

You can access the electronic health records from any computer. If you are having difficulties with this please contact IT promptly for assistance.

Resident must ensure all notes & tasks are complete prior to vacations or away rotations. *Vacations and away rotations DO NOT extend the timeline.*

PATHWAY BLOCK DESCRIPTION

During the three years of training, the categorical Pediatrics resident will have 6 blocks devoted to an Individualized Learning Curriculum (Pathway). This individualized curriculum will be determined by the learning needs and career plans of the resident. The following structure is recommended; however each resident may define their own pathways with the guidance of the Chief Residents and Program Director, in order to suit their individual needs.

Pathway Options

- Ambulatory
- Hospitalist
- Critical Care
- Sub-specialty
- Exploratory (PL-2 year only)

Requirements

- For all pathway blocks, a faculty mentor must be identified 4 weeks prior to the start of the rotation.
- The resident and mentor must define 4 specific goals for the rotation and enter them into the resident's "My Pathways" document.
- Within one week of completion of the rotation, a brief summary of goals accomplished is to be entered into the resident's "My Pathways" document.

PL-2 Pathway Blocks

2nd year Pathway blocks are intended to be individualized by the resident to support career discovery and learning needs.

Blocks 1: *Career Discernment and Foundation Building Block*

- A core elective block that has less cross-coverage time so the resident can focus more on building a solid foundation in that topic. This is potentially an elective in the field of somebody choosing a subspecialty.

Block 2: *Research/Quality Improvement or Advocacy Elective Block*

- A more open elective that allows time to do research or advocacy work that can be presented at conferences or published.
- The resident will be primary in the coverage call pool during this elective.

Block 3: *Immersive Experience and Different Perspective Block*

- Designed to give the resident an immersive experience in the area of their future career. Ideally, would allow the resident to experience a different side of a specialty by working in a community setting or at another institution.
- The resident is responsible for setting up the away rotation with the help of the Chief Residents.
- If the resident chooses an away rotation, they will be call free for the block.

PL-3 Pathway Blocks

3rd year pathway blocks are intended to prepare residents for post-graduate work. Pathway blocks will enable the 3rd year resident to have increased responsibility in patient management, teaching, and clinical skills, as

well as broaden their knowledge and procedural skills in order to create a comprehensive curriculum directed toward their future career.

Block 1: Career Confirmation Elective (CCE)

- Designed to be a leadership role with an increased level of responsibility, involving teaching and mentoring in their field of choice.
- Roles are subject to change on a resident to resident basis.
- This is a SELECTIVE BLOCK and the following roles are defined:
 - **Ambulatory Path:** If at 3OPC, the resident will staff Primary Care Exception patients and formulate plans with medical students' patients. If at a community private practice, will be expected to have higher patient volume (~10 patients per half-day shift) and more autonomy.
 - **Hospitalist Path:** "Pre-attending" at BUMC-T ward. Co-manage admitting pager with Hospital Admitter. Formulate management plans with wards teams.
 - **NICU:** Advanced decision making responsibilities. Staff blood gasses with interns. Work with Neonatologist to make the teaching schedule for the month.
 - **PICU:** Similar to NICU. Resident will take an active role in SIM facilitating, as well as resident teaching.

Block 2: Procedural Skills Elective

- This block allows the resident to build a procedural elective that is tailored to their future career goals. Each resident is responsible for scheduling this elective with the help of the Chief Residents

Block 3: Breadth of Education Elective

- This elective experience is available to fill in gaps in education in areas that we do not see as regularly in our core rotations. It may, and likely should, be split into 2 separate 2 week blocks.

Elective Repository

- A repository of electives will be made available to residents for pathway planning purposes. It will include previously completed pathways, as well as contact information for all electives.

ELECTIVES

(a) Residents must complete nine blocks of subspecialty experiences, including one required block of adolescent medicine and one required block of developmental-behavioral pediatrics. Of the remaining seven blocks, each resident must complete a minimum of four different block rotations (the Core Electives) taken from the following list of pediatric subspecialties:

Allergy/Immunology
Cardiology
Child Abuse
Dermatology
Endocrinology
Genetics
Gastroenterology
Hematology/Oncology
Infectious Diseases

Nephrology
Neurology
Pulmonary
Rheumatology

- (b) For the four required Core Electives in different subspecialties from the above list, the inpatient/ outpatient mix should reflect the standard of practice for the subspecialty, and each block must be comprised of 4 consecutive weeks in that subspecialty. The electives noted in **BOLD** are offered by the program and must be performed at the program's home institution. All others may be performed off-site.
- (c) The additional three blocks 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 and Adolescent Psychiatry
Pediatric Dentistry
Hospice and palliative medicine
Neurodevelopmental disabilities
Pediatric Ophthalmology
Pediatric Orthopaedic Surgery
Sports Medicine
Pediatric Otolaryngology
Pediatric Radiology
Sleep Medicine
Pediatric Surgery
Pediatric Rehabilitation Medicine

(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. Reading Electives must be approved by the Program Director and goals and objectives specified prior to the rotation.
2. Participation in the International Health elective and in electives not listed above must be discussed with and approved by the Program Director and Director of Global Health at least six months in advance. The elective goals, syllabus, bibliography and preceptor/evaluator must be provided. For

information on away elective policies and procedures, see below.

3. Each senior resident will arrange electives, after discussion with a 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 allowed if the elective has been assigned by the Program Director.**
5. Call free electives are restricted to PL-2 and PL-3 residents. 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 talk pertaining to what they learned.
 - e. Prerequisites (see next section) must be met in order to be approved.

AWAY ELECTIVE POLICY

- a. A Resident requesting an away elective will present the request to the Pediatric Program Director for review and approval. Prerequisites as outlined below MUST be met in order to be approved.

A houseofficer may complete an away elective only during a Call Free month.
- b. The following Prerequisites must be met in order to be approved for an away elective:
 1. Resident must be at or above the 50th percentile on the in-training exam (ITE) OR, if <50th percentile, resident must have a written, Program Director-approved improvement/study

- plan;
2. Resident must be current on assigned educational curricula
 3. Resident must be current on notes, discharge summaries, evaluations, and duty hours logs;
 4. Resident must not have had marginal pass or failing rotations.
 5. Resident must not have tardiness or no show to educational conferences.

Should the status of any of the above items change, the Program Director/Associate Program Director reserves the right to rescind approval.

- c. The Pediatric Housestaff Office **must** receive adequate prior notification (minimum **120 days**) so that a) GME has ample time to approve the outside rotation and b) BUMC Contracting Office is able to ensure that an agreement is in place for the outside training location. *If an agreement cannot be reached between the institutions prior to the start of the rotation, the resident **will not** be permitted to rotate at that site; therefore, the program **MUST** have ample time to complete the process.*
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 Residency Program Coordinator.
 2. The following documentation must be provided to Housestaff Program Coordinator no later than **120 days** prior for electives in the United States and international rotations:
 - a. A completed Outside Rotation Request form (available at <http://peds.arizona.edu/residency/electives>), **signed by the Program Director**.
 - b. Written permission from Site Supervisor. Must include resident's name, the dates of the rotation, and the name of the rotation. An email is sufficient.
 - c. Written goals and objectives for the rotation (Program Director must be consulted when writing goals and objectives).
 - d. Banner-University Medical Group Travel Authorization paperwork must be completed with the Housestaff Office a **minimum** of 120 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 residency.
- d. The American Academy of Pediatrics Resident Section awards annual scholarships for resident travel. Applications are encouraged.
- e. Residents wishing to do a Global Health elective must have the approval of both the Program Director as well as the Director of Global Health and all procedures, outlined at <http://peds.arizona.edu/residency/global-health>, must be followed.

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 competence in 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, bladder catheterization, 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. 7.5 hours of the shift will be

spent picking up new patients. The final one and a half hours 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) 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.

IV) FEEDBACK

1. Residents will have informal feedback midway through the block and formal feedback at the end of the block.
2. 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. 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.

CLINICAL COMPETENCY COMMITTEE

1. The CCC actively participates in reviewing all resident evaluations by all evaluators biannually and incorporates these evaluations into an assessment of Milestones performance for each resident. This assessment is then entered on the New Innovations® web site and used by the program to report on each resident's performance biannually to the ACGME. The CCC also makes recommendations to the program director for resident progress, including promotion, remediation, and dismissal.
2. The biannual Milestones performance assessment, generated by the CCC, is available to each resident for review in a completely confidential fashion. Further, it is used by the program director during biannual evaluation meetings with each resident to discuss and document progressive performance of the resident, appropriate to educational level. Formative feedback based on the resident's performance also will be provided during these evaluation meetings, and the resident will be encouraged to incorporate this feedback into the Individualized Learning Plan generated at each biannual evaluation.
3. The Clinical Competency Committee (CCC) must be composed of at least three members of the residency faculty, appointed by the program director. Faculty members of the CCC undergo faculty development and instruction in evaluation prior to serving on the CCC as well as biannually while serving on the CCC.

PROGRAM EVALUATION COMMITTEE

1. The Program Evaluation Committee (PEC) actively participates in:
 - planning, developing, implementing, and evaluating all significant activities of the residency
 - developing competency-based curriculum goals and objectives;
 - reviewing annually the program using evaluations of faculty, residents, and others;
 - assuring that areas of non-compliance with ACGME standards are corrected

2. The PEC must document formal, systematic evaluation of the curriculum annually and inform a written annual program evaluation based on monitoring of resident performance, faculty development, graduates' performance on ITE and ABP exams, and program quality as assessed by confidential program evaluations. If deficiencies are found, the PEC will assist the program director in preparing a written plan of corrective action which will be reviewed and approved by the teaching faculty of the Department of Pediatrics.

3. The PEC is composed of at least 3 members of the teaching faculty and equal representation from the pediatric housestaff.

- Resident Members are to be re-elected annually in July.
- The class will be polled prior to election to solicit interest, then each individual class will vote on the candidates who volunteered.
- New intern class is to elect members in July of their first year as well.
- If a Resident Member is unable to attend a PEC monthly meeting, they may designate a fellow resident from their class to attend in their stead. This excludes all recruitment-related activities and events, such as rank-night.

4. The PEC agenda and items to be voted on will be emailed to all housestaff one week prior to every PEC meeting, allowing time for PEC resident representatives to gather a consensus opinion on all potential programmatic changes.

5. Twice a year, the PEC meeting will be opened up to all residents as a "Town Hall Meeting". There will be open forum during which residents may bring up any concerns they have about the program, or changes that they would like to see made. If possible, they should add their talking points to the agenda prior to the meeting.

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 holidays worked (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 and Program Director MUST be notified of any floating holidays.
3. PL2s and PL3s may take their floating holidays during elective or clinic months and during the Development month (during the PL2 year). *No more than two days may be used in any month-long elective. Only one day may be taken each during Development, clinic or a two-week elective blocks.* Resident must find their own coverage during clinic rotations (other than the nursery or clinic person). The chief residents and Program Director 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. **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 and Program Director.
6. The Chief Residents will make every effort to accommodate an intern/resident request for a floating holiday but reserves the right to refuse the request in accordance with service or scheduling needs.
7. Floating holidays may be taken on a day scheduled for night call, however, the resident must still complete the night call duties or switch with another resident.
8. Residents do not need to use floating holidays to attend medical conferences. They may attend medical conferences during any rotation provided that they have arranged proper coverage for day and night responsibilities. Floating holidays should be used for all other absences from clinical sites.

VACATION POLICY

1. Each Houseofficer is entitled to 4 weeks 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 BUMC 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 BUMC - Wilmot

BUMC - Wilmot 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 Wilmot clinic the following morning. This phone call should not serve as a consult.

ADMISSIONS CAP PROTOCOL

CAP MAY CHANGE. PLEASE REFER TO INDIVIDUAL ROTATION POLICY.

DCMC Wards

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

Day Team max: # interns/team x 10

Intern admit: 10

Redistribute in the morning if ≥ 12 patients

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

Transfer off resident service throughout the day with attending/resident discussion and agreement

Private attendings may use hospitalists

DCMC Hematology/Oncology Ward

Diamond 6W (D6W)

Day Team max: 10 / intern

DCMC PICU

D6N, ICU only

Team max: 24

DCMC NICU

D4N only

Team max: 20

Nursery

Team max: 20

SENIOR NIGHT FLOAT & NIGHT HAWK EXPECTATIONS

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

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 (discharge paperwork completed and ready to finalize, prescriptions signed). The night attending and night float senior should also review the patient list for possible discharges and discuss with the charge nurse.
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.**
 - d. Senior will carry 2105 pager which also accepts mommy call pages. See policy on page 38.
3. Teams:
 - a. Night Float: Follow Blue and Copper team patients (except when Copper team seniors is on call; then you follow Red and Blue teams)
 - b. Night Hawk: Follow Red & H/O patients, except when Red team seniors is on call; then 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 sign out sheet.
7. Every night, update discharge paperwork. The day teams appreciate this service, since they are often busy.
8. Prior to AM signout:
 - o **review morning labs and vital signs for each patient.** Communicate abnormal values on the signout sheet that will be given to the daytime seniors.
 - o communicate with nurses regarding last minute overnight issues and questions.
 - o update the team lists on the dry erase board in the resident work room to let daytime attendings and pharmacists know which patients are on which teams.

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

WARD FLEX TEAM

1. If needed, the Flex Team will function as an “Admitter Team” comprised of one PGY-3 categorical pediatrics resident paired with one categorical pediatric intern.

- Hours: During the week, the Admit Team will work regular wards hours (6AM to 5PM)
- Cap: The Admit Team will have a cap of 10 patients.
- Duties:
 - When the Blue/Red teams are doing AM rounds, it is the responsibility of the Admit Team to admit patients, performing a full H&P and writing a note assigned to the Flex Team attending for the day.
 - The Admit Team will carry the patients that they admit in the morning.
 - The Admit Team will carry at minimum 3 patients (census permitting).
 - If the Admit Team is carrying a greater number of patients than each Blue/Red intern, they will continue to admit during morning rounds and then distribute the patients after Blue/Red rounds are completed. There will be senior-to-senior and intern-to-intern signout of all patients transferred from the Admit Team to Red/Blue team.
 - The Admit Team is required to round on their patients as well. Timing of rounding will be determined by the senior resident and attending, and may vary from day to day. The expectation is that rounds will be interrupted by morning admissions.
 - In the afternoon, the Admit Team senior continues to oversee admissions done by Red/Blue interns as needed, coordinated with the Red/Blue senior residents.
 - On nights and weekends, admissions will be given to the Red/Blue teams, alternating until a cap of 20 per team is reached. The overflow will then go to the Admit team until a cap of 10 is reached. Overflow beyond that will start an attending only team.
- Sign out: Monday through Thursday, the Admit team patients will be signed out to the Blue team/Night float for the night. Every Friday, the Admit Team patients will be divided evenly and assigned to the Blue and Red Teams for the weekend. Both Blue and Red Team should be present for Friday evening signout of Admit Team patients, to be prepared to take on their care for the weekend.
- Weekends: The Admit Team senior will cross cover wards on weekends.
- Short call: The Admit Team intern is permitted to take one short call day per week, signing out their patients to the Admit Team senior. See Short Call policy for details.

Heme/Onc Team Description

1. Hours: regular inpatient hours (0600-1700)
2. Team Composition: 2 interns (Categorical Pediatrics or Peds/EM), 1 senior resident (PL-3) and 1 attending.
3. Intern Role Description
 - a. Cap: 10 patients per intern
 - b. The Heme/Onc interns are responsible for all elements of patient care on the Heme/Onc team, including, but not limited to, all admission H&Ps, preparation for rounds, daily progress notes, orders, discharge summaries and sign-out.
 - c. BMT: It is expected that at least one Heme/Onc intern will be present for BMT rounds. They are not required to write notes, but should know the patients for continuity of care on the weekends.
 - d. Weekends: The Heme/Onc interns alternate weekend coverage. The Heme/Onc intern is responsible for BMT cross-coverage on the weekend, including rounding and writing daily progress notes.

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 PICU Resident:

PATIENT CARE

1. The PICU resident is responsible for admitting and managing the team maximum number of patients.
2. A single resident H & P is required for all patients and transfers to the ICU.
3. Orders will be written by the PICU resident.
4. The Discharge Summary, Off Service note or Transfer Summary must be completed by the resident at the time of transfer.

CO-MANAGEMENT

All other PICU patients require pediatric co-management on arrival. H&Ps 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.

ROUNDS

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

PICU Night Resident

1. The PICU night resident is responsible for the care of all pediatric patients in the PICU during their appointed shift.

SHORT CALL POLICY

Short call description:

- The short call system is designed to allow residents to have daylight hours during which they are free from clinical duties. The goal of this short call system is to promote resident wellness and avoid resident burnout.
- For all rotations, a resident may leave their clinical duties as early as 1500 if the following criteria are met:
 - Their clinical duties are completed for the day, including pending admissions
 - There are no scheduled teaching experiences for the remainder of the day
 - The accepting resident is available to take sign-out (i.e. is not busy with their clinical duties).
 - The team is in agreement (including all interns, senior resident and attending) that the resident may leave for short call.
- Of note, short call is not a scheduling requirement and should only be instituted on days when the above criteria are met. During times of high census, it is possible a resident will not be able to take short call during any given rotation.

For specific rotations:

- Wards
 - Each intern is allowed one short call day per week if clinical duties permit and all of the above criteria for short call are met.
 - When on Red, Blue or Copper Teams, the intern will sign out to the other intern on their same team.
 - When on the Admit team, the intern will sign out to the senior resident on their same team.
 - Senior residents do not take short call while on wards.
- Heme/Onc
 - Each intern is allowed one short call day per week if clinical duties permit.
 - The intern will sign out to the other intern on the Heme/Onc team.
- PICU
 - The residents will take short call on a rotating schedule if clinical duties permit and all of the above criteria for short call are met.
- NICU
 - The residents will take short call on a rotating schedule if clinical duties permit and all of the above criteria for short call are met.
- Newborn Nursery
 - Each intern is allowed one short call day per week if clinical duties permit.
 - The intern will sign-out to the other intern in the Newborn Nursery.
 - If there is only one intern in the Newborn Nursery, they may sign-out to the NICU if all of

the above criteria are met (i.e. the NICU resident is available to take sign-out).

- 3OPC Clinic
 - The 3rd year senior on clinic may not take short call.
 - All other residents may take short call on a rotating basis if the remaining patient schedule for the day permits and all of the above criteria for short call are met.
 - All residents must approve their short call with both attendings (i.e. the call-in attending and the continuity clinic attending) prior to leaving.
- Wilmot Clinic
 - The 3rd year senior on clinic may not take short call.
 - All other residents may take short call on a rotating basis if the remaining patient schedule for the day permits and all of the above criteria for short call are met.
 - All residents must approve their short call with the attending prior to leaving.

JEOPARDY CALL

Commented [1]: Chiefs will review and rewrite

- 1) Jeopardy should be reserved for acute **significant** illness, family emergency, or extreme clinical load.
- 2) PL-2s and PL-3s cover all jeopardy for senior residents. The jeopardy resident is on 24-hour call. Intern jeopardy call pool includes interns on nursery, elective, Heme/Onc, and adolescent.
- 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 chief resident. 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 PEC (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). 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.

Inpatient Coverage:

- **Interns:**

If an intern is called in to daytime cover wards & NICU then they must payback that intern with an equivalent shift.

- **Seniors:**

If a senior is called in to daytime cover wards, NICU, PICU then they must payback that senior with an equivalent shift.

This make-up day cannot be a weekday on wards or ICU since floating holidays cannot be taken 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 and the chief residents.

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). Banner Health, The State of Arizona, the Arizona Board of Regents, and the University of Arizona College of Medicine shall NOT be responsible for any complaints or claims arising out of moonlighting activities.

MOMMY CALL

Senior Residents will take Mommy call on the following schedules:

Block(s) 1-4, 11-13

- Monday – Friday:
 - 0800-1700 = Clinic
 - 1700-0800 = 2105 pager
- Saturday, Sunday and Clinic Holidays, 0800-2000 = Call
 - 0800-2000 = Call
 - 2000-0800 = 2105 pager

Block(s) 5-10

- Monday – Friday:
 - 0800-1700 = Clinic
 - 1700-0800 = Call
- Saturday, Sunday and Clinic Holidays, 0800-0800 = Call

REQUIRED PROCEDURES AND PROCEDURE CERTIFICATION

1. Each resident is required to document procedures performed on each rotation. These must be logged in New Innovations.
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 on New Innovations (<https://www.new-innov.com/Login/Login.aspx>). Documentation is REQUIRED for graduation, Board certification, and future employment.

Specific Procedures/Skills

The Residency Review Committee of the Accreditation Council of Graduate Medical Education has determined that **residents must be able to competently perform all medical, diagnostic and surgical procedures considered essential for the area of practice.** Residents must be able to competently perform procedures used by a pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results.

Residents must demonstrate procedural competence by performing and documenting the following:

- bag-mask ventilation
- bladder catheterization
- giving immunizations
- incision and drainage of abscess
- lumbar puncture
- neonatal endotracheal intubation
- peripheral intravenous catheter placement
- reduction of simple dislocation
- simple laceration repair
- simple removal of foreign body
- temporary splinting of fracture
- umbilical catheter placement
- venipuncture

Residents must complete training and maintain certification in Pediatric Advanced Life Support (PALS), including simulated placement of an intraosseous line, and Neonatal Resuscitation (NRP).

In addition, **residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.** Residents must demonstrate sufficient knowledge of the basic and clinically supportive sciences appropriate to pediatrics and must be competent in the understanding of the indications, contraindications, and complications for the following:

- arterial line placement
- arterial puncture
- chest tube placement
- circumcision
- endotracheal intubation of non-neonates
- thoracentesis

Resident should receive real and/or simulated training when these procedures are important for a resident's post-residency position.

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

PEDIATRIC RESIDENT RESEARCH PROGRAM AND QUALITY IMPROVEMENT

GOAL

The Department of Pediatrics has a special support mechanism for residents who wish to become involved in research. The program director keeps a list of all current projects within the department.

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

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

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

Contact program director for funding opportunities that may be available for residents whose research results are selected to be presented at national meetings.

QUALITY IMPROVEMENT REQUIREMENT

Residents are expected to participate in a quality improvement project, either as part of a group project or an individual project.

Goals:

The resident will be able to systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement.

This skill set and practice will be learned and achieved during daily patient care, on rounds, during didactic sessions, quality improvement activities and skills sessions (such as journal club).

Residents are encouraged to participate in a hospital quality improvement committee to develop skill set required for completion of residency.

Quality improvement and patient safety skills will be put to practice with the completion of a quality improvement project.

Examples of quality improvement projects include improving efficiency of resident handoffs, MSTAR for improvement of residents as teachers, Asthma education in clinic, Mommy Call education, and improvement of isolation practices.

The Associate Program Director will supervise the resident in determining quality improvement involvement.

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).

COVERAGE POOL 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. Must also be available for cross-cover needs as specified by the chief resident. Daytime coverage pool residents must be available by pager or phone from 5AM-5PM.

Rotation: The coverage pool may include residents on the following rotations:

- Development
- Pathway
- R/QI
- Elective

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 a provisional diagnosis and appropriate treatment plan. The diagnosis and orders are to be reviewed with the senior resident after the latter has seen the patient. 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 all team members 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 their patients, and therefore, it is essential that they 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.
7. Verbal sign out and interim summaries must be completed on all patients prior to residents transferring off service.

WARD ROUNDS

1. Daily work rounds will be made on all patients by the houseofficers. Shortly after 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, text messages, side conversations, etc.
3. Nursing staff and families must be contacted and invited to participate in family-centered rounds.

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. 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 evaluation and documentation of significant events. 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.
3. Verbal sign out and interim summaries must be completed on all patients prior to residents transferring off service.

ORDERS

1. Extreme care should be taken to insure that all orders are entered into the computer correctly. All residents 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.

DISCHARGE SUMMARIES

1. The resident is responsible for the discharge summary on all his/her 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 10:00 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.

CONTINUITY CLINIC COVERAGE

The nursery intern will cover the H/O resident when they have Continuity Clinic (scheduled by the Chief Resident).

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

PATIENT CARE

1. The PL-3 is primarily responsible for 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 giving feedback.
3. **Patient's H&Ps and orders are primarily the PL-1's responsibility.** In the event that 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. An attending physician must order chemotherapy.
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.
6. When a Sub-I is present on the wards it is the wards senior responsibility to provide H&P and discharge summary.

ROUNDS

1. Each morning, after receiving "sign-out" from the night float resident, the PL-2 and PL-3 will review and evaluate the new admissions and unstable patients 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.

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 BUMC must attend "Morning Report" at 0830 on Mondays, Tuesdays, Thursdays, and 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.
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, computers, call-rooms, etc.
 - b. Review important data for History and Physical of pediatric patient
 - c. Review SOAP note format.
 - d. Review presentations for work-rounds.
 - e. Define expectations of the student for day-to-day responsibilities and goals for the rotation.
3. The PL-3 in conjunction with the team of residents will need to provide the chief resident mid-way evaluations of medical students and coordinate final evaluation with team and chief resident.
4. The PL-3 will spend a minimum of two hours per week with the interns and medical students for demonstration of interesting physical findings and discussion of interesting cases. This teaching time should be as interactive as possible.
5. The PL-3 should be particularly aware of children admitted to services other than a pediatric service, as they may often afford very interesting teaching opportunities for the students and residents.

6. The PL-3 will research and supply current references to the ward team on selected cases. If time permits they should review and critique the articles with the team.

CONTINUITY CLINIC COVERAGE

The coverage resident will cover the ward resident when they have Continuity Clinic (scheduled by the Chief Resident).