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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 their 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.

GOALS OF PL-1 YEAR

1) acquire basic clinical and procedural skills to evaluate, diagnose and treat infants, children and adolescents with diseases that range from simple to 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.

9) Successfully communicate and work within an interprofessional team environment.

GOALS OF PL-2 YEAR

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.
8) Successfully communicate and work within an interprofessional team environment.

GOALS OF PL-3 YEAR

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 a 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.
9) Successfully communicate and work within an interprofessional team environment.

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

Please empty your mailbox at least once per block, 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.

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).

NEW INNOVATIONS

New Innovations must be checked and evaluations, work hours, procedures, and other requirements as addressed in this manual be completed in a timely fashion.

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. In addition, computers and printers are available for use in the pediatric resident lounge.

LIBRARY SERVICES

For journals that cannot be checked out of the library or found online; you may use photolibrary services. Please do not take in outside projects or books that can be checked out and copied on the Pediatric Department machine.
RESIDENT SELECTION POLICY

1) 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 GRADUATE MEDICAL EDUCATION RESIDENT/FELLOW MANUAL 2018-2019).

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

3) 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.

4) 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.

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 goals enumerated for PL-1s.

**PL-2**
Promotion/advancement from the PL2 to PL-3 year is dependent upon successful completion of the 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 Years**
All electronic evaluations 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.

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**REQUIRED EVALUATIONS**
Evaluations are completed by housestaff and faculty at the end of each rotation on the New Innovations® web site and Google Docs. 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.

CONFIDENTIALITY

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.

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
cerification 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. Final decision making 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, PGY4, or PGY5), 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 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:
1) Transfer of a patient to an ICU setting
2) End of life decisions
3) Any patient leaving against medical advice (AMA)

The level of supervision of significant procedures by residents will be determined by the attending physician, and will include a discussion of 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 (attendings, residents, students, nurses, ancillary staff) must wear identification badges displaying their name and respective role per Banner policy. 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:

1) 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.

2) 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.

3) 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.

4) Morning Report, which occurs at Diamond Children’s Medical Center three times per week, provides the opportunity for residents and faculty to discuss new inpatient admissions and problems patients.

5) Documentation of clinical skills is also assessed by interaction with residents over specific patients, during subspecialty consultations and during problem patient conferences.

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

This policy is as stated in the Graduate Medical Education Policy and Procedures Manual.
GRADUATED SUPERVISION OF RESIDENTS IN AMBULATORY PEDIATRICS

0-6 MONTHS OF TRAINING
Residents with 0 to 6 months of training should work with close supervision by the ambulatory attending including thorough discussion and patient examination.

7-18 MONTHS OF TRAINING
Residents with 7 to 18 months of training must discuss all patients with the supervising ambulatory attending.

GREATER THAN 18 MONTHS OF TRAINING
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.

ADDITIONAL PL3 RESPONSIBILITIES
PL-3s have the added responsibility of teaching and supervising medical students and residents.

ATTENDING RESPONSIBILITIES
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 evaluate each resident’s performance in primary care areas as part of their rotation 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.
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.
1) The Program Evaluation Committee (PEC) actively participates in:
   a) planning, developing, implementing, and evaluating all significant activities of the residency;
   b) developing and reviewing competency-based curriculum goals and objectives;
   c) reviewing the results of the residents' assessments of the program together with other program evaluation and survey results (internal and external) to improve the program;
   d) reviewing annually the program using evaluations of faculty, residents, and others;
   e) 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.
   a) Resident Members are to be re-elected annually in July.
   b) The class will be polled prior to election to solicit interest, then each individual class will vote on the candidates who volunteered.
   c) New intern class is to elect members in July of their first year as well.
   d) 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.
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 their 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 their 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 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.
The Pediatric Residency Program is committed to promoting patient safety and resident well-being in a supportive educational environment. This work 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.

### CLINICAL AND EDUCATIONAL WORK HOURS

1) Work 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. Work hours do not include reading and preparation time spent away from the duty site.

2) Work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and moonlighting.

3) 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.

4) Duty periods of pediatric residents may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
   a) 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.
   b) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
   c) 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. See Extension of Duty Beyond Scheduled Shift.
   d) 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.

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.

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 work hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

1) Residents must be scheduled no more frequently than every third night, for in-house call, averaged over a 4-week period.

2) 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.

   a) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

   b) 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”.
OVERSIGHT

1) Monitoring of work hours is required with frequency sufficient to ensure an appropriate balance between education and service.

2) Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged.

3) 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 work hours in New Innovations during ALL rotations. Hours **MUST** be recorded at least every 2 weeks, ideally after each shift. In addition, any work hour violations must be reported to the Program Director and/or Coordinator immediately.

FATIGUE MITIGATION POLICY

Annually, the Program Director (or designee) will present fatigue mitigation strategies to all residents and hospital-based faculty. These strategies will include recognizing the signs of fatigue and sleep deprivation, strategies to manage fatigue when possible, and how to transfer clinical responsibilities.
Residents are responsible for practicing fatigue mitigation and are expected to adjust their lifestyles to ensure access to adequate recovery sleep while on clinical rotations.

Residents are responsible for monitoring themselves for signs of excessive fatigue which could impair their ability to function and perform duties safely. They are responsible for reporting this to their senior residents and supervising faculty.

1) This reporting should be done without fear of negative consequences for the resident.

2) Once reported, resident will be immediately offered a means of relieving fatigue.

3) Any perceived negative consequences will be addressed by program leadership.

4) When fatigue impairs the ability to safely perform required duties, the following strategies will be utilized to ensure safe transfer of care for the patients and fatigue management for the resident:
   a) Patient care will be immediately transitioned to another available resident.
   b) If there is insufficient resident coverage present in the unit for the patient census, chief residents should be notified to help mobilize back up resident coverage.
   c) Supervising faculty must make arrangements to transfer clinical responsibilities if all attempts to transfer responsibilities to other residents have failed.

5) Once patient care has been transferred, resident will be offered the following options for the management of fatigue:
   a) Sleep in call room until able to return safely to clinical duties or drive home.
   b) If call rooms are not available, or it is determined to be appropriate by the resident and supervising faculty that the resident should go home instead of sleeping in the call room, resident will secure safe transportation home through either Uber/Lyft/Taxi or ride from family or peers. Part or all of the cost will be reimbursed by the Residency Program.
   c) No resident that is too fatigued to continue their clinical duties should be allowed to drive themselves.

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 work 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.

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, 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 an 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) **Quality Improvement Curriculum**: 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 Pediatric Residency Program Leadership.

PEDiatric RESIDENT ScholarLY ACTIVITY

RESEARCH GOALS

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

QUALITY IMPROVEMENT GOALS

Residents are expected to participate in quality improvement activities.

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 the skill set required for completion of residency.
PROCEDURES AND SKILLS

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 for the resident to be recommended to sit for the Pediatric Board examination.

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.

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

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 IV placement
- reduction of simple dislocation
- simple laceration repair
- simple removal of foreign body
- temporary splinting of fracture
- umbilical catheter placement
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.

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) The Attending Physician 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.
ACADEMIC CONFERENCES

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. All efforts should be made to keep absences (outside of those on nights or vacation) to a minimum. Residents with more than one unexcused absence will be reported to the program director for professionalism concerns.

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). Tuesday morning reports are given by attendings to either interns only or seniors only (typically on alternating weeks) unless otherwise noted. 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).

JOURNAL CLUB
The resident journal club is held once per block during teaching day. PL3 Residents will be responsible for giving Journal Club. All residents are expected to have read the journal club article prior to the conference.

GRAND ROUNDS
Held the second and fourth Tuesdays from 12:00-1:00 pm in room 8403 (check calendar for room changes) from approximately September to June. All residents at BUMC are expected to attend Grand Rounds, including residents on Elective, Pathway and Research/QI rotations.

M & M
Held the third Tuesday of the month in room 8403 (check conference calendar). During the second year each resident will be responsible for working with the faculty mentor to find and present an appropriate care. There will also be a third year resident assigned for additional assistance. The schedule will be determined by the chief residents and will be rotation-dependent. Guidelines and timeline provided by the chiefs MUST be followed.
BOARD REVIEW

PL3s will give a board review lecture during teaching day. Topics will be determined by the chief residents and the faculty mentor.

BLOOD CLUB

Held the first Tuesday of the month from 12:00-1:00pm in room 8403 (check calendar for room changes). Attendance is highly encouraged.

On time attendance at all educational conferences according to the attendance policy for each conference type is an expected component of professional behavior. Failure to adhere to the attendance policies may result in professionalism complaints to the Program Director.
TIME OFF

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.

FLOATING HOLIDAYS

1) Residents are entitled to 4 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 rotation attending/director MUST be notified of and approve 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 rotation attending/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 on electives, adolescent, and development in writing (email from the attending or with an attending signature) and given to the Chief Residents. For clinics and nursery, permission must be obtained from the Chief residents in writing and then communicated to the clinic 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.

MATEERNITY/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.
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) If a house officer is absent because of personal illness, family emergency or similar circumstances, the house officer should notify their senior resident and chief resident.

3) 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 AND CALL

JEOPARDY CALL

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 all residents. The jeopardy resident is on 24-hour call. Interns jeopardy call pool may include interns on clinic, nursery, elective, Heme/Onc, and adolescent.

3) 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.

4) The resident unable to take call must contact the chief resident. The Housestaff office will be notified by the Chief Resident.

5) The jeopardy person must be available and respond in a timely manner to any page. If the jeopardy resident fails to be available, she/he will pay back the jeopardized resident with an equivalent shift.

6) 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 a single jeopardy resident from missing too much elective time on their rotation during their jeopardy block.

7) 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.

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
- Adolescent
- Elective
MOMMY CALL

Senior Residents will take “Mommy Call” for 3OPC, Wilmot, North Hills, and Pantano Clinics on the following schedule:

❖ Monday – Friday:
   0800-1700 = Clinic Senior Residents for their respective clinics
   1700-0800 = 446-1204 pager, carried by Wards Senior
❖ Saturday, Sunday and Clinic Holidays = 446-1204 pager, carried by Wards Senior

BUMC CODES AND STAT 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 4-4777. Provide the operator with the patient’s (approximate) age and location.

4) The wards senior pager (446-1204) and the PICU resident code pager are the in-house first responder physician pagers. As such, all pediatric codes will be texted to these pagers. These pagers must be carried at all times and the resident carrying the pager is responsible for responding immediately to these pages.

PATHWAYS AND ELECTIVES

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 Pediatric Residency Program Leadership, in order to suit their individual needs.

Pathway Options
● Ambulatory
● Hospitalist
● Critical Care
● Sub-specialty
● Global Health
● 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.
● Global Health: Participation in UACOM Global Health Course during May.

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.
● Global Health: Would recommend that project focuses on global health or local underserved population (border health, asylum-seekers, immigrants, refugees, Native American)

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.
● Global Health: Completion of elective at international, border, or Indian Health Service site that allows the opportunity to learn how to provide care in a resource-limited setting. January of PL-2 year is the earliest to complete this rotation and you must complete your PICU rotation in advance.

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**: “Resident Hospitalist” 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.
- **Global Health**: Completion of elective at international, border, or Indian Health Service site that allows the opportunity to learn how to provide care in a resource-limited setting. Ideally you will engage in a project during the rotation that would be useful to the community. Increased knowledge and autonomy compared to second year rotation.

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

**ELECTIVES**

Resident 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**
- **Suspected Child Abuse and Neglect**
- **Dermatology**
- **Endocrinology**
- **Genetics**
- **Gastroenterology**
- **Hematology/Oncology**
- **Infectious Diseases**
- **Nephrology**
- **Neurology**
- **Pulmonary**
(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
- Pediatric Urology

(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 resident is to find a mentor for the rotation. Goals and objectives will be specified prior to the rotation as well as a finalized work product.

2. Participation in the International Health elective 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 the start of block 2 for that academic year. If a resident wishes to change their 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 except under specific circumstances approved by the Pediatric Residency Program Leadership.

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. Electives not listed above must be discussed with and approved by the Program Director

9. 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. 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.

b. The following Prerequisites must be met in order to be approved for an away elective:
   1. Resident must be in good academic and professional standing as determined by Pediatric Residency Program Leadership.
   2. Resident must be current on assigned educational curricula
   3. Resident must be current on notes, discharge summaries, evaluations, and work hours logs;
   4. Resident must not have tardiness or no show to educational conferences.
   5. A houseofficer may complete an away elective only during a Call Free month.
Should the status of the above items change, the 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.

d. The Department will reimburse a maximum of $750.00 toward away elective expenses, plus an additional $300.00 for an International Health elective. The International rotation timeline for reimbursement are listed on New Innovations. This reimbursement will only be provided if all of the above procedures are followed. This funding may only be used once during residency.

e. The American Academy of Pediatrics Resident Section awards annual scholarships for resident travel. Applications are encouraged.

f. 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.

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 and residents on certain rotations such as hematology/oncology and neonatology may 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 2 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. Any changes to continuity clinic scheduling must be in accordance with clinic policy.

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, with the exception of Heme/Onc and NICU. All clinics will be cancelled for residents on vacation, nights, or an away rotation (clinic will not be cancelled on call free unless resident is doing an away rotation).

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

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.

INPATIENT DISCHARGE SUMMARY POLICY

Discharge summaries may be done in lieu of or in addition to the daily progress note depending on the time and circumstances of the discharge. If the discharge summary is done in lieu of a daily progress note, it must be completed on the day of discharge. If it is done in addition to a daily progress note, it must be completed within 24 hours of patient discharge.

Resident Policy:

● At 48 hours past due date: Notification by Hospital Medicine Team (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.

**PATIENT / NOTE 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
  - Distribute 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
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.
  ○ The attending physician must be notified prior to the resident leaving.
● 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.
  ○ 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
  ○ Short call is only permitted during months when there are 2 interns rotating on 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.

- 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.