Table of Contents

I. Administrative
   Contact Information ................................................................. 4
   Calendar .................................................................................. 5
   Expectations ........................................................................... 7
   Supervision of Residents ....................................................... 9
   Levels of Supervision ............................................................15
   Resident Advisor Information .............................................22
   Procedure Logs ....................................................................... 26
   Evaluation ................................................................................ 29
   Websites Frequently Used .................................................... 30
   Duty Hours .............................................................................. 31
   Grievance Policy .................................................................... 34
   Dress Code ............................................................................... 38
   Drug and Alcohol Policy ....................................................... 39
   Gifts, Gratuities, and Interactions with Vendors Policy .......... 42
   USMLE Policy for GME ......................................................... 43

II. Clinical Policies & Procedures
   Admission Policies ................................................................. 45
   Anesthesia Coverage for Pediatric Ward Patients............... 46
   Dictation System (Discharge Summary) ............................... 47
   Emergency Response System, Neonatal (NERT) ................. 48
   Emergency Response System, UVA Protocol ....................... 53
   Infant Security System ............................................................ 68
   Be Safe .................................................................................... 69
   Language Assistance Services .............................................. 71
   Safety Guidelines for Attending Physician Oversight ........... 73
   Patient Communication .......................................................... 75
   Medallion ................................................................................ 76

III. Rotation Guidelines
   Comm. Peds/Child Advocacy Portfolio ................................. 78
   Community Pediatrics .............................................................. 80
   Continuity Clinic ..................................................................... 81
   Newborn Nursery .................................................................... 82
   NICU/ICN ............................................................................... 104
   PICU ........................................................................................ 105
   Sedation Rotation ................................................................. 109
   Senior Ward Expectations .................................................... 110
   Medication Reconciliation .................................................... 112
   Teach/Clinic Resident Duties ................................................ 116
IV. Appendices

Appendix 1: Rotation Forms .................................................................118
Appendix 2: Evaluation Forms ..........................................................121
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Calendar

June – Middle:
- Welcoming and Farewell Party for residents
- New interns: Hospital orientation, PALS, Newborn Resuscitation, Departmental orientation, Epic training
- Transition to new Chief Resident

June – 3rd week:
- PL-I Beach Week and first week of work for new interns

July – 2nd week: In-Service exam for all residents

July – August: Acute Care Lecture Series
July – September: PL-2’s USMLE, Step 3

August-November – Monthly resident evaluations at end of housestaff meetings (4th Thursday)

September:
- September 30th: PL-2’s MUST have successfully completed USMLE Step 3
- AAP Advocacy Day, Washington, DC
- Fall meeting with mentor

October:
- ILP due prior to semi-annual meeting
- Semi-annual individual evaluation meetings for all housestaff with Dr. Waggoner-Fountain
- AAP National Meeting – Fall Session
- General Pediatric Certifying Board Exam
- Virginia Residency Fair and All Play at AAP Chapter Meeting

October-January:
- Intern Recruiting – Monday or Tuesday night dinners with housestaff
- Tuesday or Wednesday Interviews

November:
- Pediatric Resident Retreat
- Costa Rica Week
- Clinical Competency Committee meets for individual resident milestone evaluations

December:
- Holiday parties
- Semi-annual individual meeting to review CCC milestone evaluation with Dr. Waggoner-Fountain
January
- PL-3-register for ABP General Pediatrics Certifying Exam and License
- Legislative advocacy day

February:
- 2nd week: Ranking Session for Intern Applicants
- September 30th: PL-2’s MUST have successfully completed USMLE Step 3
- Completion of required Annual ACGME anonymous resident survey

March:
- March 1 –Mid-March: Match Day!
- Newborn Resuscitation and PALS retraining for rising PL-3s

March – May: PL-2s, BCLS, NRP, and PALS retraining.

April:
- April 17 – 19 McLemore Birdsong Conference

April – June
- Semi-Annual housestaff evaluation meetings with Dr. Waggoner-Fountain
- Resident/Advisor spring meeting
- AAP Spring Session
- PL-2’s prepare CV for review

Early May –
- Clinical Competency Committee meets for individual resident milestone evaluations
- Pediatric Academic Society Meeting

May:
- UVA Children’s Hospital Research Days – 2 consecutive Thursdays
- Required annual anonymous curriculum evaluation by residents and faculty

Late May/June:
- Housestaff Appreciation Dinner for housestaff
- Semi-annual individual meeting to review CCC milestone evaluation with Dr. Waggoner-Fountain
Expectations

In addition to the clinical and didactic expectations noted within the educational goals of the individual components of the training program, there are additional important expectations of this residency education program as follows:

- Housestaff will attend approximately 70% of the eligible Noon Conference, Grand Rounds, and Morning Report. Residents on all other services, without concurrent clinical or educational responsibilities requiring their presence elsewhere, are also expected to attend Morning Report.

- Housestaff will maintain a log of procedures which they have successfully performed in the New Innovations procedure log. This list should include the history number of the patient, the date, and the person who supervised the procedure. It is appropriate if you demonstrated or taught the procedure to someone else that this also be documented. This information can be entered into the New Innovations procedure log. Residents will ask supervising faculty, fellows, residents or nurse practitioners to sign off on the first three procedures performed in the NICU, intermediate and newborn nurseries including intubations and line placement.

- At the end of the first year of residency, we will ask residents to select a primary course of emphasis for their studies and training and education. This will help the resident create their Individualized Learning Plan (ILP). Areas of emphasis or tracts include but are not limited to: Global Health, Child Neurology, General Pediatrics, Procedural Based Subspecialty Pediatrics, Cognitive Based Subspecialty Pediatrics, and GME Education.

- Scholarly activities as an expectation for all housestaff may be accomplished in a number of settings or circumstances as follows:
  - Participation in journal club and the research conferences of the general and subspecialty services. All residents will lead journal club at least once during residency and will be formally evaluated on this presentation.
  - Participation in clinical or other research projects sponsored by the faculty is encouraged. Individual research projects are encouraged and the housestaff may apply with appropriate faculty sponsorship for UVA Children’s Hospital Research Grants.
  - Evidence based morning report presentations scheduled with rotation. There will also be morning report presentations that will be in a CPC case format. These morning report presentations and case discussions will be formally evaluated.
  - Preparation of a Noon Conference is required of all PL-2 and PL-3 residents with formal evaluation by at least one faculty member.
  - Attendance at the annual Research Day Activities of the department is required.
  - Participation in advocacy activities as outlined in the advocacy portion of the goals and objectives and documented in ILP.
  - Annual ILP created and reviewed with program director as well as selected advisor.
- Housestaff are not allowed to moonlight and are cautioned that unapproved extramural professional activities are not covered by your malpractice insurance as provided by the medical center.

- All residents will present a case at department MMI at least once during residency and will be formally evaluated on their presentations.

- Residents are allowed five days off (M - F) that are not during an inpatient rotation for interviews. All five of these days cannot be used during a required core block elective rotation. Residents must find coverage for other responsibilities they have (ED, medallion, continuity clinic, morning report presentations, etc). Additional days needed for interviewing must be vacation. These policies fit the regulations set out by the American Board of Pediatrics.

- Maintenance of continuity clinic patient log.

- Maintenance of duty hour log with update weekly.

- Completion of ACGME annual survey and departmental curriculum survey.
Supervision of Residents

General Inpatient Service Physician Chain of Command
All patients in the UVa Children's Hospital must have an attending and may have a resident available by pager or phone 24 hours a day. Questions regarding patient care should be addressed to the physicians in the following order:

1. Service of record intern or PIC 1306
2. Service of record senior resident or PIC 1204
3. Service of record Chief resident (if different than #2) PIC 1475
4. Service of record attending or covering attending (PIC # 1731)
5. PICU resident and attending (1733)

The next physician on the list should be called if the nursing staff does not receive what is felt to be an appropriate response after the second call to the preceding physician. If clinical condition warrants, the PERT protocol should be activated. Any healthcare provider or parent can activate a PERT (Pediatric Emergency Response Team)

Newborn Nursery Chain of Command
Questions regarding patient care must be addressed in the following order:

Weekdays between 0700 and 1600:
NBN intern or nurse practitioner
NBN Attending Physician (1201)
NBN Medical Director, Ann Kellams, MD, PIC 6793, cell 953-6637
(Back-up only if for some reason not avail: NICU Fellow on call, NICU Attending on call)

Nights after 1600 until 0700, Weekends or Holidays after intern has signed-out (e.g. for continuity clinic):
NICU intern or NP on call
NICU Senior Resident on call
NBN Attending on call
NBN Medical Director, Ann Kellams, MD, PIC 6793, cell 953-6637

The next physician on the list should be called if the nursing staff does not receive what is felt to be an appropriate response after the second call to the preceding physician. If clinical condition warrants, the NERT protocol should be activated. Any healthcare provider can activate a NERT (Newborn Emergency Response Team)

NICU Physician Chain of Command
Daytime:
1. Intern of record
2. Senior resident of record
3. NICU NNP
4. Service Fellow
5. NICU attending
6. For other emergencies, the medical director (Robert Sinkin) should be called
Nighttime:
1. Intern on call
2. Resident or Nurse Practitioner on call
3. Fellow on call
4. NICU attending on call
5. If for some reason NICU attending is not available (beeper not working, etc.), call the NICU medical director (Robert Sinkin)

**PICU Physician Chain of Command**

For all pediatric medical patients:
1. Resident on call
2. Fellow on service (if in house)
3. PICU attending
4. If for some reason PICU attending is not available (beeper not working, etc.), call the PICU director (Bill Harmon)

For all surgical patients:
1. Resident on call for that service and PICU resident on call
2. Chief resident on call for that service
3. Attending surgeon for that service
4. PICU attending on service

The attending is required to be called with every admission. That may be before, on arrival, or after the patient is seen-depending on the patient's clinical situation. The resident always notifies the fellow or attending prior to the patient admission. The resident also discusses the patient with the attending after they have seen the patient.

**Clinics**

All patients are discussed with a supervising faculty member after an initial evaluation by the resident.

**ED**

a. All patients are discussed with a supervising faculty member after an initial evaluation by the resident.
b. For trauma patients, an attending or the Pediatric Surgery chief resident will be present and assist with the initial evaluation.
c. Discuss before discharge with attending again.

**Pediatric Resident Guideline for Attending Notification**

**Pediatric Acute Ward: General ward and specialty pediatric medical service patients:**

Alert Attending if:
1) Transfer to ICU
2) Urgent consultation or transfer to another service
3) PERT team or CODE12 team called. PEWS criteria escalation has automatic notification of senior resident
4) Unexpected critical lab value
5) Death of patient
6) All new admissions
7) Resident team has management questions or concerns
8) Parent requesting to take child out AMA or knowledge that a family plans to lodge a formal complaint with patient representative team.
9) Stat or urgent consultation request to general or specialty consultant from surgical, family medical team.

**General Ward Attending PIC 1731**
- Cardiology Attending PIC 1833
- Nephrology Attending PIC 1744
- Pulmonary Attending PIC 1314
- Neurology Attending PIC 1842
- Hematology Oncology Attending PIC 1734
- Endocrinology Attending PIC 1963
- Gastroenterology Attending PIC 1749

**UVACH Intensive Care Units:**
Alert Fellow/Attending:
1) With all admissions
2) Emergent transfer to Operating Room or other procedural area
3) Code 12 team called
4) Unexpected death of a patient
5) Resident team has management questions or concerns
6) Urgent Consultation request from Pediatric Emergency Department (PICU) or NBN. Labor and Delivery (NICU)

**PICU Attending PIC 1733**
**NICU Attending PIC 1732**
**ICN Attending PIC 1836**

**Newborn Nursery:**
Alert covering fellow/attending if:
1) Transfer to NICU or PICU
2) Transfer to surgical service
3) NERT or Code 12 team called
4) Death of a patient
5) All new admissions requiring frequent reassessment or demonstrating physiologic/hemodynamic instability
6) Resident team has management questions or concerns
7) Parent requesting to take child out AMA or knowledge that a family plans to lodge a formal complaint with patient representative team.

Healthy newborns with stable assessments admitted to NBN do not require immediate attending notification. If the NICU team is called to the delivery for any reason, the NBN attending must be notified of the admission.

Residents should notify attending of record if they have knowledge that a family plans to lodge a formal complaint with patient representative team.

**NBN Attending PIC 1201**
A. SUBJECT: Graduate Medical Trainee Supervision Policy

B: EFFECTIVE DATE: January 23, 2014 (R)

C: POLICY:
This policy outlines the University of Virginia Graduate Medical Education requirements regarding progressive responsibility of GME Trainees (hereinafter “trainees”) and trainee supervision. The Policy incorporates all applicable University of Virginia Medical Center and Accreditation Council of Graduate Medical Education policies, procedures and standards of accreditation.

The Clinical Staff of the University of Virginia Health System has overall responsibility for the quality of professional services provided to patients, including patients under the care of trainees. It is the responsibility of the clinical staff to assure that each trainee is supervised in his/her patient care responsibilities by a member of the clinical staff who has been granted clinical privileges.

The attached protocol contains mandatory implementation procedures related to supervision of trainees.

D. Procedure
1. Supervision of Trainees

In the clinical learning environment, each patient must have an identifiable attending physician who is ultimately responsible for that patient’s care (CPR VI.D.1).

a. The name of the attending physician of record shall be available to trainees, faculty members and patients.

b. In certain situations, the attending physician may delegate supervisory responsibility to another caregiver (e.g., senior level resident) in accordance with individual RRC requirements. Ultimately, supervision rests with the attending physician.

c. Trainees shall inform patients of their respective roles in each patient's care (CPR VI.D.1.b).

2. Levels of Supervision

a. Each training program must demonstrate that the appropriate level of supervision is in place for all trainees who care for patients (CPR VI.D.2).

b. To ensure oversight of resident supervision and graded authority and responsibility, each program must use the following classification of supervision (CPR VI.D.3):
i) Direct Supervision – the supervising physician is physically present with the trainee and patient (CPR VI.D.3.a).

ii) Indirect Supervision with Direct Supervision immediately available – the 2 supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision (CPR VI.D.3.b).(1).

iii) Indirect Supervision with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision within 30 minutes after contact (CPR VI.D.3.b).

iv) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered (CPR VI.D.3.c).

3. Clinical Responsibilities

a. The clinical responsibilities for each trainee must be based on PGY-level, patient safety, trainee education, severity and complexity of patient illness/condition, and available support services (CPR.VI.E).

b. Progressive authority and responsibility, conditional independence, and level of supervision must be assigned by the program director and faculty members (CPR.VI.D.4) in accordance with individual RRC and Certifying Board requirements.

4. Escalation of Care

Notwithstanding the general categories of supervision set out above, a trainee shall **verbally** notify the responsible Attending Physician within 90 minutes of any of the following events:

a. Patient admission to hospital and/or service within 90 minutes. b. Transfer of patient to or from the intensive care unit or to a higher level of care
c. Need for intubation or ventilator support
d. Cardiac arrest or significant changes in hemodynamic status (i.e. Code 12 or MET team activation)
e. Significant change in clinical status
f. Development of significant neurological changes
g. Development of major wound complications
h. Medication errors requiring clinical intervention
i. Any significant clinical problem that will require an invasive procedure or operation
j. Patient death
k. Notification of patient representative that family wishes to lodge a formal complaint
l. Activation of IRPA for anything other than routine procedures
m. Patient or patient’s family request to see, or to speak with the Attending Physician.

Individual departments may have additional events or more urgent time restrictions that qualify for notifying the responsible Attending Physician.

Approved, GMEC, University of Virginia Health System: September 1992
Revised: GMEC, June 20, 2001
Medical Center Policy 0163: Access to Electronic Medical Records and Institutional Computer Systems

From: Kent, Monica *HS
Sent: Thursday, July 02, 2015 12:17 PM
Subject: Medical Center Policies effective July 1, 2015 (Access to Medical Records)

July 2, 2015

Dear All,

Please note that the proposed Medical Center policy change regarding access to one’s own personal medical records in Epic, is now in effect. As a result, “Covered Persons” (anyone with access to Epic), “…..are expected to use MyChart® to electronically access, review and retrieve their own personal health records, or those of family members (including spouses and minor children) or others whose records they are authorized to access, review and retrieve; Covered Persons may also contact HIS to obtain copies of such records. Covered Persons may not access, review or retrieve their own EMR in Epic or in any other institutional computer system nor may they access, review or retrieve any other person’s medical record (i.e. that of a minor child, spouse, parent, etc.) in Epic or in any other institutional computer system unless they are authorized to do so as part of their role-related duties.”

Please reference the revised policy via the link, below,

Thank you –

Policy 0163
Access to Electronic Medical Records and Institutional Computer Systems
Covered Persons with access to Epic and other institutional systems containing PHI will no longer be permitted to access their own personal EMR in such systems. Covered Persons are expected to use MyChart® to electronically access and retrieve their own personal health records, or to contact HIS to obtain copies.
(Administrative Policy)
Levels of Supervision for Procedures by Pediatric Resident Physicians

See [https://www.healthsystem.virginia.edu/intranet/housestaff/privilegeshome.cfm](https://www.healthsystem.virginia.edu/intranet/housestaff/privilegeshome.cfm) at the GME Website.

University of Virginia Graduate Medical Education
Pediatrics Residency
Year 1 in Program

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Can Perform With:</th>
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<tbody>
<tr>
<td><strong>See Generic List</strong></td>
<td></td>
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<tr>
<td><strong>Core Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>Render any care in life-threatening emergency</td>
<td>Senior Resident, NNP, or Fellow Present</td>
</tr>
<tr>
<td>Supervise Allied Health Professionals on this service</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td><strong>Procedural Sedation</strong></td>
<td></td>
</tr>
<tr>
<td>Procedural sedation</td>
<td>Faculty Present</td>
</tr>
<tr>
<td>Local Anesthesia</td>
<td>Faculty in Area</td>
</tr>
<tr>
<td><strong>General Pediatric Medicine</strong></td>
<td></td>
</tr>
<tr>
<td>Abscess drainage</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Arterial Blood Gas</td>
<td>Senior Resident, NNP, or Fellow in Area</td>
</tr>
<tr>
<td>Arterial Catheterization</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Arthrocentesis</td>
<td>Faculty Present</td>
</tr>
<tr>
<td>Aspirations &amp; Injections, joint or bursa</td>
<td>Faculty Present</td>
</tr>
<tr>
<td>Bladder catheterization</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Bone Marrow Aspiration</td>
<td>Faculty Present</td>
</tr>
<tr>
<td>Cardioversion</td>
<td>Faculty Present</td>
</tr>
<tr>
<td>Central Venous Catheterization</td>
<td>Fellow/Faculty in Area</td>
</tr>
<tr>
<td>EKG Interpretation</td>
<td>Senior Resident or Fellow Present</td>
</tr>
<tr>
<td>Excisions</td>
<td>Senior Resident or Fellow Present</td>
</tr>
<tr>
<td>Feeding tube placement (nasal or oral)</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Lumbar Puncture</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Pap Smears</td>
<td>Senior Resident or</td>
</tr>
<tr>
<td>Procedure</td>
<td>Responsible Party</td>
</tr>
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<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
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<tr>
<td>Paracentesis</td>
<td>Fellow in Area</td>
</tr>
<tr>
<td>Pericardiocentesis</td>
<td>Faculty Present</td>
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<tr>
<td>Respiratory Management</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Right or Left Heart Catheterization</td>
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<tr>
<td>Tendon/Joint Injections</td>
<td>Faculty Present</td>
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<tr>
<td>Thoracentesis</td>
<td>Senior Resident or Fellow Present</td>
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<tr>
<td>Tracheal Intubation</td>
<td>Senior Resident or Fellow Present</td>
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<tr>
<td>Tube Thorascotomy</td>
<td>Senior Resident or Fellow Present</td>
</tr>
<tr>
<td>Venipuncture</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td><strong>Allergy &amp; Clinical Immunology</strong></td>
<td></td>
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<tr>
<td>Puncture tests</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Skin biopsy</td>
<td>Faculty Present</td>
</tr>
<tr>
<td>Spirometry</td>
<td>Senior Resident or Fellow by Phone</td>
</tr>
<tr>
<td>Aspirations &amp; Injections, joint or bursa</td>
<td>Faculty Present</td>
</tr>
<tr>
<td>Tendon Sheath, Ligament, or trigger point injections</td>
<td>Faculty Present</td>
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<tr>
<td>Phlebotomy</td>
<td>Senior Resident in Area</td>
</tr>
<tr>
<td>Chemical therapy administration</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td><strong>Hematology and/or Oncology</strong></td>
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<tr>
<td>Peripheral smear</td>
<td>Faculty Present</td>
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<td>Intrathecal drug delivery</td>
<td>N/A</td>
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<tr>
<td><strong>Infectious Diseases</strong></td>
<td></td>
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<tr>
<td>Prescription of antiretroviral chemotherapy</td>
<td>Faculty by Phone</td>
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<tr>
<td><strong>Rheumatology</strong></td>
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<td>Aspirations &amp; Injections, joint or bursa</td>
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<td>Tendon sheath, ligament or trigger joints</td>
<td>Faculty Present</td>
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<tr>
<td>Soft tissue injection</td>
<td>Senior Resident or Fellow in Area</td>
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<tr>
<td><strong>Neonatal Limitations</strong></td>
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<tr>
<td>Endotracheal Intubation of Term Infant</td>
<td>Senior Resident or Fellow Present</td>
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<td>Endotracheal Intubation of Preterm Infant</td>
<td>Senior Resident or Fellow Present</td>
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<tr>
<td>Delivery Room Resuscitation of Term Infant</td>
<td>Senior Resident or Fellow Present</td>
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<td>Procedure</td>
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<tr>
<td>Endotracheal Surfactant Delivery</td>
<td>Senior Resident or Fellow Present</td>
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<tr>
<td>Umbilical Artery Catheterization</td>
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<tr>
<td>Umbilical Venous Catheterization</td>
<td>Senior Resident or Fellow in Area</td>
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<tr>
<td>Partial Volume Exchange Transfusion</td>
<td>Senior Resident or Fellow in Area</td>
</tr>
<tr>
<td>Total Volume Exchange Transfusion</td>
<td>Faculty in Area</td>
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</tbody>
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## University of Virginia Graduate Medical Education
### Pediatrics Residency
#### Year 2 in Program

<table>
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University of Virginia Graduate Medical Education  
Pediatrics Residency  
Year 3 in Program

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Documented meetings between an individual resident and mentor or advisor for purposes of feedback and guidance must occur at least twice a year. Mentors must guide the residents in their ability to use self-assessment techniques and analysis of events that exemplify particularly positive or negative behaviors to identify personal and professional strengths and weaknesses. In response, residents must develop relevant learning plans that begin during and extend beyond residency. (RRC, 2007)

Summary of Suggested Guidelines for Housestaff Advisor Sessions

- **Review Individualized Learning Plan (ILP)**
  - Review ILP assessment
  - Review ILP goals for improvement

- **Reading and Study Strategies**
  - Highlight the need to engage in a reading/self-study program early, and help identify plan if need be. Suggested strategies include:
    - Utilizing the ‘item content feedback’ from the In-Training Examination to guide your reading
    - Using the UVA Pediatric Residency Training Program Curriculum’s Goals & Objectives during each rotation (printed and on-line versions)
    - Reading *PREP/Peds in Review* and utilizing *PREP* archived questions as studying tools (available in hard-copy and online through [www.pedialink.org](http://www.pedialink.org)) for PL2s and PL3s
    - Med Study Review books with monthly curriculum at noon conference board review for PL2s and PL3s
    - Using major textbooks & journal articles
    - Case-based learning & focused reading from patient encounters
    - Utilizing preceptors from rotations to discuss related topics & questions from PREP or the In-Training examination.

- **Evidence based Medicine**
  - Review the concept of lifelong learning, and the importance of participating in both Journal Club and EBM teaching sessions.

- **Work Hours**
  - Review the existing policy and screen for compliance (important!)
Moonlighting
- No Moonlighting is allowed.

Continuity Clinic Discussion – Should include a discussion of:
- Awareness of required minimum number of sessions per year = 36
  Minimum number (averaged over year) of patients per sessions
  (for PL-1 res = 3, for PL-2 res = 4, and for PL-3 res = 5)
- Discussion of completed continuity clinic modules (on average, one
  per month)

Evaluations –
- Annual surveys of residents about the program (anonymous)
- Annual surveys of faculty about the program (anonymous)
- Curriculum Committee (faculty and residents) review rotation
  feedback and survey feedback quarterly
- Student evaluations
- Faculty evaluations (anonymous)
- Fellow evaluations (anonymous)

Certification Requirements
Please review
- NBME Step 3 after PL-1 year. Must be passed before March of
  PL2 year
- NRP/PALS (every 2 years)
- Permanent license application during Spring PL-3 year
- ABP application during Spring PL-3 year

Career Goals & Professional Development
- Resources include faculty, program leadership, colleagues;
  encourage dialogue and availability
- Helpful websites:
  http://www.aap.org/en-us/professional-resources/Pediatrics-as-a-Profession/Pages/Pediatrics-as-a-Profession.aspx
☐ Curriculum vitae & personal statement preparation
  o We’re available to help with this at any time, and support their effort to pursue fellowship and job opportunities.

☐ Encourage Scholarly and/or Community Activities
  Examples include:
  o Research electives
  o Longitudinal projects
  o Community projects

☐ Satisfaction with Program/Feedback
  o Foster environment for resident empowerment, provide venue for open dialogue and communication about the general satisfaction/strengths & weaknesses of program.

☐ Suggestions for program improvement by the resident
  o Foster environment for resident to communicate new ideas for improvement and offer solutions to existing problems.

☐ PLEASE REMEMBER TO DOCUMENT YOUR VISIT.
  o This completed and signed checklist itself can serve as documentation.

__________________________________________________________________________
Faculty Advisor Signature & Date             Resident Signature & Date

__________________________________________________________________________
Faculty Advisor name printed             Resident name printed
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Procedure Logs

Date: June 23, 2014
To: Pediatric Housestaff
From: Linda A. Waggoner-Fountain, M.D.
RE: Procedure Logs During Residency Training

I have been asked what types of procedures should be listed in your procedure logs. During your departmental orientation, you each received a small handbook from the American Board of Pediatrics (ABP) designed to assist residents in understanding the ABP Tracking and Evaluation Program. Under procedural skills, the following are direct quotes from the ABP (2014 ABP Evaluating Your Clinical Competence in Pediatrics, pages 4-5):

"Your performance of certain technical procedures should be observed, evaluated, and documented by qualified physicians. Successful mastery of these skills includes an understanding of their indications, contraindications, complications, and the ability to interpret their results. The ability to obtain informed consent and to assure appropriate pain management is essential."

The Review Committee (RC) for Pediatrics states that each resident must be able to competently perform procedures used by a pediatrician in general practice. This includes being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of application results. Residents must demonstrate procedural competence by performing the following procedures:

- Bag-mask ventilation
- Bladder catheterization
- Giving immunizations
- Incision and drainage of abscess
- Neonatal endotracheal intubation
- Lumbar puncture
- Peripheral intravenous catheter placement
- Reduction of simple dislocation
- Simple laceration repair
- Simple removal of foreign body
- Temporary splinting of fracture
- Umbilical catheter placement
- Venipuncture

All residents must complete training and maintain certification in Pediatric Advances Life Support, including simulated placement of an intraosseous line and Neonatal Resuscitation.
In addition, residents must be competent in the understanding of the indications, contraindications, and complications for the following procedures:

- Arterial line placement
- Arterial puncture
- Chest tube placement
- Circumcision
- Endotracheal intubation of non-neonates
- Thoracentesis
- Conscious sedation

With regards to how many of what procedures should be logged, some general guidelines include the following two categories:

Log each procedure throughout residency
- LP
- UAC
- UVC
- Intubation
- Conscious sedation-procedural
- Bag-mask ventilation

Log procedures until competent (usually about ten procedures)
- Venipuncture
- IV placement
- Bladder catheterization
- Pain management
- Reduction and splinting of simple dislocations/fractures
- Arterial puncture
- Giving immunizations
- Simple laceration repair
- Simple foreign body removal
- Incision and drainage of abscess

At the University of Virginia

PL1s need to have three intubations and three line placements (UAC, UVC or peripheral arterial lines) directly observed by a faculty member, fellow, NNP or senior resident and documented in writing during the nursery rotations. If this is not completed, then we will need to create additional opportunities for you to successfully complete this requirement. This will be reviewed with your Individual Learning Plan (ILP).

Recording Your Procedures

Please record your procedures in the New Innovations procedure log. Please be sure to put in who your supervisor was for the procedure so they can comment on your competence. This email will be sent to them when you do this.
How to log on: www.new-innov.com/login
Institution login: uva
Username: first initial of your first name, followed by last name
Password: same as above, you will need to change it after logging in the first time

I strongly suggest logging all of your procedures including attendance at deliveries these for your own personal use when you request hospital privileges after you complete residency.

I strongly suggest that you document all conscious sedations you perform, at least 10 cases of patient management and at least 10 – 20 newborn deliveries each of your three years of residency. Probably recording all of the deliveries you have attended is the best.
Evaluation

Residents will be evaluated on their patient care, medical knowledge, their own practice-based learning and improvement, interpersonal and communication skills, professionalism and their awareness and responsiveness to a systems-based practice. A variety of forms used for documentation are to be found after this page.

Evaluation is a continuous process throughout the residency training. A formal written evaluation will follow the completion of each rotation and the completed evaluation forms are available to the residents through the Program Coordinator's Office in hard copy and electronically via the online evaluation site.

Twice yearly there will be a formal review with the Program Director and/or the Associate Program Director. This review will be based on results of monthly evaluations, review by the Faculty Housestaff Evaluation Committee, student evaluations, 360° evaluations, unsolicited comments, evaluations of presentations, ITE scores, direct observations.

At least twice yearly, each resident will be assessed by the residency Clinical Competency Committee (CCC) on each of the ACGME pediatric specific RRR milestones. These assessments will be submitted to the ACGME on a semiannual basis and the PD will review each resident’s assessment with them on an individual basis.

At least twice yearly, each resident will meet with their selected advisor to discuss their ILP, career plans, and anticipated needed support for upcoming six months.

The In-training Examination of the American Board of Pediatrics, given in mid-July, is required of all residents. The results of the ITE will be discussed with each resident individually by the Program Director.

Housestaff are encouraged to seek evaluation from faculty and/or supervising housestaff midway through rotations or at any time the house officer deems appropriate.

Housestaff will be asked to provide periodic (usually monthly) written, anonymous) evaluations of faculty teaching effectiveness. These evaluations are critically important to the successful academic careers of the faculty and we strongly encourage you to provide this feedback. You will not be harmed by being frank!

Housestaff have been instructed in medical student evaluation and are to complete student evaluations on appropriate rotations.

Annually, in May, the housestaff will be asked to provide a formal evaluation of the Pediatric Residency curriculum.

Departing 3rd year residents will have two exit interviews with 1) the department chair and 2) the program director. We strongly encourage your frank assessment of your educational experience.

The curriculum committee, chaired by the Associate Program Director, is composed of housestaff and faculty. Please use this forum to present your suggestion for changing or improving the curriculum.
SEE Appendix 2 for Evaluation Forms

Websites

New Innovations:  www.new-innov.com/login

Department website (intranet):  https://www.healthsystem.virginia.edu/intranet/childrens/

ACGME:  www.acgme.org

American Board of Pediatrics:  www.abp.org

American Academy of Pediatrics:  www.aap.org

Pedialink (ILP and Access to Peds in Review):  www.pedialink.org
**Duty Hours**

**Policy on Duty Hours**

The general pediatric residency training program structures its residency rotations to be in compliance with the universal ACGME duty hour requirements.

Residents are to work no more than 80 hours per week averaged over a four week period. Certain inpatient rotations including the ICU and ward rotations will have one week where duty hours will be over 80 hours. This has been done on purpose to allow residents a full weekend off the subsequent week. This averages to < 80 hours/week over a four week cycle.

Residents have one day (24 hours) in seven, completely free of clinical duties. As noted above, on some inpatient rotations, residents may work for 13 days in a row to have a subsequent entire weekend off.

The ambulatory clinic phone call rotation has at-home call responsibilities. The supervising faculty are aware of call restrictions and the necessity to monitor for excessive fatigue.

There is no moonlighting allowed by residents in the general pediatric residency training program at the University of Virginia. The chief residents (PL-4s) may occasionally moonlight but have no in-house call responsibilities routinely scheduled. The program director monitors external moonlighting done by the chief residents.

**Duty Hour Violations**

*Duty hours must be logged at least weekly.* The only exceptions are for a rotation in a foreign country and vacations. These will be reviewed weekly by the program director. The Program Director will review duty hours weekly. If there are rotations with multiple residents with repeated duty hour violations, the program director will work with the supervising faculty and the chief residents to modify the rotation to accommodate duty hour requirements.

If an individual is having difficulties fulfilling duty hour requirements, the program director will work with the chief residents, supervising resident (if applicable) and the individual resident to improve time management. If these techniques do not ameliorate the duty hour violations, the program director will have the resident work 1 on 1 with a senior faculty member on time management skills and the program director will have close observation of progress and intervene as necessary. If a resident is close to violating duty hour violations (either 30 hour or 80 hr/wk on average) the program director will instruct the resident to sign out immediately and wait for them to leave.

**DUTY HOUR REQUIREMENTS (effective July 1, 2011)**

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

**Mandatory Time Free of Duty**

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

**Maximum Duty Period Length**
1. Duty periods of PGY-1 residents must not exceed 16 hours in duration. PL-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.

2. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

3. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

4. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

5. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

6. 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. Under those circumstances, the resident must:

   (a). appropriately hand over the care of all other patients to the team responsible for their continuing care;

   and,

   (b) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

7. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

**Minimum Time Off between Scheduled Duty Periods**

1. PL-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

2. Intermediate-level residents [PL-2] & Final level residents [PL-3s] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

**Maximum Frequency of In-House Night Float**

1. Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

**Maximum In-House On-Call Frequency**

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
At-Home Call

1. 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.
   1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

2. 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”.

ACGME-approved: September 26, 2010 Effective: July 1, 2011
Modified by L. A. Waggoner-Fountain, May 23, 2011
GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 06

A. SUBJECT: Grievance

B. EFFECTIVE DATE: December 19, 2013 (R)

C. POLICY: Policy on Grievance

This policy is established to provide a mechanism for resolving disputes and complaints that may arise between a graduate medical trainee and his or her program director or other persons involved with the administration of the educational program.

There shall be a process for adjudicating graduate medical trainee complaints and grievances related to the work environment or non-academic issues related to individual residency programs or faculty.

Definitions

Complaint – A written or verbal expression of dissatisfaction with the work environment, individual residency programs or the faculty.

Grievable Complaints (“Grievance”). A grievable complaint is a concern or issue that a graduate medical trainee may feel is unjust and/or an unfair practice that may affect his or her ability to carry out duties as required by both the ACGME and the program.

Grievable complaints include the following:

(1) A program’s consistently exceeding the ACGME Duty Hour regulations without regard to the graduate medical trainee’s well-being.
(2) Complaints related to a graduate medical trainee feeling unsafe and/or unprotected due to lack of security provided by the program or Medical Center.
(3) Complaints related to a disciplinary action brought forth by the Program Director as a result of trainee misconduct.
(4) Complaints related to inappropriate behavior, including mistreatment, by any member of the Medical Center or School of Medicine as defined in Medical Center Policy 262.

Complaints based solely on the following actions are not subject to this process and thus are considered "not grievable":


(1) Decisions regarding and/or documentation of areas of deficiencies in academic performance or remedial actions, or placement on academic remediation (see Policy on Assessment of Performance of Graduate Medical Trainees).

(2) Establishment and revision of salaries, position classifications, or general benefits

(3) Work activity accepted by the graduate medical trainee as a condition of employment or work activity that may be reasonably expected to constitute a part of the job

(4) The content of policies, procedures and other rules applicable to graduate medical trainees

(5) Work and duty assignments within the Medical Center

(6) Discrimination on the basis of race, national origin, religion, sex, age, handicap, or sexual orientation. These complaints are handled in the manner specified in the University of Virginia Office of Equal Opportunity Programs.

III. Procedure:

A. Step 1: (If Grievance is with Program Director, skip to Step 2.) The graduate medical trainee and program director shall make a good faith effort to resolve complaints informally. If the complaint is not resolved informally and if the complaint is grievable, as defined above, the graduate medical trainee shall, within 10 calendar days of the event or action giving rise to the grievance, notify the program director in writing of the nature of the grievance, all pertinent information and evidence supportive of the grievance and a statement of the relief requested. Within 7 calendar days after receipt of this notice, the program director shall meet with the graduate medical trainee and attempt to reach a solution along with a third party (e.g. Vice Chair of Education of department, member of GME Office). Within 5 calendar days of this discussion, the program director shall inform the graduate medical trainee in writing of the resolution of the grievance and shall address both the issues raised and the relief requested. A copy of the program director's resolution shall be provided to the appropriate Department Chair and to the Designated Institutional Official (herein after “DIO”) and Associate Dean of Graduate Medical Education.

B. Step 2: If the program director's written resolution is not acceptable to the graduate medical trainee, the graduate medical trainee shall notify the Department Chair (if Program Director is Department Chair, skip to Step 3) in writing within 10 calendar days of receipt of the program director's resolution. This notification shall include a copy of the program director's resolution and all other information supportive of the graduate medical trainee's grievance. Within 7 calendar days of receipt of the grievance, the Department Chair shall meet with the graduate medical trainee to discuss the grievance and attempt to reach a solution with third party present. Within 5 business days of this meeting, the Department Chair shall send to the graduate medical trainee a written response to the issues and relief requested. A copy of this response shall be provided to the DIO.

C. Step 3: If the graduate medical trainee disagrees with the decision of the Department Chair or the Program Director is the Department Chair, the graduate medical trainee shall present a written statement to the DIO within 10 calendar days of the receipt of the Program Director/Department Chair’s decision. The statement shall describe the nature of and basis for the grievance and include copies of the decisions of the Program Director and the Department Chair. Failure to submit the grievance in the ten day period shall constitute waiver of the grievance process and the decision of the Program Director/Department Chair will be final. The DIO shall review all written information and decide whether further meetings or inquiry could be helpful to resolve the issue. Within 10 calendar days of receipt of the graduate medical trainee’s
statement, the DIO shall provide to the graduate medical trainee a written decision on the grievance. This decision shall be final.

D. The DIO may extend these times for good cause.

IV. Confidentiality

All participants in Steps 1, 2 and 3 of the grievance process shall not discuss the matter under review with any third party except as may be required for purposes of the grievance procedure. The Chief Executive Officer of the Medical Center and the Dean of the School of Medicine may be notified of a grievance and such notification shall not constitute a breach of this confidentiality requirement.

GMEC Approval: January 19, 2000
GMEC Approval: April 2007
GMEC Approval: September 16, 2009
Reviewed/Revised: GME Policy Subcommittee, December 10, 2013
Approved: GMEC, December 18, 2013
From: Kirk, Susan *HS
Sent: Tuesday, April 15, 2014 11:54 AM
To: CL Residency/Fellowship Directors
Cc: Farineau, Diane W *HS
Subject: HIPAA Violations by GME trainees

We have had an uptick in the number of residents and fellows committing HIPAA violations as discovered through the Corporate Compliance Office's Fair Warning system. Although UVA's HIPAA policy is emphasized at orientation, and is part of every GME Trainee's annual retraining, it may serve everyone well if, as program directors, you could remind your residents and fellows of the rules:

Accessing a spouse's (or family member's) record without prior written documentation of permission to do so will result in a 3 day suspension without pay and with mandatory reporting of the HIPAA violation by UVA to the Board, and then subsequently by the resident on future verifications and licensing applications.

Accessing a minor child's record will result in a three day suspension without pay but no reporting to the Board of the HIPAA violation. The suspension must be reported by the resident and mentioned on future verifications and licensing applications. GME trainees who are parents may either ask for a written copy of their minor child's record through the Medical Records Department, or sign up for MyChart Proxy.

I will remind everyone that these are not GME policies and procedures, but those of the Health System. We in the GME Office are often left in the unfortunate situation of enforcing them, however.

Thanks for your help,
Susan

Susan E. Kirk, MD
Designated Institutional Official and Associate Dean for GME University of Virginia Health System
Dear Residents and Faculty,

Recently remarks have been made by patients’ families and members of our own team, that on occasion, outfits worn by residents and faculty have been unprofessional and distracting. Specific concerns are addressed below.

Tights or leggings worn without a dress/skirt/tunic/sweater or top that reaches nearly to the knees is considered too form fitting to be professional dress.

Denim pants (AKA jeans) are not appropriate either. Expensive jeans are still denim pants and the color does not make denim OK. If you are on a non-patient care experience such as conducting research you should still dress professionally. If you are consistently attending morning report, noon conferences, resident interview days in jeans you may be sending the wrong message. This applies to both male and female staff members.

T shirts with print or logos can be worn under a scrub top but not as the sole top. Logos, phrases, expressions that in any way could be considered offensive, inappropriate, crude, or convey messages/advertise products that are not usually considered appropriate in the medical center/professional setting (alcohol, tobacco,) etc should never be worn, even under scrub tops.

Flip flops, low cut tops, low rise pants etc. are not professional either.

In general, common sense: if you have enough insight or concern or question as to whether or not your attire is appropriate for work, you should not wear that outfit.

**Here is the summary of the Medical Center dress code:**

School of Medicine employees, faculty and staff alike, are expected to dress appropriately for their job responsibilities and to wear the appropriate uniform or quality of apparel appropriate to their jobs. Examples of inappropriate attire include, but are not limited to: denim pants (all colors), shorts, sweat shirts (unless designated as part of a uniform), sweat pants, T-shirts with print, tank tops, halter tops, and other apparel as designated by the supervisor. Scrub suits are to be worn only in areas for which approval has been granted. Appropriate footwear should be worn in accordance with duties performed.

**You can find the details in Medical center policy #0051; Attire and Personal Appearance**

Thank you for dressing professionally at all times when here at the Medical Center.

Nancy McDaniel
To all University of Virginia academic division employees and students:

The U.S. Department of Education requires that each institution of higher education distribute its alcohol and other drug policy annually, in writing, to every student and employee.

If you supervise staff who do not have regular access to e-mail, please print this message and distribute to all employees.

The University's Alcohol and Drug Policy regulates the sale and service of alcoholic beverages on University property and informs the University community of state and federal laws and penalties concerning substance use and abuse, health and behavioral risks of drug use, and resources for treatment and educational programming in accordance with federal law. [Drug-Free Schools and Campuses Regulations; 20 U.S.C. 1011i and 34 C.F.R. Section 86.100 (a) (1).]

The following is a summary of the University's alcohol and drug policy. The full text can be found in the Student Record or by clicking the STU-001 link from the on-line Policy Directory at: https://etg07.itc.virginia.edu/policy/policylookup

Approval to use alcohol at an event on University property or at a University function involving University of Virginia students requires approval a minimum of one week in advance in writing from the Vice President for Student Affairs. Please submit the Use for Alcohol Request Form (available at http://www.virginia.edu/vpsa/affairs.html) to request approval.

The University of Virginia prohibits the illegal or otherwise irresponsible use of alcohol and other drugs. It is the responsibility of every member of the University community to know the risks associated with substance use and abuse. This responsibility obligates students and employees to know relevant University policies and federal, state, and local laws, and to conduct themselves in accordance with these laws and policies.

**Alcohol**

Virginia State laws concerning the purchase, possession, consumption, sale, and storage of alcoholic beverages include the following:

- Any sale of an alcoholic beverage requires a license from the Virginia Alcoholic Beverage Control (ABC) Board;
- Alcoholic beverages are not to be given, sold, or served to persons under 21 years of age;
- Alcoholic beverages are not to be given, sold, or served to persons who are intoxicated;
- State law prohibits: drinking in unlicensed public places; possession of an alcoholic beverage by a person under 21 years of age; falsely representing one's age for the purpose of procuring alcohol; and, purchasing an alcoholic beverage for a person who is under 21 years of age.

The University of Virginia assumes no responsibility for any liability incurred at any event not sponsored by the University where alcohol is served and/or sold. Students and members of Contracted Independent Organizations or of organizations with a Fraternal Organizational Agreement are always expected to conduct themselves in accordance with the laws of the Commonwealth of Virginia and to assume full responsibility for their activities and events.

Any student found in violation of this policy is subject to the entire range of University Judiciary Committee sanctions described in the Statement of Students' Rights and Responsibilities,
including suspension and expulsion. University personnel found in violation of this policy are subject to appropriate personnel sanctions.

**Drugs**
Unauthorized manufacture, distribution and possession of "controlled substances" (illegal drugs), including marijuana, cocaine, and LSD, are prohibited by both state and federal law and are punishable by severe penalties. The University does not tolerate or condone such conduct. Students and employees who violate state or federal drug laws may be referred by University authorities for criminal prosecution.

Whether or not criminal charges are brought, all students and employees are subject to University discipline for illegally manufacturing, distributing, possessing, or using any controlled substance (i) on University property, (ii) at University functions, or (iii) under other circumstances involving a direct and substantial connection to the University. Any student found to have engaged in such conduct is subject to the entire range of University Judiciary Committee sanctions described in the Statement of Students' Rights and Responsibilities, including suspension and expulsion. University personnel found in violation of this policy are subject to appropriate personnel sanctions.

**Federal and State Penalties**
Federal and state law penalizes the unlawful manufacturing, distribution, use, and possession of controlled substances. Federal law holds that any person who distributes, possesses with intent to distribute, or manufactures a controlled substance on or within one thousand feet of an educational facility is subject to a doubling of the applicable maximum punishments and fines. A similar state law carries sanctions of up to five years imprisonment and up to a $100,000 fine for similar violations.

**Drug-Free Workplace Policy**
The use of alcohol by all employees while on University property, including meal periods and breaks, is absolutely prohibited except when authorized in advance by the University for approved University functions. No employee will report to work while under the influence of alcohol or illegal drugs. Violations of these rules by an employee will be reason for evaluation/treatment for a substance use disorder or for disciplinary action up to and including dismissal.

**Consultation and Treatment**
For Students:
Substance use consultations, comprehensive mental health evaluations, including risk assessments for all substance presentations, treatment, and/or referral for students and concerned friends or family is available through Student Health's Counseling and Psychological Services (924-5556).

For Faculty and Staff:
No cost, strictly confidential information, evaluation, intervention, and referrals for faculty, staff, and family members are available through the Faculty and Employee Assistance Program (FEAP). FEAP staff are licensed professionals with expertise in substance abuse, mental health, family, and workplace issues. Consultation for chairs and other faculty administrators is also available (243-2643; or 1-800-847-9355, 24 hours a day).

The full text of University policies and sanctions; laws and penalties concerning substance use and abuse; health and behavioral risks of drug use; and resources for treatment and educational
programming can be found in the Student Record or by clicking the STU-001 link from the on-line Policy Directory at: https://etg07.itc.virginia.edu/policy/policylookup

Executive Vice President and Chief Operating Officer
Leonard W. Sandridge approved distribution of this message
Medical Center policies 0008 ("Gifts, Gratuities and Interactions with Vendors") and 0013 ("Vendors, Sales and Service Representatives") apply to all persons providing patient care or other services within or for the benefit of the Medical Center, regardless of employer {“Covered Persons”}. Of particular note are new provisions which govern interactions between Covered Persons and any and all Medical Center or University vendors, sales or service representatives. These changes have been coordinated with policy changes adopted by the School of Medicine, and reflect similar efforts underway at academic medical centers across the country. Copies of revised policies 0008 and 0013 are attached for your review.


Highlights of these revised policies include the following (Note: please consult the policies directly for in-depth discussions of each of these highlighted topics):

**Covered Persons are prohibited from soliciting or accepting:**

*Meals* (which include bagels, donuts, coffee, etc.) offered or provided by any vendor, sales or service representative on Medical Center or University grounds. Unrestricted grants given to the Medical Center or the University may be used to provide food or beverage at an educational event or function; also, meals or beverages can still be accepted from vendors, sales or service representatives when offered to a large group of people at a trade show, exhibit or other professional meeting;

*Promotional materials* (pens, calendars, notebooks, etc.). Items of nominal value having legitimate educational purpose will be permitted;

*Gifts* for services performed within the scope of Covered Persons’ official duties;

*Product samples* for personal or family use, including but not limited to medication samples or ancillary product samples such as infant formula, lotions, etc.

These policies also provide new guidance for vendor, sales or service representative support of educational conferences, programs and events, requiring that such support to be in the form of unrestricted gifts made to the Medical Center or the University. Finally, patient care areas, where vendor, sales or service representative meetings may generally not occur, are more specifically defined to exclude physician offices, but include patient units, nursing stations, conference rooms located in patient care units, physician lounges, patient care areas of outpatient offices (including clinics located off-grounds), surgical areas or the Emergency Department. Exceptions may be made for in-service training (i.e., when a vendor, sales or service representative is on site to conduct instruction on the use of specific devices or equipment) or technical consultations (i.e., vendor, sale or service representative presence during procedures or for equipment repair or maintenance) conducted in accordance with Medical Center Policy 0013 and other relevant Medical Center policies.

Mary Anne Harkins; Associate Special Advisor to the CEO
USMLE Policy for GME

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 07

A. SUBJECT: Passing USMLE, Steps 2 and 3

B: EFFECTIVE DATE: February 15, 2012 (R)

C: POLICY:

Purpose

To provide a process for residency and fellowship programs to require successful passage of Step 2 and Step 3 for either matriculation into a GME training program, and/or promotion within a GME training program.

Policy

All medical students, residents and fellows who have accepted an offer to join a training program at the University of Virginia must successfully pass Step 1 and both parts of Step 2 of the USMLE (or its equivalent) by the first day of orientation. Exceptions must be approved by the Graduate Medical Education Committee.

All medical residents who are currently enrolled in a GME training program must take and pass Step 3 of the USMLE (or its equivalent) by March 1st of their PGY-2 year. Failure to pass USMLE Step 3 by March of the PGY-2 year may result in non-renewal of their appointment. Fellows entering a training program must show evidence of successful passage of Step 3 prior to entering their fellowship program. Exceptions must be approved by the Graduate Medical Education Committee.

Trainees who take extended sick leave or leave of absence for personal reasons may be granted an extension at the discretion of the trainee’s Program Director. The Program Director need not present this extension to the full GMEC but must inform the Graduate Medical Education Office (GMEO). Once the trainee returns to full duty, a plan for completion of the USMLE must be instituted and communicated to the Graduate Medical Education Office.

Since residents will not be expected to use vacation time to take the exam since it is a GME requirement, time spent taking the exam will be logged as duty hours.

The trainee will have six months to pass the examination from the date of GMEC approval of his/her exception. The program director or graduate medical trainee must report back to the GME Office or GME Committee successful completion (or failure to complete) of this requirement.

Residents should take the appropriate licensing examination early in their training to permit adequate time to re-take the exam if more than one attempt is needed. Residents should register for the USMLE Step 3 or equivalent licensing (or its equivalent) examination no later than November 1st of their PGY-2 year to allow for scheduling, grading, and notification of results by
March 1. Residents who fail USMLE Step 3 (or its equivalent) after two attempts must be presented to the GMEC by the Program Director or Chair of the Department for discussion.

GMEC Approval: November 19, 2008; applies to all residents and fellows matriculating July 1, 2009 and thereafter.
GMEC Policy Subcommittee Review – May 11, 2010 / GMEC Review/Approval: May 19, 2010

GMEC Reviewed: July 21, 2010 GMEC Reviewed/Approved: August 18, 2010
GMEC Policy Subcommittee Reviewed/Approved: February 14, 2012
GMEC Reviewed/Approved: February 15, 2012
Admission Policies

Internal Referrals to UVA CH for Unscheduled Inpatient Admission (North Ridge Pediatrics, Orange Pediatrics, and ALL UVA CH clinics)

Acute Care Pediatrics
- If admitting to your own service please call the bed center 434-924-5156 and then call the admitting resident on your service to provide report and hand off of care.
- If admitting to general pediatrics service page the triage officer PIC 9482 (usually pediatric chief on call) and he or she will coordinate getting the correct services to facilitate the admission.
- If bed is available and if the child is in the Battle building call Medic 5 (2-2000) for internal transport support.
- If there is no bed available the triage officer will contact the CH medical administrator on call to determine appropriate disposition.
- If patient needs IV, blood work or other tests the default is to be admitted thru the ED. Please call the Peds ED 924-9273 and ask to speak with the Peds ED attending.

Pediatric Intensive Care
- Call the PICU (434-924-1761) and ask to speak with the PICU attending.
- If no answer after 7 rings page PICU attending on call (PIC 1867).
- If bed is available and if the child is in the Battle building call Medic 5 (2-2000) for internal transport support to the PICU.
- If bed is available and the child is at North Ridge Pediatrics or Orange Pediatrics the PICU will assist with contacting Medcom if transportation is needed.
- The PICU will coordinate getting the correct services to facilitate the admission.
- If bed is not available, the PICU will coordinate with the ED to take care of child until PICU bed available or disposition made.

Neonatal Intensive Care
- If the patient is an infant that needs management of Hyperbilirubinemia and is at the exchange transfusion level, page the NICU fellow PIC 9238 to determine location for the admission.
- If bed is available and if the child is in the Battle building call Medic 5 (2-2000) for internal transport support to the NICU.
- If bed is available and the child is at North Ridge Pediatrics or Orange Pediatrics the NICU will assist with contacting Medcom if transportation is needed.
- The NICU will coordinate getting the correct services to facilitate the admission.

All admissions to UVA CH need to be initiated in the ED if the child needs any of the following urgently:
- IV access
- Blood work
- Radiology imaging

To facilitate please call the Peds ED 924-9273 and ask to speak with the Peds ED attending.
Anesthesia Coverage for Pediatric Ward Patients

From: Logan, Ashley F *HS
Sent: Tuesday, February 09, 2010 10:13 AM
To: Rich, George F *HS; Mendelsohn, Mark J *HS; Miller, Nikki M *HS
Cc: Waggoner-Fountain, Linda *HS
Subject: anesthe sia coverage for pediatric ward patients

It has taken me a week, but wanted to just summarize our meeting last week regarding setting up anesthesia sedation for radiology studies on pediatric ward patients. As far as the nights and weekends, we decided that the pediatric ward team will page 1311 and request a consult. If there is any resistance or confusion with either of these steps, attending to attending communication will be initiated.
As far as weekdays during regular working hours the pediatric ward team will 1) page the schedulers at 1598, 2) if the schedulers say there is in fact room that day for the case the ward team will then page 1311 and request a consult. And again if there is any resistance or confusion with either of these steps, attending to attending communication will be initiated.
We will be asking the pediatric residents to keep track of how often this occurs and if it is going smoothly. We'll reassess in a few months. Please let me know if there are any questions. Thanks,

Ashley
The discharge summary should be a concise summary of the hospitalization that can be used by referring physicians and other clinicians as a synopsis of the hospital stay. Coders will use the summary to identify the final diagnoses for reimbursement. It is not necessary to dictate the H&P or lab results, just the significant findings. Ideally, the summary should be no longer than 1½ - 2 pages.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) specify certain required elements that are included below:

Discharge Summary Requirements:
- Dictating Physician
- Patient Name
- Medical Record Number
- Admit Date
- Discharge Date
- Attending Physician Name
- Final diagnoses (Principal and Secondary)
- Procedure performed and treatment rendered
- Reason for Admission
- Course in hospital/significant findings
- Complications affecting treatment
- Condition on discharge
- Pneumococcal vaccination status, flu vaccination status (in season)
- Complete medication list including OTC, with dosage and frequency
- Discharge disposition
- Instructions/follow-up to patient or family at time of discharge
Neonatal Emergency Response Team System (NERT)

University of Virginia Medical Center
Clinical Protocol
Neonatal Emergency Response System (updated 7/14)

The Neonatal Emergency Response Team (NERT) system dispatches a NICU team to the patient’s bedside to assess and assist in care when a neonate exhibits defined physiologic changes indicative of deterioration, decompensation and/or impending arrest.

This rapid response system, which is also in place for adults (MET, BERT) and Pediatrics (PERT), supports the institutional goals of improving patient safety and outcomes and reducing mortality, and aligns with the Institute for Healthcare Improvement’s “Save 100K Lives” national campaign and the Anthem Q-HIP quality partnership in which the UVA Medical Center participates.

The Neonatal Emergency Response Team includes:

**Page #75 (as of July 1, 2014)**

- Newborn Nursery RN 9523
- NICU Admit Nurse (NICU RN2) 9233*
- NICU Fellow 2 9238
- NICU RN1 9344*
- NICU NNP ON CALL 1 9415*
- NICU SHIFT MANAGER 9234
- RESP THPY NICU THERAPIST 1212
- THE WOMEN’S PLACE SCRUB NURSE 9207*
- THE WOMEN’S PLACE SHIFT MANAGER 9202
- PEDIATRIC NEWBORN NURSERY INTERN/NP 1695
- PEDIATRIC NICU RESIDENT 1704

* = not required

Protocol

1. A NERT alert should be activated when there is a significant, sudden, or rapid change in a patient’s condition. This may present as an acute development, abrupt appearance, or rapid progression of any of the clinical parameters outlined below, or other relevant clinical criteria. The bedside clinician should use clinical judgment in applying these criteria (see Table 2). NERT may not be indicated if the patient’s assigned physician and nurse are in agreement that the local team and resources are adequate to address the current clinical situation.

NERT activations are initiated by clinical staff only. Patients and/or family members may alert a patient care provider of their concern regarding a change in the patient’s condition that may benefit from additional resources and/or support of a critical care team. In these circumstances, the decision to activate the emergency response system remains the responsibility of the patient care provider who considers all aspects of the patient’s situation in this decision.
2. The bedside clinician or HUC activates NERT by calling 4-2012. The NBN Attending is text paged simultaneously with the following information: “Call Ext., NERT Alert, Patient Name, Unit, Room Number, Condition” (Ex: “Call 3-6202, NERT Alert, Baby Shifflet, Newborn Obs Room, Room 8140, Seizure activity.”)

3. Physicians and responders are to confirm notifications via a call-back to the operator within five minutes. After two unconfirmed pages, operators should call the NICU at 4-2335 for assistance. NOTE: All NERT responder pagers will receive a daily “test” page which requires a confirmation call-back to the operator.

4. Upon arrival, NERT responders assess the patient and implement interventions to stabilize the patient. The response team may utilize the Emergency Response Protocol Order Set based on established indications. (see Table 3). A custom form (Emergency Response Record) which is similar to a code sheet will be used to document and analyze NERT events and outcomes.

5. If not present during the NERT event, the NBN Attending is STAT paged if any critical condition occurs. If at any time during the NERT event cardiac/respiratory arrest occurs, the Newborn protocol to call the Code Team is followed.

6. Responders disengage from an event when one of the following occur:
   - The patient is stabilized.
   - Continued close monitoring in the newborn observation and procedure room or the mother’s room (if able) is required and the charge nurse and/or manager adjust staffing levels to appropriately care for the patient.
   - There is a decision to transfer the patient to the NICU. At that time, the newborn staff follows the unit’s established transfer procedure.

7. The Children’s Hospital Resuscitation Committee oversees the NERT program and reviews/addresses key performance measures. This information is forwarded for review by the Children’s Hospital Outcomes & Operations Team and the Women’s Outcomes & Operations Team.

Clinical decisions tools are general and cannot take into account all of the circumstances of a particular patient. Judgment regarding the propriety of using any specific procedure or guideline with a particular patient remains with that patient’s physician, nurse, or other health care professional, taking into account the individual circumstances presented by the patient.

Origin: 6/07
Update: 1/08
Update: 07/14
Approved 6/07: _______________________________________
Ann L. Kellams, MD; Medical Director, Well Newborn
Jon Swanson, MD; Medical Director, Neonatology
Rob Sinkin, MD; Medical Director Newborn Services
Joyce Thompson, Manager, The Women’s Place  
Deb Owens, Manager, NICU  

Table 1. NERT GROUP

<table>
<thead>
<tr>
<th>Paging Group #75</th>
<th>Required:</th>
</tr>
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<tbody>
<tr>
<td>1704</td>
<td>PEDIATRIC NICU RESIDENT (Res-elect)</td>
</tr>
<tr>
<td>1212</td>
<td>RESP THPY NICU THERAPIST</td>
</tr>
<tr>
<td>9238</td>
<td>NICU Fellow 2</td>
</tr>
<tr>
<td>9234</td>
<td>NICU SHIFT MANAGER</td>
</tr>
<tr>
<td>9202</td>
<td>THE WOMENS PLACE SHIFT MANAGER</td>
</tr>
<tr>
<td>9523</td>
<td>NEWBORN NURSEY RN</td>
</tr>
<tr>
<td>1695</td>
<td>PEDIATRIC NEWBORN NURSERY INTERN/NP</td>
</tr>
<tr>
<td>Not Required:</td>
<td></td>
</tr>
<tr>
<td>9344</td>
<td>NICU RN1</td>
</tr>
<tr>
<td>9415</td>
<td>NICU NNP ON CALL 1</td>
</tr>
<tr>
<td>9233</td>
<td>NICU ADMIT NURSE (NICU RN2)</td>
</tr>
<tr>
<td>9207</td>
<td>THE WOMENS PLACE SCRUB NURSE</td>
</tr>
</tbody>
</table>

**Back-up NERT:**  
For no response to test pages, operator should call 4-2335 for further assistance

For additional assistance, one of the following may be utilized as the situation dictates:  
Neonatal Code 12  
Ward Team (PIC 1204 and PIC 1306) to 4-2022  
NICU at 4-2335 to send extra help  
PICU team at 4-1761 or a “Peds Code 12” at 4-2012  
Call the ER Team 4-9290
Table 2: Criteria & Physiologic Trigger Guidelines for Neonatal Emergency Response

Team Activation

Note: NERT is not mandatory and should only be activated when additional resources and/or a critical care assessment/interventions are required.

<table>
<thead>
<tr>
<th>Newborn (NERT)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
</tr>
<tr>
<td><strong>Neurologic</strong></td>
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<tr>
<td></td>
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<tr>
<td><strong>Respiratory</strong></td>
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<tr>
<td><strong>Cardiovascular</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal / Genitourinary</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Hypoglycemia</strong></td>
</tr>
</tbody>
</table>

**NOTE:** Any diagnosis-related V/S exceptions are to be noted by the physician in the patient’s PTP.

Table 3. NEONATAL EMERGENCY RESPONSE ORDER SET
### Diagnostics

- **Accucheck:** Indication: Change in neurological status; Tremors; Seizures; Respiratory distress; Emesis; Refusal to eat

- **Lab work**
  - CDP - Indication: Infection concerns; Change in neuro status; Seizures; Lethargy; Hypoxia; Respiratory distress; Hypotension; Pallor with anemia concerns; Bleeding; Fever; Temperature instability
  - Basic Metabolic Panel - Indication: Seizures / Altered neuro status; Tremors, Hypotension, Tachycardia / Bradycardia; Arrhythmia; Emesis
  - Blood Gas (A, V or C) - Indication: Altered neuro status; Seizures; Respiratory distress; Tachypnea; Hypoxemia; Poor perfusion; New onset murmur; Arrhythmia; Abdominal distention with respiratory compromise; Emesis with concerns for metabolic acidosis

- **Cardiopulmonary monitoring with continuous pulse oximetry** - Indication: Seizures; Respiratory Distress; Cyanosis; Hypoxemia; Tachycardia / Bradycardia; Hypotension; Pallor; Altered perfusion; Arrhythmia

- **Chest X-ray** - Indication: Respiratory distress; Hypoxemia; Tachypnea; New onset murmur; Unilaterally diminished breath sounds; Distant (muffled) heart tones; Emesis (r/o aspiration)

- **Abdominal X-ray** - Indication: Abdominal distention; Emesis

### Interventions

- **Suctioning** – Indication: Respiratory distress; Emesis

- **O2 administration** – Indication: To maintain O2 Sats > 92%; Respiratory distress; Central cyanosis

- **IV fluid bolus (volume expansion)** – Indication: Hypotension; Tachycardia / Bradycardia; Pallor; Bleeding; Poor perfusion

- **IV fluid bolus (glucose)** – Indication: Documented hypoglycemia (Accucheck <45 with variable presentation)

### Invasive Procedure/s

- **Insertion of Peripheral IV**

**PERT (Pediatric Emergency Response Team)**
From: McGahren, Eugene D *HS

Sent: Monday, June 16, 2014 6:02 PM

To: CL Surgery Fellows/Residents; Rasmussen, Sara K *HS; Rodgers, Bradley M *HS; Kane, Bartholomew J *HS; Corbett, Sean T *HS; Herndon, C.D. Anthony *HS; Jane, John A JR *HS (MD-NERS Pediatric Pituitary); Roberts, Sarah E. (NSGY & PEDS) *HS; Early, Stephen V. *HS (MD, Otolaryngology); Kesser, Bradley W *HS; Hashisaki, George T *HS; Drake, David B. M.D. *HS; Gampper, Thomas *HS; Lin, Kant Y *HS; Romness, Mark J *HS; Abel, Mark F. *HS; Wheeler, Martha *HS; McCormick, Janice D *HS; Gangemi, James J *HS; Chamberlain, Rebecca S *HS; CL Pediatrics MD-Faculty; CL PEDS - Residents
Cc: McGhee, Linda H *HS; Hoke, Tracey R *HS; Borowitz, Stephen M *HS; League, Karin Wilson *HS; Coleman, Maureen *HS; Lee, Laura *HS (MD-PEDT Critical Care); McDaniel, Lynn M *HS; Tyson, Amber *HS; Nataro, James *HS; Matherne, Paul G *HS

Subject: PERT

To all who care for patients on 7 Acute:

Please also remember that when a PERT is called, the primary team for that patient is still responsible for the primary care of the patient and must remain engaged throughout the PERT process. This is true even if the patient will be moved to the PICU. The responding PERT team does include a pediatric resident. This resident is separate from the pediatric general ward team. The latter is not part of the PERT response. Presence of a pediatrics resident was felt to be a valuable resource as some of the covering residents for surgical subspecialty patients in particular have very little pediatric experience. In addition, this resident is in close proximity to all ward patients and can typically respond and be present immediately. However, the primary team is called during a PERT and is expected to respond, direct care of the patient appropriately-with input and assistance from the pediatrics resident as appropriate-and remain engaged until the PERT reaches its resolution. The covering primary service attending for that patient is also called and is engaged in the decision making. Please let me know if there are any questions. Thanks for all you do for our patients.

Gene McGahren MD, Lynn McDaniel MD
Medical Directors
7 Acute UVACH
The basics of PERT
1. Pediatric version of MET
2. May be triggered by any clinical staff (RN, RT, MD) for the following:
   a. Concern about the patient’s clinical state
   b. PEWS score 6 or greater
   c. Acute change in mental status
   d. New onset / prolonged seizure
   e. Airway threat
   f. Hypoxia not relieved by moderate O2 therapy
   g. Severe respiratory distress or hypoventilation
3. The decision to call a PERT should NEVER be questioned
4. Team composed of the PICU charge nurse, PICU RT, pediatric ward senior resident
5. A pediatric medicine consultant for the primary team in the treatment of an acutely ill or clinically concerning pediatric patient
6. Goal – To provide early interventions to prevent deterioration of an acutely ill or clinically concerning pediatric patient
   a. Best case scenario – child stabilized and safely remains on the floor
   b. Not always possible (transfer to PICU not a failure of PERT)
7. Not an automatic PICU consult
   a. Primary team or PERT team may request one if desired
8. Primary team called before or at same time as PERT team

PEWS – Pediatric Early Warning Score
1. A numeric score from 0-10, based on behavior, respiratory exam, and cardiovascular exam
2. Done by nursing with vital signs
3. At progressively higher scores, additional personnel will be called to the bedside to evaluate the patient, determine necessary interventions, and time of next evaluation
   a. Score of 3 – senior nurse comes to bedside
   b. Individual score of 3 – senior nurse and intern come to bedside
   c. Score of 4 – senior nurse and intern come to bedside
   d. Score of 5 – senior nurse, intern, and senior resident come to bedside
   e. Score of 6 – PERT activated
4. Goal – Early detection of potential to deteriorate results in the ability to intervene earlier and change the hospital course for the patient

Role of the primary team in a PERT
1. Arrives at bedside within 10-15 minutes of PERT activation
   a. If not able to come to bedside immediately, must be available for telephone consultation with PERT team
   b. If the situation is sufficiently severe enough that the PERT team cannot wait 10-15 minutes for primary team to arrive, a code 12 will be activated and begin resuscitative measures according to PALS guidelines
2. Works with PERT team to determine treatment plan for patient
3. Works with PERT team to determine disposition of the patient
   a. Remains on primary team’s service
   b. Transfers to general pediatric service
   c. Transfers to the PICU
4. All actions by the pediatric ward senior will be documented on the emergency response record as well as in a note written by the resident and co-signed by the ward attending
5. At any point, if primary team desires, they may assume full care of the patient and release the PERT team
6. If the primary team does not arrive / telephones within 10-15 minutes of PERT activation
   a. The PERT team may independently begin care of the patient as per PERT protocols
   b. The PERT team will continue to attempt to reach the primary team during this time period, paging successively more senior members of the primary team as needed until a response is returned
## Pediatric Early Warning Score (PEWS)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior</strong></td>
<td>Playing/ Appropriate</td>
<td>Sleeping</td>
<td>Irritable</td>
<td>Lethargic/ confused OR reduced response to pain</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>Pink or capillary refill 1-2 seconds</td>
<td>Pale or capillary refill 3 seconds</td>
<td>Gray or capillary refill 4 seconds OR tachycardia of 20 above or normal rate</td>
<td>Gray and mottled or capillary refill 5 seconds or above. OR tachycardia of 30 above normal rate or bradycardia</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Within normal parameters, no retractions</td>
<td>&gt; 10 above normal parameters, using accessory muscles OR 30+% FiO2 or 3+ liters/min.</td>
<td>&gt;20 above normal parameters retractions. OR 40+% FiO2 or 6+ liters/min.</td>
<td>5 below normal parameters with retractions and/or grunting. OR 50% FiO2 or 8+ liters/min.</td>
<td></td>
</tr>
</tbody>
</table>

Add 1 point to total for “parental concern”

**TOTAL SCORE**

### “Normal” values:

<table>
<thead>
<tr>
<th>Age</th>
<th>Heart rate (beats per minute)</th>
<th>Respiratory Rate (breaths per minute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonate</td>
<td>70-190</td>
<td>30-50</td>
</tr>
<tr>
<td>1-11 months</td>
<td>80-160</td>
<td>30-45</td>
</tr>
<tr>
<td>1-2 years</td>
<td>80-130</td>
<td>20-30</td>
</tr>
<tr>
<td>3-4 years</td>
<td>80-120</td>
<td>20-30</td>
</tr>
<tr>
<td>5-7 years</td>
<td>75-115</td>
<td>20-25</td>
</tr>
<tr>
<td>8-11 years</td>
<td>70-110</td>
<td>12-20</td>
</tr>
<tr>
<td>12-15 years</td>
<td>Female: 70-110 Male: 70-100</td>
<td>12-20</td>
</tr>
<tr>
<td>&gt;15 years</td>
<td>Female: 60-100 Male: 55-95</td>
<td>12-20</td>
</tr>
</tbody>
</table>

OR use patient’s baseline if it is usually out of the “normal” range
Changes to the pediatric cardiac ECMO team

The Pediatric cardiac ECMO team is a pager list that has been created to reduce the number of steps a clinician must take in order to activate ECMO in the situation of a coding (or nearly coding) pediatric cardiac patient. Previously, this team did not cover the Neonatal Intensive Care Unit. As of March 3rd, 2014, this team will now cover all areas of the hospital including the Neonatal Intensive Care Unit and replaces the Neonatal Cardiac Code 12 team.

As a reminder, the Pediatric Cardiac ECMO team should only be activated if there has been a clear decision by the physicians involved in the resuscitation of the child that ECMO support is warranted (reversible condition, witnessed arrest). To activate this team, please call the emergency hospital operators (4-2012) and ask that the “pediatric cardiac ECMO team” be activated to your specific location. A page will go out that will bring the PICU / NICU, cardiology, TCV, ECMO, RT, OR scrub nurse, and pediatric surgery to your location. Separate calls must be made to blood bank for ECMO blood prime and to pharmacy for a heparin infusion.

In the non-ICU settings, this is NOT the team to activate first if your patient is rapid decompensating or begins actively coding, even if he or she is a pediatric cardiac patient. Please initiate a PERT or a pediatric code 12 to ensure that initial resuscitation of the patient begins promptly. Activation of the pediatric cardiac ECMO team may occur once there is a clear decision for ECMO support.

Please see the attached guideline for details. Feel free to contact me with any questions: ll7ba@virginia.edu.

Thanks!

Laura Lee
CLINICAL DECISION TOOL DEVELOPMENT TEMPLATE

Title: Pediatric cardiac ECMO team

Purpose: The pediatric cardiac ECMO team will bring all the personnel needed for emergent chest opening or potential ECMO cannulation to the patient’s bedside with a single phone call to the hospital emergency operators.

Patient Population: Pediatrics

Definitions:
- ECMO – extracorporeal membrane oxygenation
- PICU – Pediatric Intensive Care Unit
- NICU – Neonatal Intensive Care Unit
- TCV – Thoracic cardiovascular surgery

Patient Criteria/Indications for Treatment:
A pediatric cardiac ECMO team may be called on any pediatric cardiac patient who is in cardiac arrest or in imminent cardiac arrest and there is consideration for open chest massage or ECMO support as part of the resuscitation process. This may include post-operative cardiac patients, heart failure patients, and patients with sudden cardiac arrest stemming from a reversible cardiac event. This team may be activated from anywhere within the University Hospital, including, but not limited to, the Pediatric Intensive Care Unit, the Neonatal Intensive Care Unit, 7 acute unit, the catheterization lab, and the electrophysiology lab. This team should NOT be activated in any patient who is NOT actively in cardiac arrest or imminent cardiac arrest. Rather, in the non-cardiac arrest scenario, please contact services required for chest opening / ECMO cannulation individually. Of note, this team replaces the neonatal cardiac code 12 team.

Treatment/Documentation:
In the event a pediatric cardiac patient is in full or imminent cardiac arrest and there is a desire of the treating team for open chest massage or ECMO support, the Pediatric Cardiac ECMO Team should be activated. Anyone may activate this team at the request of the treating team. The team can be activated by calling the emergency hospital operators at 4-2012 and asking that the Pediatric Cardiac ECMO Team be paged. The caller should state the location that the team should respond to (ex: PICU room 7197, 7W 7182, EP lab #3) and the patient’s last name if possible. The hospital emergency operator will then alert the team with the following page “Ped Card ECMO, Location, Patient’s last name” (ex: “Ped Card ECMO, PICU 7197, Jones”). There should be an attempt of the treating team to contact the TCV surgery attending directly.

The pediatric cardiac ECMO team page list will compromise of the following members:
- PICU attending
- PICU fellow
- PICU resident
- PICU shift manager
- NICU attending
- NICU fellow
- NICU NP
NICU resident
NICU shift manager
Children’s Hospital charge respiratory therapist
Cardiology attending
Cardiology fellow
TCV attending
TCV 2nd year fellow
TCV congenital fellow
TCV NP
ECMO I/II
OR charge RN
Pediatric surgical chief (days)
Surgical super chief (nights)
Pediatric surgery attending on call

Roles
PICU attending / fellow / resident
❖ For patients NOT in the NICU - Primarily responsible for directing the resuscitation of the patient while awaiting ECMO support. Responsible for placing all medication and blood product orders that will be needed for ECMO support. In the event of resuscitation that occurs outside of the PICU and the resuscitation is being adequately directed by the patient care team prior to the arrival of PICU physicians, that patient care team should continue direction of resuscitation. In this circumstance, the some of the PICU physicians may disengage from resuscitation to ensure that all orders are in place to facilitate ECMO support.
❖ For patients in the NICU – PICU attending / fellow may help provide direction for the resuscitation of the neonatal patient until the NICU attending or his designee is able to arrive at the bedside

PICU shift manager
❖ For patients NOT in the NICU - Primarily responsible for ensuring adequate PICU nurse coverage for potential ECMO patient and current PICU patients. Helps or directs others to bring equipment (headlamps, TCV cart, OR table, etc...) to the PICU bedside to facilitate ECMO cannulation. If code event occurs outside of PICU, is responsible for making sure that bed available in PICU to receive patient prior to or after ECMO cannulation.
❖ For patients in the NICU – Primarily responsible for helping NICU staff with medication preparation, may also help with setting up for open chest procedure
NICU attending / fellow / NICU NP / resident
- For patients in the NICU - Primarily responsible for directing the resuscitation of the patient while awaiting ECMO support. Responsible for placing all medication and blood product orders that will be needed for ECMO support.
- For patients NOT in the NICU – Primarily for notification, may need to provide support for any neonates already on ECMO if cannulation is required in the PICU.

NICU shift manager
- For patients in the NICU – Brings code med box / TCV open chest tray / IOs / albumin from PYXIS to bedside. Responsible for ensuring adequate NICU nurse coverage for potential ECMO patient and current NICU patients.
- For patients NOT in the NICU – Primarily for notification, may need to provide support for any neonates already on ECMO if cannulation is required in the PICU.

Children’s Hospital charge respiratory therapist – Primarily responsible for providing respiratory support during the resuscitation. In the event of resuscitation that occurs outside of the PICU / NICU and there is adequate airway management by the current patient care team, the Children’s Hospital charge respiratory therapist may disengage from the resuscitation and prepare within the receiving unit for the arrival of the patient.

Cardiology attending / fellow - Responsible for providing expert consultation on the patient’s anatomic and physiologic status. Provides echocardiography support as appropriate.

TCV attending / fellow - Responsible for cannulating for ECMO if a transthoracic approach is required

TCV NP – Provides additional support to the TCV attending / fellow for ECMO cannulation

ECMO I/II – If ECMO is required, responsible for setting up / priming the ECMO circuit, requesting blood from blood bank for prime, requesting appropriate blood product orders / ECMO orders are placed in EPIC by PICU physicians, ensuring that heparin is given prior to cannulation. Brings ECMO cannulation tray / soft pack to bedside. If necessary, should call in any ECMO staff on call.

OR charge RN – Responsible for identifying an OR scrub nurse or tech to help with an emergent ECMO cannulation and sending the identified person to the patient location. In order of preference: cardiac OR staff, regular OR staff, cardiac call staff, regular call staff. OR scrub nurse responsible for opening ECMO cannulation tray / soft pack.

Pediatric surgical chief (daytime support) - Helps facilitate ECMO cannulation if a neck approach is deemed most appropriate (in consultation with attending pediatric surgeon). If a transthoracic approach is to be undertaken by TCV surgery and there is sufficient surgical help, the pediatric surgical chief may disengage from the events.

Surgical super chief (night time support) – Helps facilitate opening of sternal incision / sternum to permit open heart massage during resuscitation if deemed necessary by code team leader. May provide additional surgical support for TCV surgeons during ECMO cannulation.

Pediatric surgery attending on call – Provides ECMO cannulation if a neck approach is deemed most appropriate with the support of the pediatric surgery team. If a transthoracic approach is to be undertaken by TCV surgery and there is sufficient surgical help, the pediatric surgery attending / residents may disengage from the events.

Outcome Measures:
1. Time from start of code to ECMO cannulation
2. TCV mortality
Education Plan:
Education will be provided to the services most likely to use this team: PICU, NICU, 7 acute, cardiology, EP lab, and cath lab. Education will be in the form of a written description of the purpose of this team and how it is activated.

Reviewers:

Disclaimer:
Guidelines or protocols are general and cannot take into account all of the circumstances of a particular patient. Judgment regarding the propriety of using an specific procedure or guideline with a particular patient remains with the patient’s physician, nurse, or other health care professional, taking into account the individual circumstances presented by the patient.

Revision History:

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Description</th>
<th>Owner(s) Name, Credentials, Title</th>
<th>Committee Approval*</th>
<th>Date of Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/12/12</td>
<td>1</td>
<td>Original</td>
<td>Laura Lee, MD</td>
<td>Children’s Hospital Practice</td>
<td>9/12/12</td>
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<tr>
<td>2/12/14</td>
<td>2</td>
<td>Revision to incorporate the NICU</td>
<td>Laura Lee, MD</td>
<td>Children’s Hospital Practice</td>
<td>2/12/14</td>
</tr>
</tbody>
</table>

*Adults* - Patient Care Committee approval is required if the guideline will be used in multiple areas or if the local area does not have a practice committee to approve the guideline. If approval is required through other committees (such as patient safety, infection control, etc), please list those committees and dates of approval as well.

*Pediatrics* - Children’s Hospital Clinical Practice approval is required if the guideline will be used in multiple areas or if the local area does not have a practice committee to approve the guideline. If approval is required through other committees (such as patient safety, infection control, etc), please list those committees and dates of approval as well.
Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0187

A. SUBJECT: Medical Emergency Response (formerly Emergency Response and Cardiopulmonary Resuscitation (Code 12))

B. EFFECTIVE DATE: October 1, 2013 (R)

C. POLICY:

An emergency response team (ERT) capable of providing advanced life support shall be available at the University Hospital and at all buildings physically connected to University Hospital¹, twenty four hours per day, seven days per week and three hundred sixty five days per year for any medical emergency including cardiac arrest, respiratory arrest, or acute illness or injury requiring medical interventions.

All Medical Center locations that are not physically connected to University Hospital where patient care is delivered are responsible for assuring the provision of basic life support by qualified healthcare providers during a medical emergency while awaiting advanced life support units, such as Medic V or local EMS agencies. Once an advanced life support unit arrives, staff representatives are expected to participate as needed until the emergency has ended or the patient is moved to another location.

D. DEFINITIONS:

1. First Response: Early and/or initial medical care that occurs in potential life and limb threatening situations; this care can include not only medical care but also safety, comfort and emotional support of an injured or ill person until the designated response team arrives on the scene and assumes care.

2. Medical Emergency Team (MET): Medical emergency response program designed to alert the primary physician of a change in patient status and bring a critical care RN and respiratory therapist to the acute care patient bedside when certain physiologic triggers of concern occur and immediate assessment and/or interventions are indicated.

3. Adult Code 12 Team: Medicine Resident, Anesthesiology Resident, Respiratory Therapy Supervisor, Nursing Supervisor when available, Pharmacist, Chaplain, MET Nurse, unit staff.

¹ See also https://www.healthsystem.virginia.edu/intranet/emergency-management/EmergencyPreparednessandResponseGuideforUnits/UnitRedBookDocuments/Unit_Red_Book_Documents.cfm
4. Pediatric Code 12 Team: Pediatric Resident, Surgical Resident, Anesthesiology Resident, Nursing Supervisor when available, Pharmacist, Respiratory Supervisor, Chaplain, PICU nurse, unit staff.


6. Pediatric Emergency Response Team (PERT): Medical emergency response program designed to alert the primary physician of a change in patient status and bring a critical care RN, respiratory therapist and pediatric resident to the acute care pediatric patient bedside when certain physiologic triggers of concern occur and immediate assessment and/or interventions are indicated.

7. Newborn Emergency Response Team (NERT): Medical emergency response program designed to alert the primary physician of a change in patient status and bring a critical care RN and respiratory therapist to the newborn patient when certain physiologic triggers of concern occur and immediate assessment and/or interventions are indicated.

8. Emergency Transport Team (ETT): Emergency response team that provides advanced/basic life support services and patient transport.

9. Process and response activated only for a behavioral emergency involving inpatients and Emergency Department patients within the University Hospital. (See Medical Center Policy No. 0172 “Responding to Behavioral/Security Emergencies”).

E. PROCEDURE:

1. Persons seeking to activate an ERT shall follow procedures outlined in the medical emergency portion of the Emergency Preparedness and Response (EP&R) Sheets which are located in the Unit Red Book.

2. The following outlines Basic Life Support procedures that every location should follow:

   a. recognize the problem;

   b. activate the response process by dialing the number identified in the EP&R sheets;

   c. provide the patient’s location;

   d. provide patient information., i.e., the nature of the complaint or problem;

   e. Specify whether the Adult Code 12 Team, Pediatric Code 12 Team, Neonatal Code 12 Team, MET, PERT, NERT or ETT is required;

   f. remain on the phone until the emergency operator has all necessary information

3. Life saving techniques, including but not limited to CPR and/or airway protection, shall be provided according to a staff member’s training level/ability and job description until care is transferred to a designated healthcare responder and/or the patient is transported to a definitive
treatment area. Healthcare providers must follow a ‘hand off of care’ practice to another healthcare provider. A patient shall not be left unattended.

4. Each patient care area, regardless of its location, is responsible for establishing and maintaining a system to:

a. Assure availability of properly trained personnel (see Medical Center Policy No. 0265 “Emergency Response Training”) and equipment for emergency basic life support response. Areas that maintain code carts, ventilation boxes, and/or drug boxes shall conduct daily checks whenever the patient care unit is open, and shall document checks on the Code Cart and Operational Emergency Equipment Checklist.

b. Educate staff in activation of the emergency response systems.

c. Document:

i. Resuscitation events on the designated form (Code 12 Event Record) or in Epic as designated for your location

ii. MET/PERT/NERT events per Epic electronic medical record documentation

iii. ETT response events on “BLS/ALS Patient Transport Record”

d. Inform the Medical Emergency Response Sub-Committee of significant changes in emergency response practice, in writing, prior to implementation.

Medical Center Policy No. 0187 (R)
Approved December 1996
Reviewed August 1999
Approved by Patient Care Committee
Approved by Clinical Staff Executive Committee
Spine Clearance Communication

From: Harmon, William *HS
Sent: Thursday, December 11, 2014 11:03 AM
Subject: Pediatric Spine Clearance Communication

Children's Hospital Team:

Time has demonstrated complex communication issues related to spine clearance within the Children’s Hospital. This setting involves many services spanning both pediatric and adult care environments. Recently, representatives of pediatric surgery, neurosurgery, orthopedics and pediatrics met and came up with a standard protocol to assure clear team communication and documentation. No new wheels were invented, but rather we are reinforcing current procedure and are requiring appropriate Epic order entries as the final marker of process completion. The following is to be used as standard procedure. We will monitor outcomes and welcome input over time for adjustment:

1) Spine clearance requires a clearly stated note in Epic that has been finalized/signed by the consulting attending physician.

2) Once the spine has been cleared, the consulting service (ortho spine, neurosurgery, pediatric surgery) communicates directly with the primary service (PICU, others).

3) The primary service then has the responsibility to update spine (C,T,L) orders in Epic. These are found in the Pediatric Trauma order set. Several orders must be addressed:
   a) There is a specific order that states the spine is cleared and that the c-collar can be removed. This should be selected.
   b) Any previous restrictive activity order (i.e. log rolling) must be discontinued.
   c) A new and less restrictive level of activity order then needs to be placed.

4) The patients spine will not be considered clear until the Epic orders have been updated appropriately.

5) It is suggested that this information be updated on the white board in patient rooms.

These steps assure documentation, an Epic order trail, and mandate inter-team communication. These procedures will be monitored by the PICU/CH UBL and brought back to our working group for input as needed. Please disseminate this communication to all house staff, nursing etc. in your respective units. Thanks everyone for your compliance and feedback.

Bill Harmon

William G. Harmon, MD
Associate Professor of Pediatrics
Medical Director, Critical Care Services University of Virginia Children’s Hospital Box 800386
Charlottesville, VA 22908
ED to PICU Admission Procedure

October 2014

Goal: Ensure effective transitions of care from the ED to the PICU

1) The admission process from ED to PICU when beds are available needs to include the following steps:

Step 1: Make contact with the PICU to notify regarding the possible need for PICU care. In this setting the PICU is initially alerted of an admission from:

- Via a call from the ED charge nurse, resident or EM attending.

Step 2: Make contact with the PICU to request acceptance of pt to PICU.

- The initial contact (Step 1) may occur at the time of Step 2.
- The PICU attending must approve all bed requests.
- In most cases this is matter of course. However, if there is a question of PICU medical necessity, or bed availability, then the PICU attending must take primary triage responsibility.
- If there is a concern in any of these areas then it is the co-responsibility of the PICU and EM attending to speak to each other directly and come to a mutually acceptable course of action.
- In some cases this will mandate direct patient evaluation in the ED by the PICU attending (or fellow) in order to come to the best conclusions. This may also require a discussion with various subspecialty services.

Step 3: Handoff of pt from ED to PICU

- EM resident to PICU resident handoff is mandatory surrounding any ED to PICU admission.
- If the patient has been in the ED for an extended period of time prior to PICU admission, then ongoing handoff of care between subsequent shifts of ED residents and ED attending is critical so that an up to date report can be delivered at the time of PICU transfer. The ED resident is responsible for contacting the PICU resident to give updated information on transfer.

2) Transfer Request Procedure During times of High Census (“Administrator Status”):

- Children’s Hospital Administrator status will be widely communicated (to Direct Call, the Bed Center, and Pediatric ED). When Administrator Status is active, patient transfer requests through Direct Call or the ED should not be automatically accepted if there is a concern that the patient may require a PICU bed. In this setting the 24/7 in house PICU attending should be contacted by calling 4-1761 or via the page operator.
- The PICU attending, based upon preplanning and ongoing discussion with the administrator, will decide whether or not a PICU bed can be made available or not.
- If not, together with the CH Bed Czar (CH Medical administrator on call), alternative arrangements for patient care will be made. This may include:
  - If pt. is at an outside institution, then a “triangle transport” using UVA transport services may be arranged. Interval medical advice should be offered while these arrangements are being made. It is important to maintain a sense of service to our referrers, even if we are unable to accept the patient due to census issues.
  - Consider the possibility that the child may be appropriate for care on 7-Acute.
  - If the patient is already in our ED, we can consider to out-transfer to another institution.
- Any out-transfers need to be approved by the administrator on call (Bed Czar) and Karin League
  - Care could continue in the ED until a PICU bed becomes available as a PICU “Boarder.” SEE BELOW.

3) Patients in the ED “Awaiting PICU”:

- There will be times when a patient arrives to the ED and requires a PICU bed without availability and it is decided to initially care for the child in the ED.

If the child is to remain in the ED until a PICU bed becomes available, then the team needs to recognize that the “Awaiting PICU patient” is not to be “admitted” to the PICU service until they leave the ED. Salient management points include:

  - The PICU team is committed to assisting with the care of these children. However, they cannot take minute to minute and order writing responsibility for such patients.
  - If direct care consultation by the PICU team is desired in the ED, please make a clear request for the PICU team to come to the ED and evaluate the patient (4-1761 or on call page). A PICU representative (attending or fellow) will directly evaluate the patient in the ED in a timely fashion.
  - The PICU team will remain available for advice and input throughout the duration of the waiting time in the ED.
  - In all of these situations all efforts will be made to move the patient to the PICU as quickly as possible.
  - Frequent “check in” communication is the expectation between nursing staff, residents and attendings.
  - Importantly, as the ultimate PICU admission may cross shift changes, it is necessary that the both teams continue handoffs of care.
  - ED to PICU resident handoff should occur at the time the patient transfers up to the PICU, in order to assure complete and up to date transition.

Despite efforts to do so, every combination and permutation of events cannot be anticipated. A general sense of cooperation and open communication will help navigate these challenging situations. Attending to attending communication should be the default mode of communication in any uncertain situation.
March 11, 2009
TO: Pediatric Faculty and Housestaff
FROM: Nancy McDaniel, M.D.
RE: New infant security system- please share with your colleagues

Safe Place® Infant Security System goes LIVE today~

As of March 11th, 2009- our infant security system will be replaced with a new and improved system! The new Safe Place® system is more interactive and sophisticated than our old system. 7Central and 7West are the areas that are protected by this system. The NICU/PICU areas are not. As a “security sensitive area” we are required to have a separate safety plan that addresses the unique needs and challenges of our environment. This document is found in the Safety and Security Manual on each unit.

Patients that will be enrolled in the system:

1. All infants under 12 full months of age in the acute care setting.
2. All patients that are known or suspected abduction risk.
3. Patients requiring other enhanced security measures will be evaluated for use of the electronic transmitter during the security screening process in the acute care setting. Application of the electronic transmitter will be done in collaboration with the security personnel performing the security assessment.

What do you need to know?
All patients are screened for safety and security needs upon admission, and if enhanced security measures are required, nursing staff implement them right away, and communicates as needed to social work and security. If in the course of your work, you become aware of any unsafe or potentially unsafe circumstance, notify the patient’s nurse immediately so that any necessary action can be taken.

Can these patients leave the unit?
Yes- if a patient is wearing a transmitter- then we must “tell” the system that they are leaving the perimeter of the unit. If you want to take a patient wearing a transmitter off of the unit, notify the nurse and he or she can assist you.

What do I need to do if the system alarms?
In the event of an alarm (they sound like a civil defense/ tornado siren) you would immediately assist the unit staff in securing the unit- ask for direction if you are unsure. CODE 9 is our institution’s missing child code, and all staff receive annual mandatory training.

See Medical Center Policy 0141 Infant Abduction:
MCP 0175 Threat Assessment:

We lock the unit doors and you are not allowed to badge anyone you do not know into the units.
Jennifer T. Hall
RN Administrative Coordinator
Acute Care Pediatrics
(434) 243-2736 outside pager (434) 961-1041 PIC # 6753
Be Safe

Date: June 4, 2014
To: Pediatric Faculty and Housestaff
From: James Nataro, MD

Colleagues,

It is a busy time of change for the Children’s Hospital! In addition to closing the KCRC this last weekend, and preparing for the long-awaited opening of the Battle Building, the Department of Pediatrics and the Children’s Hospital have embraced enthusiastically the institution’s Be Safe initiative. Dr. Shannon has shared, “Be Safe is an attempt to accelerate our progress toward high performance by focusing on the elimination of harm to patients and workers. Quality and safety are the new currency of partnerships vital to our future success as an academic medical center. The renewed effort requires a revitalized structure.”

As part of this effort, all patient services and units are being re-evaluated, and some re-tooled, with this focus. We have also seen consolidation of Medical Director positions with specific metrics articulated for patient safety and quality measures. In order to ensure that we achieve our important goals, our leaders are reordering priorities, often reserving additional time and effort for Quality Programs. Additional leadership positions are being created. More important, commitment of ALL our personnel to an environment that is safe for patients and employees alike is paramount.

I recognize that the Neonatal ICU not only plays a leading role in providing high-end life-saving care to the region’s most challenged newborns, but it also sets the standard for outstanding care in the context of all our missions. As our NICU goes, so goes our Children’s Hospital. Accordingly, I am pleased to announce an adjustment in NICU leadership. Effective July 1, 2014, we are reinstituting the NICU Medical Director as a separate leadership position, which will report to Dr. Robert Sinkin in his current role as Medical Director for Newborn Services. The NICU Medical Director will be responsible the day-to-day operations of the hospital’s largest unit with Dr. Sinkin responsible for coordination of the various service lines affecting newborns, which includes NICU, NETS, newborn nursery (and breastfeeding medicine) and ECMO for neonates (plus other areas in which newborns obtain care). The NICU Medical Director will be working closely with Dr. Sinkin, as well as Dr. Paul Matherne, ACMO, and Ms. Karin League, Associate Director for Women’s and Children’s, in ensuring that the individual services provide excellent, seamless care for newborns throughout the Medical Center.

I am pleased to announce that Jonathon Swanson, M.D., M.Sc. will assume the new role of NICU Medical Director. Together with Ms. Debra Owens, interim nurse manager, Jon will ensure timely and multidisciplinary responses to unit-based matters. As Chief Patient Safety and Quality Officer for the Children’s Hospital, Jon has already been tasked with responsibility for addressing a large number of NICU issues; this additional appointment will facilitate these unit- and system-based endeavors. Dr. David Kaufman will remain as Assistant Medical Director of the NICU, while continuing to expand his research in neonatal infection-related issues (CLABSI, hand hygiene, etc.). David will also continue as medical supervisor for the ECMO program (both neonatal and pediatric). Dr. Ann Kellams will continue in her role as Director, Well Newborn and Breastfeeding Medicine Services and Dr. Alix Paget-Brown will continue to serve as the Medical Director of NETS and Associate OMD for the Medical Transport Program.

Please welcome Jon into his new role and thank you for all that you do for our most vulnerable population. I believe that we are positioned to continue demonstrating our commitment to excellence.

Sincerely,

Jim Nataro and Rob Sinkin
Pediatric Neurology Inpatient Consult Service

-----Original Message-----
From: Bailey, Russell C *HS
Sent: Thursday, April 10, 2014 7:44 PM
To: CL Neuro Residents
Cc: Goodkin, Howard P. *HS; Rust, Robert S. *HS; Heinan, Kristen C. *HS; Jansen, Laura A *HS; Ramirez-Montealegre, Denia *HS; Southerland, Andrew *HS; Swanson, Jonathan R *HS; Woods, William A *HS
Subject: Child Neurology Change

All,

I wanted to inform you of a change occurring in terms of our pediatric neurology inpatient consult service. As you all know, we frequently are consulted on children who subsequently require outpatient studies such as MRI Brain, EEGs and less frequently others as well as rescue/abortive and daily medications that often require titration schedules. Those of us who see these patients in follow-up have found that the studies are not ordered or ordered incorrectly and/or medications (both rescue meds and daily meds) are not prescribed or titrated incorrectly. Our belief is that this is a system issue, and that these errors are largely due the fact that the ordering physician is a general pediatric or ED resident who is unfamiliar with the specifics of the studies and medications we frequently request. These errors then run the risk of compromising patient safety and the quality of the care we provide our patients.

Therefore, after discussions amongst the Child Neurology faculty and the leadership within the Children’s Hospital and Pediatric Emergency Department, we’re initiating changes in our responsibilities as the consulting service. As a means of improving quality of care, patient safety and coordination of care, effective immediately the consulting pediatric neurology service (i.e. neurology resident) will be responsible for:

1. Ordering all outpatient neuroradiology studies (MRIs, etc.)
2. Ordering all outpatient EEGs (or other neurophysiologic studies)
3. Writing all scripts and titration schedules for neuro-related medications such as AEDs and migraine prophylactics
4. Writing all scripts for rescue or abortive medications (i.e. Diastat, sumatriptan, etc.)

Please let me know if you have questions or concerns in this regard. As should always occur in such situations, and in order to minimize errors as everyone adapts to this change, over the next few months we ask that each of your remain particularly diligent about effective verbal communication with the general pediatric and emergency department teams. As always, thank you for the excellent care you provide our patients.

Thank you.

Regards,

Russell

Russell C. Bailey, MD
Assistant Professor of Neurology and Pediatrics Director, Pediatric Epilepsy Monitoring Unit Department of Neurology University of Virginia PO Box 800394 Charlottesville, Va 22908
Email: rb4fz@virginia.edu
Phone: 434-243-1552
All,

To clarify...Our responsibility is to provide interpreter services free of charge to patients with limited English proficiency. If a patient refuses an interpreter or wishes to use a family member we are to notify them that we provide this service free of charge for their benefit. If the patient still refuses, we are not to insist or require that we provide the interpretation. We should ask that the health care provider document that an interpreter was offered and the patient denied. An exception to this would be if the patient is using minor children, even then we discuss the risk with the healthcare provider and explain our policy and rationale to the patient. See attached Medical Center Policy 0156.

Let me know if you have any questions.

Thanks, Sally

Sally LeBeau
Manager, Hospitality & Language Assistance Services
University of Virginia Health System
PO Box 800704
Charlottesville, Virginia 22908
Office: 434-924-9244
Fax: 434-924-1266
sallylebeau@virginia.edu
See Medical Center Policy No. 0156
Contact Us:
Mon – Fri 0800-1700: 434.982.1794
Emergent After-Hours Only: 434.982.1600
Email: “R Language Services” in the global address book
Website: https://www.healthsystem.virginia.edu/intranet/language/

How to contact a Limited English patient at home (without the blue phone):
To make an appointment, communicate results, etc.
1. Dial 9-1-800-481-3293.
2. At the first prompt, enter the 9 digit account number - 501013449
3. At the second prompt, enter the 4 digit PIN ___0621________
4. Say the language you want.
5. Confirm your language.
6. You will be asked if you need to add an additional remote person to the call (other than the interpreter), say YES.
7. Follow the prompts to enter the person's phone number.
8. When the interpreter greets you, say you are adding an additional person. Give the interpreter the name of the person you are calling and the purpose of the call.
9. Press 1 when ready to connect the additional person to the call.

How to communicate with a walk-in patient or a person in clinic (without the blue phone):
Follow steps 1-5 above. You will need to pass your phone handset back and forth.

How to contact an interpreter with a Limited English patient on the phone, if you receive an inbound call (without the blue phone):
If a Limited English patient contacts you to schedule an appointment, to speak with a nurse, etc.
1. Ask the patient to hold/wait a moment.
2. Press FLASH, TRANSFER or CONFERENCE depending on your phone
3. You will get a dial tone and patient is placed on hold.
5. At the first prompt, enter the 9 digit account number - 501013449
6. At the second prompt, enter the 4 digit PIN ___0621________
7. Say the language you want.
8. Confirm your language.
9. When asked if you want to add an additional person, say NO.
10. When the interpreter comes online tell them your name and that you are conferencing the caller in.
11. Press FLASH *4 or CONFERENCE and all parties will be connected.

How to contact a deaf patient at home:
Virginia Relay is a free telecommunications service to communicate with the deaf; dial 7-1-1 or 800-828-1140 and you will be connected with an operator who will assist you.

Proficiency Testing: We facilitate testing of Spanish bilingual providers that are interested in communicating healthcare information to patients. Contact us for more information.
Patient Safety Guidelines for Attending Physician Oversight

Attending Physician Oversight of In-Patient Care

1. When the attending assumes responsibility for the care of a patient, the patient and/or family will be provided a card that identifies the attending physician (e.g. business card or service can develop informational card that describes how service works). This card may be provided by the attending directly or through licensed independent practitioner of the attending’s team.

2. The name and/or service of the attending physician will be listed on the white board in each patient’s room by unit-based staff. The attending or his/her designee will be responsible for ensuring the accuracy of the name listed.

3. Resident physicians shall notify the attending physicians within 90 minutes of the following circumstances:
   - All admissions
   - Transfer of patient to a higher level of care
   - Consultation for urgent condition
   - Code 12 or MET, PERT, NERT team activation
   - Notification of patient representative that family wishes to lodge a formal complaint
   - Patient death

4. All patients admitted by 5PM on weekdays and NOON on weekends (sat/sun) shall be evaluated by an attending physician with documentation by close of day.

5. The attending physician [or fellow] shall receive evening report from the resident physician on the status of all patients who are not progressing according to the established plan of care.

Physician Response to Changes in Patient Condition

1. Each attending physician service shall establish clear guidelines for how to contact the physicians on their team when there is a change in a patient’s condition, including guidelines for escalation (i.e., resident, chief resident, fellow, attending). These guidelines shall be easily accessible to unit staff.

2. When contacting physicians via pager, nurses and other staff should use text paging to communicate nature of request and to assist physicians with triage of pages.

3. Physicians are expected to respond to changes in patient condition pages within 5 minutes.
- If unable to respond to page within 5 minutes, physicians should ask someone to respond on their behalf.
- If urgent response is needed and no response from physician within 5 minutes, nurses and other staff should page physician again or follow physician/service escalation guidelines.
- Physicians covering inpatient services should sign-out pager when not on call or to appropriate covering person when not on service. If pager is left on, there is an expectation that all pages will be responded to.

All inpatients at the University of Virginia Medical Center have an attending physician who is ultimately responsible for all medical decisions regarding their care and who is responsible for managing changes in their condition.

4. Nurses and other staff should also use their own chain of command if no response is received from physician or if the response received is not satisfactory.

5. Nurses and other staff should use SBAR (situation, background, assessment, recommendation) technique to communicate their concerns to physicians in an efficient and effective manner.

6. All members of the healthcare team must be familiar with guidelines for activation of the MET team and are expected to activate when indicated.
January 3, 2014

To: All Providers in the Children’s Hospital

From: Jonathan Swanson, MD
Assistant Professor of Pediatrics
Division of Neonatology
Chief Quality Officer for Children's Services

Subject: Patient Communication in the Children's Hospital

Starting Monday, January 6th, there is a renewed effort to improve patient communication across the medical center including the Children’s Hospital. This effort will require all providers (both nursing and physician/LIP) to be aware of and support.

• The first is the use of SBAR to communicate a concern. You may hear:
  “Dr. Smith – This is the Situation with your patient, this is the Background that you need to know, this is my Assessment of what is happening, this is my Recommendation for next steps.”

  When an RN calls and you hear this script, please pay attention, allow the RN to complete the presentation, and respond thoughtfully. Providers should also feel empowered to ask an RN to present a concern in SBAR format if desired. Feedback on this process should be shared with the aCMO (Paul Matherne) or myself.

• The second communication effort centers around hand-off of care. The medical center has endorsed the IDEAL format (Identify, Diagnosis, Events, Anticipation, Leave time) for all hand-offs of care between providers. However, it has been suggested that this be required at the time of change of the Attending of Record for inpatients.

  A standardized approach is recommended so that hand-off communication occurs in a consistent and thorough manner, decreasing the likelihood of something being forgotten or overlooked. Hand-off communication should be verbal, with emphasis on information that is not available in the medical record. Reading a medical record should not be relied upon as the sole method of communication. The mechanics of handoff documentation is not specified as it may vary by clinical service. Feedback on IDEAL should again be directed to the aCMO or myself.

Please let me know if you have any concerns or questions.

Thanks!

Jon
The PGY-2 or PGY-3 Medallion resident takes phone call for the General Pediatric Practices at the Primary Care Center, Orange, and Northridge. The Medallion schedule is indicated on the residents’ schedule in New Innovations. The clinic attending on-call schedule is also in New Innovations.

The Medallion residents take clinic phone calls from parents between 5:00 pm and 9:00 pm on weeknights, Monday through Friday.

Patients call their usual office phone number to reach the on-call Medallion nurse triage line: Primary Care Center 434-924-5321; Orange 540-661-3025; Northridge 434-980-6555.

When the parent calls between 5:00 pm and 9:00 pm, he/she is transferred to an answering service that records:
- the child’s name and birthdate
- the reason for the call
- the caller’s name, relationship to the child, and call-back number
- the office where the child is followed
- the child’s physician’s name.

The answering service then pages the resident on-call to the answering service number. If the resident has not responded to the page within 10 minutes, the answering service will page the resident again. If the resident does not answer after the 2nd page, the attending on-call is paged. If the resident would like help in deciding what advice to provide, he/she can page the attending on-call to discuss the problem. The resident should document the call in EPIC as a telephone encounter – this can be done the next day. The resident should also follow up with the appropriate office the next day if indicated. The resident should page the attending at 9:00 pm to sign out.

After 9:00 pm on weeknights until 8:00 am the next morning, and all day/night on weekends, the calls are answered by a nurse-triage service with back-up by the attending on-call.

If patients need to be seen the following day, they can call the appropriate office after 8:00 AM to schedule an appointment. If patients need to be seen on a weeknight in the early evening, they can make an appointment in Charlottesville at the Northridge office on Monday, Tuesday and Thursday evenings between 5:00 pm and 8:00 pm. The Northridge office number is 434-980-6555. Alternatively, they can be seen at the Orange office on Monday and Tuesday evenings between 5:00 pm and 6:30 pm. The Orange office number is 540-661-3025.

Outside of these weeknight hours, the patients can be seen at the UVA Pediatric Emergency Room. If you refer a child to the ED, please notify the ED by calling 434-924-2231 and ask to speak with the attending. Please do not call a “back number.”

If patients need to be seen on weekends, they can call Northridge after 8:00 am on Saturday or after 12:00 noon on Sunday to make an appointment to be seen at the Northridge office on Saturday between 9:00 am and noon or on Sunday between 1:00 pm and 4:00 pm. The phone number at the Northridge office is 434-980-6555.

If a parent who speaks a language other than English calls for advice, it is possible to access an interpreter through the Cyracom system.

If you trade a medallion shift with another resident, it is your responsibility to contact the answering service and the hospital operator to notify them (in addition to notifying the Chief Resident so the change can be made in New Innovations). TeleHealth Solutions (answering
service) can be reached at 1-704-512-7800 or email changes to TeleHealthCallSchedule@carolinashealthcare.org.
Community Pediatrics/Child Advocacy Resident Portfolio

PL-1 Community Pediatrics Week

Pre-reflective essay #1 (submit)
Introduction to advocacy and community pediatrics
Meeting Your Legislator Video/introduction to Pediatric Day at the General Assembly
Poverty simulation (spent.org)
Community Pediatrics/Child Advocacy Skills Self-Assessment PL-1

Community experiences:
  A Windshield Survey (cultural competency)
  Navigating Charlottesville: A Parent’s Perspective (city bus tour)
  Charlottesville Boys and Girls Club
  Foothills Child Advocacy Center (child abuse center)
  Community Services Board Child Psychiatry Clinic (community mental health services)
  Blue Ridge Care Connection for Children (case management exercise)
  Jefferson Area CHIP (community home visit program)
  Other (please specify)

Post-reflective essay #2 (submit)

PL-2 Community Pediatrics Rotation

Reflective essay on the “real life” of a pediatrician (submit)
Community Pediatrics/Child Advocacy Skills Self-Assessment PL-2
Community experiences:
  ChildHelp (foster care)
  Piedmont Regional Dental Clinic (oral health)
  Legal Aid Justice Center (Charlottesville Medical-Legal Partnership)
  Blue Ridge Care Connection for Children (case review)
  Rappahannock Rapidan Community Services Board (community mental health services)
  Thomas Jefferson Health Department (public health and epidemiology)
  Orange Boys and Girls Club (community education/public speaking)
  Work with educational consultant (Orange)
  Work with child psychologist (Buckingham)
  Other (please specify)

Needs Assessment exercise (issue identification/data analysis) (submit)
Community Health Project (project development/grant writing) (submit)
Community Resource Guide (resource identification/patient identification) (submit)
View “Locked Out” documentary on massive resistance (cultural competency/literacy)
Read The Real Life of a Pediatrician

Other Community Pediatrics/Child Advocacy Experiences During Residency
Local:
  Submit a CATCH grant (please describe project briefly)
Obtain funding for a CATCH grant (please describe project briefly)
  Public speaking to community group
Media Project (TV, radio, paper) on child health topic
Community Outreach (i.e. health fairs, etc. Please specify)

Legislative:
  Pediatrics Day at the General Assembly (state legislative advocacy)
AAP Legislative Conference, Washington DC (federal legislative advocacy)
AAP Capitol Hill Day, Washington DC (federal legislative advocacy)
Meeting Your Legislator at Home exercise (legislative advocacy)
  Richmond Public Health Policy Rotation (state policy making)
  AAP Washington Office Rotation (federal policy-making/legislative advocacy/professional organizations)
  Vote in state and/or national elections
  Work with VA AAP lobbyist

Leadership:
  Resident Advocacy Leadership Institute, VA Chapter, AAP (leadership/advocacy opportunities/professional organizations)
VA AAP Resident Board Member (attend state AAP meetings) (professional organizations)
AAP Delegate (attend October AAP meeting)
Key Contact, AAP FAAN network

Other:
  Complete Child Advocacy Toolkit learning modules on VA AAP website
Other (please specify)
Community Pediatrics Rotation

Central Virginia Community Health Center (CVCHC) and Orange Pediatrics

Orange Pediatrics – Contact Dr. Diane Pappas before start of rotation

Dr. Diane Pappas - Email: dep6b@virginia.edu

CVCHC – Contact Dr. Shivaram before start of rotation. See contact info below.

From: Latha Shivaram [mailto:lashshivaram@gmail.com]

It would be good to give my tel # and / or email address to residents who plan to come out to CVCHC so they can call / email me before they begin their rotation.

They are welcome to call me at home or on my cell.

CVCHC : 434-581-3271 then 0 and ask for Dr. Shivaram


From: Pappas, Diane E *HS
Sent: Friday, July 25, 2014 1:14 PM
To: Waggoner-Fountain, Linda *HS
Cc: Pappas, Diane (dep6b)
Subject: PL2 Community Pediatrics rotation

I met yesterday with Latha and I think we have a workable plan for the residents to continue to work with her at CVCHC. Latha is there on Wednesdays and Fridays, so during the rotation, the residents will work with Latha on those 2 days each week. This should get us back up to 8 days at CVCHC during the 4 week rotation. We are hoping to put together a "fitness clinic" that the resident would work in the clinic on Fridays, as the CVCHC has no resources for counseling/assessment of children with obesity. On the other days, they will come to Orange for clinic or be assigned to various community experiences as we have been doing. I have made some substantial revisions to the curriculum based on resident feedback and am streamlining some of the activities/requirements of the rotation and will share this with you as soon as I have it finished.
Continuity Clinic

Continuity Clinic provides each resident with an ongoing continuity experience. Each resident participates in a minimum of 36 clinics each year of residency. The clinics are located at the Primary Care Center, Northridge Pediatrics, and Piedmont Pediatrics. First year residents are expected to see at least three patients per session, second year residents are expected to see at least four patients per session, and third year residents are expected to see at least five patients per session. Residents record the patients seen each week in clinic. In addition to direct patient care, residents are required to complete on-line Ambulatory Pediatric Care Curriculum modules which are assigned monthly.

Amy Wrentmore, M.D.
Director, Pediatric Continuity Clinic

A second longitudinal experience will be added to PL-2 and PL-3s based on career orientation. These additional clinic experiences will occur during elective months. These patient experiences will be documented in the residents continuity composition book with notation of experience along with the patients sticky label.

Augusta Pediatrics Continuity Clinic

Learning Objectives
1) To increase resident understanding of community pediatrics.
2) To increase resident understanding that many other forces, including family, educational, cultural, spiritual, economic, environmental, and political act significantly on the health and functioning of children.
3) To promote the health of all children within the context of the family, the school, and the community in which they live.
4) To promote collaboration with the family, the school, and the community’s own resources to achieve optimal accessibility, appropriateness, and quality of services for all children.
5) To develop the skills necessary to advocate for those who lack access to care because of social, cultural, geographic, or economic conditions, or special health care needs.
6) Be familiar with the patient care and medical knowledge required for the management of well children, including:
   | monitoring normal growth and development
   | routine immunization schedules
   | routine screening procedures
   | anticipatory guidance
7) Be able to diagnose and manage common outpatient problems and illnesses, including:
   | upper respiratory infections, pharyngitis and otitis media
   | gastrointestinal problems, such as diarrhea and vomiting
   | common skin problems, such as eczema and impetigo
   | common behavioral problems, such as enuresis and ADHD
   | chronic medical issues, such as asthma and obesity
8) Develop communication/interpersonal skills and demonstrate professionalism necessary to develop effective working relationships with patients, families and colleagues.
Newborn Nursery Rotation

Please read prior to starting in the Newborn Nursery.


Welcome to the NBN (Updated January 2012)

We hope you enjoy the privilege of examining these little babies in their first hours and days of life and interacting with the families at this important time in their lives.

The Nursery is different than most places in the hospital in that the assumption is that the babies are “normal.” However, always be mindful and respectful of the fact that this may not be the case. Every piece of information is important and may be the only clue that something is wrong.

We take care of a relatively high risk population of infants and newborns can be unpredictable, so as a result, we have a multitude of “checky-boxes” that all must be completed for every baby.

Below are some guidelines and pearls that we hope will help you feel settled more quickly so that you may learn and enjoy the rotation in a supportive and low-stress environment!

If you have suggestions for this Orientation Handout or for the rotation in general, please let the Medical Director, Dr. Kellams, know so others may benefit from your experience.

Thank you for reading this over carefully and for asking any questions that you may have about the information presented.

I. The Basics

Dress
White coats are optional. You must have bare forearms when examining infants and wash/sanitize up to your elbows between babies. If you wear a white coat, the sleeves must be rolled up. If you are going to hold or feed a baby up against you, put on one of the gowns located in the cabinet above the sink or put a clean blanket on over your trunk.

Infection Control
1. You must wash/sanitize your hands before and after every patient contact and in and out of every room, even if you don’t touch anything.
2. First thing upon arrival, scrub with the chlorhexidine soap at the sinks. After that, the hand sanitizer will suffice before and after each baby.
3. Use alcohol or sanitize your equipment (i.e. stethoscope and ophthalmoscope) after each use.
4. If you are coughing or have rhinorrhea, wear a mask at all times while in the nursery or patient rooms. If you are febrile or achy, have nausea or vomiting or some other extremely contagious illness, please notify the attending.

Logistics & Rounding
Attendings try to arrive by 7:30 AM. Before Morning Report or Grand Rounds, residents should touch base with the Attendings about the discharges and make sure the discharge orders are in by 9:00 AM!
Rounds in the Nursery begin at 8:30 AM every day except Thursdays when they begin at 9:00 AM after Grand Rounds. You should examine your patients, gather all necessary information, talk to the nursing staff before rounds and be prepared to present your patients. However, if the room is asleep or the baby is breastfeeding, do not disturb them; instead do the exam on rounds. Rounds will include going to see each baby and family together as well as informal teaching based on cases presented. At TOC the Attending’s discretion, there may also be a more formal teaching session immediately after rounds 2-3 times/week. Always report the daily weight and what % down it is from the birth weight.

At least one resident and 1-2 medical students should stay until sign-out at 4:00 PM. Up to two students are allowed to attend deliveries. Downtime should be used for reading, Clipp cases (med students), viewing the http://www.monkeysee.com/ website (keyword "newborn", then click on "Dr. Ann Kellams" to view discharge teaching videos), discharge talks, and daily work. Residents are expected to attend Pediatric Morning Report at 7:45 AM every day. You should plan on following about 2-3 patients a day. Arrive early to pick up a new baby before rounds.

Medical Students will be asked by the Attending to review an article from the current literature regarding a pertinent topic in newborn medicine. The presentation should be very brief (5 minutes) and will occur on Thursday or Friday of the rotation (this may be attending-dependent). This exercise will educate the team and is a good way to practice wading through the mounds of literature that will come your way at an alarming pace! See the manila folder by the computers.

The resident should page the attending to "run the list" at 3:00 PM every day, before signing out to the NICU at 4:00 PM. The Attending should be notified of all NON-routine admissions (see the NBN admit guidelines), respiratory distress, hypoglycemia, unanticipated need for phototherapy, mom Hep B+, GBS+ not treated, maternal chorio or fever, any transfers of babies to/from the NBN, other changes in clinical status, or any questions – day or night.

Residents should provide both the NBN nurses and the NICU team with a copy of the sign-out sheet every day at 4:00 PM.

Weekends
Medical Students are required to work one weekend day on the weekend in between their ICN and NBN rotations. They should divide themselves up such that there is at least one student who has been in the NBN that week and one who is new to the NBN each day. Rounds begin at 8:30 AM (may vary by attending). It is expected that all information will be gathered and all babies examined before rounds (if baby awake and not feeding, otherwise examine on rounds). Students who have been in NBN should pre-round on at least two patients and help orient the "new" students. Students new to NBN should plan to pre-round on one patient, preferably one who will still be there on Monday. All students should stay until the work is done and help with discharge talks, phone calls, review of mom’s charts, and daily work.

On Monday, students who have been in ICN the week before should come in early enough to pre-round on 1-2 patients.

Deliveries
Please visit the ORs and a Delivery Room prior to being called to a delivery to familiarize yourself with the equipment and its use. Either a senior resident or one of the L&D nurses can show you around. The newborn interns should take turns carrying the delivery pager and going to deliveries with the NP between 10:00 AM - 4:00 PM. The senior resident in the Intermediate Nursery should be attending these deliveries as well and serving as the back-up. This is the "Newborn Team."

Up to 2 medical students can go to deliveries at a time. Decide in advance who will be up front and who will be observing. If more help is needed, or the ICN senior is not there, the NICU team should be called.
For normal deliveries between 10:00 AM - 4:00 PM, the Newborn Team should be called to all normal deliveries as well as those that need assistance. This does not mean that all of these babies need to be resuscitated and put under the warmer and removed from their mothers. Rather, unless medically necessary for the baby or the mom, any initial assessment should be done with baby on the mother's chest for normal deliveries. Keep the baby skin-to-skin with mom for the first 2 hours and delay all routine meds/assessment if they are well. For moms who have indicated breastfeeding, please encourage her and the nursing staff to keep the baby with mom and to try to get the baby on the breast within the first hour, even for c-sections.

Nurse Practitioners
We are very fortunate to have two nurse practitioners, Mary Jane Jackson and Sarah Sutton, assigned to the NBN, and they will be a huge resource to you. One of them will attend rounds every day from 8:30 until ~11:00 AM unless they are away or at a meeting. On days when there is one pediatric intern (and one of them is here; see schedule posted above the computers in the nursery), one NP will cover half of the census if there are more than 7 babies. On days when there are two interns, one NP will cover the census if there are more than 14 babies. This includes pre-rounding and presenting on the patients she is covering and being responsible for updating the sign-out sheet.
They are NRP certified and attend deliveries. This is especially useful on afternoon when the intern is at clinic and cannot attend deliveries.
It is the resident’s responsibility to let them know their clinic schedule so they can arrange to be there to cover the Newborn Nursery in the afternoon.

Emergencies
Please refer to the Admission Guidelines in the book on the nurses desk for reasons to call the NBN attending, and please feel free to call for any and all questions at any time.
You can always call down to the NICU for non-emergent questions: 4-2335.
There is a NERT (Newborn Emergency Response Team) which is basically the NICU team and the NICU charge nurse for times when you need an urgent hand and do not have time to page, be placed on hold, etc for acute status changes in babies that are not codes, but have potential to become codes: (e.g., needs an IV, unexpected status change).
There is a "code" button in the NBN that can be pressed, on the wall by the nurses desk, that rings down to the NICU and to the Labor & Delivery HUC desk that can get more emergent help.
Neonatal Code 12 is available by dialing 2-2012 as for other codes throughout the hospital. Be sure to say "newborn" or "neonatal" (i.e. not pediatric) so you will get the NERT team emergently. This includes an overhead page. Perinatal codes are very different and are reserved for emergent delivery situations involving mother and baby (i.e. not just baby) and will get the NICU team plus OB, anesthesia, OR, etc.

Additional Guidelines Note:

7/31/2014

1) The NBN nursery attending is to be called at night about every delivery we attend if the baby is going to stay in the NBN. This is the job of the resident on call and if there is no resident on call it will be the job of the nurse practitioner or fellow that attended the delivery.
2) Also we are to write a short note using the smartphrase .nbdelivery. This has been updated to include a statement at the end that says the newborn nursery attending was notified within 90 minutes of the delivery. This is a Joint Commission mandate; we cannot do anything about this.
3) For acute issues regarding NBN babies, the post-partum nurses are to make the first call to the pediatric resident on call. On the nights there is no resident, the call will go to the neonatal nurse practitioner. If the baby needs to be assessed, the resident will go evaluate the infant; if
help is needed, he/she is to ask the nurse practitioner or fellow on call. Unless the baby needs to be transferred to the NICU immediately based on the assessment, the resident is to call the NBN attending, discuss the management of the baby and place any necessary orders based on that discussion. If the decision is to get a CBC or other labs, that provider is responsible for following up on the lab(s) and letting the NBN attending know the results if necessary.

Brooke

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Recommended Experiences

**While in the Newborn Nursery, try to:**
- Attend a C-section
- Attend a vaginal delivery
- Observe/practice neonatal resuscitation
- Encourage/support breastfeeding
- Observe a lactation consultant
- Observe a social work evaluation
- Observe and participate in the Dubowitz/Ballard exam
- Assign an Apgar score
- Master newborn discharge teaching
- Use the downtime for the required reading and preparation of your presentation
- Teach yourself, colleagues, students, staff about issues in newborn medicine
- Observe a circumcision from the baby/nursing perspective
- Keep your eyes and ears and heart open to the awe and wonder and excitement that is right before your eyes!

**II. Admissions & Discharges**

**Admissions**
For all babies, at minimum, *we MUST know* the mom’s Hep B status, RPR Status, HIV status, GBS status, how long they were ruptured prior to delivery (>18 hr is prolonged), and Blood type as soon as possible because these can all change our direct management of the baby for each admission.
Identify who the baby’s doctor will be and put the PCP information in the Problem List with an estimated date for the first appointment based on when you think the baby will go home (usually within 1-2 days of discharge).
All babies should have their mother's charts, inpatient and prenatal, reviewed and documented.

**When first meeting families:**
- Discuss feeding schedule (see Feeding section).
- Identify who PCP will be (if UVa Family Practice, the baby should be on FP service, not ours, in hospital).
- Resident enter admit orders. Be sure to select Hep B vaccine.
- Take a PsychoSocial History (see attached guidelines).
- Give the Breastfeeding Pep Talk to moms wanting to nurse.
- Ask if the parents want a circumcision.
- If either EGA or Ballard is <37 weeks, the infant should be considered a "Preemie" or "Late Pre-term" infant. Warn the parents that the baby may not be ready for discharge as early as a term baby would be.
- If baby is a preemie, have parents bring in the car seat – before the date of discharge – for the car seat trial, and alert the nursing staff.
- If there are transportation or complex psychosocial issues that may interfere with discharge, make sure the social worker is involved early in the hospital stay.
- Whether the baby is Large, Appropriate, or Small for gestational age (LGA, AGA, SGA) is determined by plotting the WEIGHT of the baby on the growth chart in Epic. Uncheck the “patient filter” box and scroll down to “Premature Infant Fenton”. It is good to state and report where the L and HC plot as well). SGA, LGA, and preemies, and infants of diabetic mothers, automatically need sugars and hemoglobins checked after birth. A protocol is posted behind the computers. Be sure to plot EGA and Ballard dates if there is a discrepancy.
- Encourage mothers and babies to be skin to skin as much as possible. This helps the babies thermoregulate and encourages frequent breastfeeding. Also suggest that they "room in" rather than send the baby to the nursery.

**Discharges**

**Guidelines for Every Baby**

We are supposed to have **orders in** for babies who are being **discharged by 9:00 AM** (babies are supposed to leave before 12:00 Noon). To make this possible, here are a few guidelines to follow:

- Give Discharge Teaching Talk on the afternoon before discharge.
- We always round first on babies going home that day, so final discharge orders may be put in during rounds (or, ideally, before rounds, if ok’d by Attending) – before 9:00 AM! If orders are not in by 9:00 AM for a medical reason, let the nurses know why.
- Be sure any consultants involved in the care know about the baby early-on and when the baby is supposed to go home.
- If ordering a Cardiology consult, also order a pulse-ox check, four extremity BPs, and an EKG.
- Be sure everything on the Discharge Checklist is complete (e.g., ABR [hearing test], NBS, Hep B).
- Use the **Discharge Book** that each patient receives before going home to demonstrate points to the parents and to make sure you cover everything in your "Discharge Talks".
- Medical Students: You should first observe a Discharge Talk (or view the video), then be observed giving one and receive feedback, and then you can give on your own.
- The Resident is responsible to write on the board each afternoon the expected discharges for the following day.
- Discharge labs should be done by the nurses between 0400 and 0600 on the date of anticipated discharge, to be back in time for rounds and clinically-relevant.
- All babies have their heels poked to obtain blood for the **State Newborn Screen**. This must be done **after 24 hours of age**, otherwise it would need to be repeated. Therefore, we **do not** routinely discharge babies home before they are 24 hours old.

**Discharge Appointments**
If discharged at < 48 hours, or if the baby is premature, jaundiced, close to 10% weight loss, or with a complex psychosocial situation, a PCP appointment should be made for the day after discharge. Ask the HUC to make this appointment the afternoon before discharge. This can be tricky over the weekends and holidays and may require follow-ups on the 8th floor.

Options for follow-up appointments:
Often, if you call the PCP yourself, you can make arrangements for the baby to be seen even if they don’t have a formal clinic. Any baby who has had a complicated medical course deserves a phone call to the PCP to give them a heads-up.

The only UVA clinic over the weekend is at Northridge on Saturday morning. They will not see babies who are not following up at one of the UVA sites.
Do a weight/bili check on the 8th floor. Have the parents check-in at the East/Labor & Delivery HUC station at 7:45 AM. Notify the HUCs and RNs of the babies who are coming the day before they are due to come in. They will page you when the family arrives. If a serum sample is needed, the RN will draw it; it is sent with an outpatient lab slip. Any 8th floor follow-up appointments for breastfeeding babies are considered Breastfeeding Medicine follow-ups and the HUC and LC should be alerted.

There is a list of Referral Doctors on the bulletin board, and SW is also a good resource for lining up PCPs.

**When Mom is being discharged but baby is not ready**
We try not to separate moms and babies, particularly those who are breastfeeding. If mom is ready for discharge but baby needs to stay, usually the mom can “board” in her room.

If we are very full, here are things to try (in this order):
1. Talk to the OBs to see if they have a reason to keep mom an extra day (allowed 48 hours after SVD, 72 hours after C/S).
2. Talk to charge nurse to see if mom can “board” in her room (with understanding she may get kicked out” if census is very high). Also check rooms 51-54 on 8 Central (not typical post-partum rooms).
3. Talk to NICU charge nurse about availability of “Rooming-In” room on 7th floor (baby needs to stay on 8th floor) – night by night basis, no one other than mom can stay; use 8C Day Room during day.
4. Talk to PICU charge nurse about availability of Sleep Room on 7th floor near PICU – night by night basis, only for mom, shared room with multiple cots/beds; use 8C Day Room during day – not great.
5. Last resort – Talk with SW about Ronald McDonald House. This is not a great option for breastfeeding moms as it is impossible to get back and forth q2-3h through the night. If use this option for a breast-feeder, will need to supplement the baby and get mom a pump!

**III. Charting and Sign-Out**

**Documentation (Epic tips)**

**Signing into EPIC**
Be sure when you sign into EPIC that you choose the “UVHE NEWBORN NURSERY” environment to have access to all of the tools and screens.

**Sign-Out**
Residents or NPs are responsible for printing signout sheets for themselves and the attending in the am. Each patient should have a “refreshed” “.problcom” in the text section of their signout sheet.

**Pre-Rounding**
The resident is responsible for pre-rounding on at least 7 patients each day. (If there are more than 7 patients, the NP will see the remainder. If there are more than 14, the census will be split equally.) Pre-rounding should include gathering all information including prenatal information on new patients, reviewing the order set, updating the problem list to the best of their ability, and beginning and “pending” the note. Babies can be examined with the team on rounds unless there is a clinical concern, and families do not need to be awakened or babies removed from the breast prior to rounding as a team. Families appreciate fewer interruptions.

**NBN Order Sets**
Search "neo" and choose “newborn admission”.
Need to check the box for Hep B.
Nurses should initiate the admission orders and give the shot within 8 hours of birth.
“Eyes, Thighs, Delivery Summary completed, and Hep B”.
For late pre-term infants or infants that you are worried about:
Use the NICU order set and tailor for that baby, and/or add additional orders to the NBN order set--think about things like frequency of vital signs or pulse ox checks, or minimum feeding orders in particular.

**Labs**
For labs, we have asked that the "normal" for NBN be "unit collect", but please check each time until this is the default. If you need a venous stick, enter it as such and let the baby’s nurse know as well.
For routine labs, please use the following schedule: 0600, 1400, 2200 as much as possible, even if it means labs are 7 instead of 8 hours, or 13 instead of 12, etc.

**PCP Appointment**
Please still ask on the first meeting with the patient (nurses and HUCs are to be asking prior to delivery!) to make sure not UVA FM pt. For now, the PCP appointment request is a misc type-in order, HUCs should be making the appointments as requested and entering the dates/times in the discharge instructions.

**Viewing Mom and Delivery Information**
Click on the blue "admission" activity tab on the far left in baby’s chart.
At the very top, click to expand "maternal data"--then a whole bunch of mom info will populate.
Scroll down near the end to "delivery summary" which will give you the apgars, any resus (if really a code, this will still be recorded on paper), and also time of rupture.
Click on “beginning” or “end of maternal data” to enter mom’s chart.
In UVA index view tool bar, wrench in “pregnancy view” for a lot of information, or click on mom’s “Admission tab to scroll through ACOG information and to view her admission H and P-- you should scroll through her pregnancy progress notes for issues and to see if she saw MFM for complications, etc. Ultrasounds are found under mom’s “Chart Review” and clicking on “media”.
If can't find something, ask the OBs.
Also, if some of her care was not at a UVA site, they are keeping hard copy prenatal records in a drawer at the 8 central HUC desk for the moms.

**NBN Vitals and I/Os**
Go down to the bottom of the blue activities tabs on the far left and click "More Activities" and then click on "View doc flow sheet". Then you can choose "nbn vitals" "ballard" "newborn I/Os" and see what you need to see.
Growth Charts - AGA/LGA/SGA

Go down to the bottom of the blue activities tabs on the far left and click "More Activities" and then click on "Growth Chart", unclick the “patient filter” box, and scroll down to “Prem Infant Fenton” and then click on the tabs for weight, length, HC.

Note, these use the estimated dates from the pregnancy, so if there is a discrepancy between that and Ballard, make sure you visually check both, if one of them makes the baby SGA or LGA, the baby should be treated accordingly.

RNs should be putting this information in the comments section of the Ballard flow sheet.

Charting / “Problem List”

Keep this up-to-date as your main source for documenting daily assessment and plans for your baby. Doing so is extremely valuable for not only your daily note, but also for the sign-out sheet, and for billing. It also appears in the discharge instructions for the patient, to serve as a back-up method of communication with the PCP and gets placed in the “Birth History” section in the “History” section of EPIC.

Anyone should be able to look at the problem list and, at a glance, be able to determine anything and everything about that baby that is different than the usual.

On every patient, pull up the problem list, make sure you agree, use the "overview" section for each problem to enter your comments and current thinking/plan, and add any problems that you need to, and then hit "mark as reviewed."

The first problem for every baby should be:

“Single or twin liveborn delivered in/out of hospital by (or not) cesarean” NOTE: It is helpful to click on “detail” and change the way it is displayed to say “SVD” or “C/S” and include the reason, ex. “SVD, induced for preeclampsia”. NOTE: label this problem as a “high priority” so that it will appear first in all of the different places in EPIC.

In the “overview” section under this first problem, type in: “.Birthsent” to bring in the standard signout template information and the discharge planning checklist, this should be updated daily as should the problem list.

For any random things related to mom, if you can’t find them when you search: use "maternal condition affecting fetus or newborn" and type the details in the comments.

On rounds, while one person is presenting, another person can be updating the problem list with the information and plan for that day while the attending is listening, and in real time reviewing the vitals, I/O’s, and daily note for the baby.

The PCPs in the UVA sites will then view the hospital problem list in the clinic and “resolve” the appropriate ones that are no longer an issue.

Assessment and Plan

If you go back and add a problem or an update, do so in the problem list so it is saved, and then just hit the symbol for “refresh” at the top of your note, and the updated version will pull in.

NOTE: You do not have to close up your note to update the problem list.

Feeding/Reason for Formula Given

For the Joint Commission, the reason for any formula used must be recorded whether mom is breast or bottle feeding. We thought the nurses could capture this, but for The Joint Commission, they can only collect the information that the LIP records. So, there is a drop-down menu in daily and discharge notes: "no formula given, exclusive bfing" OR: "formula given, mom's choice, no medical indication, after education, etc" OR "formula given medical indication (either bfing contraindicated and state why, or maternal or infant indication, and state why).

Hep B – where to find if it has been given
“UVA index” view in “patient summary”, click on “medication history” for baby and view whether or not it has been given and the date, it will appear in green if already given—supposed to be done soon after birth.

**NBN Note Templates**
To find the NBN note templates: go to "Notes" in the blue activities bar at the left, (i.e. not the "notewriter") and click on "new note" then, in the smart text space toward the top, type "nbn" and hit enter, then choose from the list either the “NBN HandP” or the “NBN Basic” (which is the daily and/or discharge note).

Much information in these notes autopopulates if it has all been entered in the correct places, but please double-check each day that the information is there as this is the only documentation that the outside PCP’s will be receiving.

Residents/NPs should be starting the notes (and “pending them”), and updating the problem lists, and then the attending should be editing and co-signing (trying to do this on rounds.) NOTE: For the NP’s, leave the physical exam section blank as this needs to be completed by the attending, but note as you are presenting what you found.

At the bottom of every note that you are co-signing for the resident (i.e. not an NP), you should type ".att" and hit enter to add the attestation that you have reviewed the history and seen the patient, talked with family. If it was started by an NP, the attending will be the owner of the note.

**Med Student/NP Notes**
For med students and/or NPs, they can edit the "problem list section" on the blue tabs and start the note and complete everything BUT the PE section, and "pend" it, the attending will then complete the PE section, and bring in the updated problem list by refreshing, and no attestation should be included for this note.

For medical students, they should be writing a daily note and “pending” it, and the attending should be reviewing this note while the student presents and giving them feedback in real time. They should not use “.problcom” but rather should be creating their own assessment and plan section for practice. Once the note has been reviewed and feedback given, then the note can be “deleted” (but note, still is visible in the system).

**Editing Note Templates**
If you do not like something that appears in green in the note templates, you can highlight it, right click on it, and choose "make text editable" to change it.

**Charging**
For charging, go to "charge capture" and then click on "newborn" at bottom of the list, pick your code, then click on "full detail" at the bottom of that box and use the arrows to make sure the problems are checked that you want to include and are in the right order that they should appear.

Also make sure for the modifier to type "gc" to indicate that it was a clinical teaching patient.

You only have to type in the number of minutes if you are “upcoding” because it was a more complicated newborn.

When done with charges, scroll all the way to bottom left and hit "close".

If you need to change a charge, you can click on it and hit "full detail" to change the date or order of problems. If you need to change the charge itself, hit "review charges" and then click the ‘X’ at the far right of it to delete that charge and start over.

**Hearing Screen Info** – Still on paper, in the yellow chart.

**Consent forms** – Still on paper, also yellow charts.
**Biliblankets or Breast Pumps for Home**
If there is a medical need, notify SW as soon as possible.
Go into the “discharge” tab, and then “order reconciliation” and then “new orders for discharge” and “place new orders” and then “DME other” and type in “bili blanket” or “dual electric hospital-grade breast pump” and include the reason for need and/or the patient’s most recent bilirubin level.

**Concerns?**
EPIC is still a work in progress, and we appreciate everyone’s understanding as we try to address the issues and as the dust is settling regarding what information will live where in the system. We definitely want to hear your feedback about things that are working and not working, but PLEASE NOTE that ALL concerns need to be directed to Dr. Kellams either in person or via email. No changes are to be made to the templates without her prior approval.

**Sign-Out**
Med students should sign out with the resident or NP prior to leaving at 4:00 PM.
The Resident or NP should page the NBN attending at ~ 3:00 PM to sign out prior to signing out to the NICU team. A copy of the sign-out should be given to the NBN nurses as well as the NICU team.
The sign-out sheet should be printed from the Epic patient list as instructed.

**IV. Care Guidelines**

**Bilirubin**
All babies will have a bilirubin level checked prior to discharge. If there have been no issues, this can be a transcutaneous bili (or TCB). If the level is high-intermediate or high risk, or if it is above 11, a serum bili will be run automatically.
All bilis should be plotted according to the baby’s age in hours, on the Bhutani curve, and reported on rounds as such, stating which risk category the level is for that age. Note: this curve is for healthy term babies only.
Special care should be taken in the case of an ABO or RH set-up or in a baby less than 36 weeks gestation. The Phototherapy Guidelines curve should also be plotted based on the risk factors for the baby. The “light level” according to this curve should also be reported on rounds, and whether the baby is close or not.
If mom is O and baby is either A or B, it is considered an ABO Set-up. It is important to know whether the Coombs test is positive or negative. Either way, beginning at 6 hours of age, we will check hematocrit and bilis (H and B’s) and depending on the level, will set a schedule for checking.
The same applies if the mom is Rh neg and baby is Rh positive.
Fig 2. Nomogram for designation of risk in 2840 well newborns at 36 or more weeks' gestational age with birth weight of 2000 g or more or 35 or more weeks' gestational age and birth weight of 2500 g or more based on the hour-specific serum bilirubin values. The serum bilirubin level was obtained before discharge, and the zone in which the value fell predicted the likelihood of a subsequent bilirubin level exceeding the 95th percentile (high-risk zone) as shown in Appendix 1, Table 4. Used with permission from Bhutani et al. See Appendix 1 for additional information about this nomogram, which should not be used to represent the natural history of neonatal hyperbilirubinemia.
Circumcision:

Pros:
Less STD transmission (if unprotected sex)
Less UTIs and penile cancer (very low baseline risk anyway)
Commonly done in the US

Cons:
Risks: bleeding, removing too much or too little foreskin, infection, needing a “re-do”
No real medical reason to do it
The AAP and CDC have said there is not enough evidence either way to make a recommendation. It is therefore left to personal choice.

The OBs do the circs and should be notified prior to the discharge day by touching base with the OB Resident.
Feeding
All mother and baby charts should have charted whether the mom plans to breast or bottle feed. "Both" should not be recorded as we do not recommend any formula supplementation unless there is a medical reason or until the baby is at least 2 weeks old.

*If bottle-feeding*, the baby should feed 15-30ml every 3-4 hrs (not to exceed 45ml/feed in first 48 hrs). *If breastfeeding*, the mother needs to be counseled with the breastfeeding "Pep Talk":

1. Put the baby at the breast at least every 2-3 hours day and night.
2. Make sure the baby's mouth is WIDE open before letting it try to latch on.
3. If the baby is not all the way on, or if the baby moves off the breast a bit, or mom is experiencing any pain, break the seal and start over to avoid soreness and to "train" the baby to open mouth wide.
4. It takes the average baby 6-8 times to latch on per feeding, early on, until it learns.
5. There are drops of milk in the breast right now, but what is there is very important milk – rich in nutrients and Ab's, and all the baby needs.
6. The baby does not need any supplementation. We will watch the baby carefully and let mom know if there is any medical indication for supplementation (weight, voids, stools, exam).
7. The "ounces" of milk do not normally come in until the baby is 3-5 days old, and this is the way it is supposed to be. Mom can trust her body (that has grown this beautiful baby); it knows what to do!
8. Giving pacifiers and bottles to the baby can make it harder for the baby to learn to open its mouth very wide and can send the wrong signal to the breasts (i.e. if there is no baby trying to nurse on the empty breast, they "think" that no more milk is needed). It is all supply and demand. If the baby is hungry, put him on the breast whether much is coming out or not.
9. Practice "rooming in" and keep the baby skin-to-skin while mom is awake, to encourage frequent feeding and to catch the baby when he or she stirs to try a feeding.

Breastfeeding "Pep Talk" - For all New Moms Planning to Breastfeed:

1. We think it is the best way to feed your baby!
2. Try to keep the baby in the room with you all the time so you can nurse frequently.
3. Put your baby to the breast within the first hour of life.
4. You have exactly what your baby needs from the very first day.
5. Feed your baby at least every 2 to 3 hours day and night, even if you have to wake him or her up!
6. Your breasts will not FEEL full until 3 to 5 days.
7. DO NOT offer any formula to your baby. This will hurt your chances of teaching your baby how to breastfeed. Talk with us BEFORE giving your baby any formula.
8. Ask for help if you need it from the nurses, doctors, or Lactation Consultants.
9. Breastfeeding SHOULD NOT be painful. Get help if you are feeling pain!
10. Do not use a pacifier for the first month or until breastfeeding is well-established.

If there is a medical indication for *supplementing*, or the mom, after being counseled, still would like to offer one, try to *set the following parameters*: (coming soon there may be a consent form for them to sign)

OK to supplement 15ml (1st 48hrs) or 30ml (after 48hrs) q feed after breastfeeding attempt. Mom should pump on both sides for at least 10 minutes or until milk stops flowing (whichever is longer!). This way, the breasts do not miss out on the opportunity to be "told" to make milk.

Involve the Lactation Nurse.

Anything else requires a physician order. If mom completely changes her mind and wants only to bottle-feed, no order is needed.
On rounds, for bottle feeding, report the range of ml taken on each feeding and the average interval (e.g., 15-30 ml q 3-4 hours), and report on any gaps longer than 4 hours. Also report the number of feedings in the past 24 hours.

For breastfeeding, report on the range of minutes on each side for the feedings and the average interval (e.g., 15-20 minutes q 2-3 hours), or attempts vs. good feedings. Ask the nurses how feeding is going. Look at the lactation notes. Also report the number of feedings in the past 24 hours.

**Glucose**

There is a protocol posted for babies at risk for hypoglycemia (including infants of diabetic mothers, SGA, preemies, "stress" or need for resuscitation, sick infants, hypothermic infants, etc.). A glucose level of 40 or higher is considered normal. If the level is below 40, follow the protocol to feed the baby by breast or bottle, depending on mom's plans. If the baby remains symptomatic or cannot po feed or it is persistently low, the baby will need an IV Dextrose bolus with D10 (or higher if needed), and may need to go to ICN for IVF if not able to keep up or po feed. Anytime the sugar is low, the protocol should be started (or re-started).

**Group B Strep/Infection Risk**

If moms are GBS positive or are unknown (unless they were a C/S and not ruptured prior to delivery), it is important to know whether they received antibiotics prior to delivery and, specifically, how many doses and how long before delivery. **1 dose at least 4 hours prior to delivery is considered "adequate" treatment, and the baby is treated as normal. Anything less than 4 hours is considered "inadequate"; a CDP should be drawn on the baby as a baseline and the baby must be observed for at least 48 hours per the CDC guidelines (posted behind computers).**

In babies in whom infection is suspected (i.e. they are acting sick):
- Get blood cultures and LP
- Start antibiotics (amp and gent) and continue for at least 48 hours
- Repeat CBC 12 hours later

**If mom has "true" chorio** (i.e. fever with uterine tenderness, purulent or foul-smelling fluid, tachycardia, etc.), this is the one exception in which even the well-appearing baby should be placed on 48 hours of antibiotics and have a CBC and Blood Culture according to the CDC guidelines, due to the much higher risk of infection in the baby.

**Hepatitis B**

All babies receive their first vaccine in the hospital. The nurses administer the shot in the thigh, well before discharge, and the baby can sometimes get a little redness or swelling at the site. Usually there are no other side effects.

The nurses "consent" the moms for the vaccine by telling them about it, handing them a VIS (vaccine information sheet), and having the mom sign the immunization sheet. If there are questions or the mom "declines", the nurse will alert the resident for further discussion.

If the mom is Hep B surface Antigen positive – the baby needs to receive both the vaccine and HBIG within 12 hours of birth!

If the mom is Hep B unknown – the baby needs the vaccine within 12 hours while we wait for mom’s result. If it is still not known at the time of discharge, there is one week in which to find the answer; however, most PCPs do not have HBIG, so we often give it prior to discharge anyway.

If parents decline the Hep B vaccine, this needs to be documented in the chart.

The date the vaccine was given needs to be documented on the discharge checklist in the problem list.
Output
Babies should void at least once in the first 24 hours of life, and stool at least once in the first 48 hours. A rough estimate of urine output is one void per number of days old (1 day, 1 void, etc.) all the way up to 6 when they should begin having at least 6-8/day. Transition (green or brown) or yellowish stools should be documented in the chart as well as the number of voids and stools.

Non-English Speaking Patients
Try first to get an interpreter. If they are not available, use the cyracom phone. When using this, try to maintain eye contact with the patient. Always document that you used the cyracom in the chart.

Tricks
Blood Types: Baby's blood type will be checked on the cord blood if there is a potential for a "set-up" (i.e. if mom is O or if mom is Rh negative.) The baby's blood type (cord blood) will be listed under mom's name in the computer. Baby's blood types can also be found in the baby's admission tab under maternal data.
G=gravida (number of pregnancies, including this one) P=parity (number of live births, including this one). Sometimes further broken down into TPAL Term, Preterm, Abortions (specify SAB or TAB), and Living children
EGA=Estimated Gestational Age (by dates); most accurate is by a sure LMP or by a first trimester U/S Dubowitz=Ballard Exam for physical maturity. Performed by the nurses within 2 hrs on all new babies (watch them do one of these!). Should be within 1-2 weeks of EGA or else it is repeated.
SVD=Spontaneous Vaginal Delivery NSVD=Normal Spontaneous Vaginal Delivery-loosely used to refer to all vaginal deliveries, even those that were induced, etc. If induced-need to state reason why, also need to state if the vaginal delivery was vacuum or forceps-assisted C/S=c-section, need to state reason why...
RR=Red Reflex, and all babies should have this done and documented in their note on day of admission and day of discharge.
Do not rely on the information in the baby's chart alone, always go through mom's chart as well, on every baby AND ask OBs and Moms about questions that remain. Outside facilities may need to be called as well.
All babies receive vitamin K shots to prevent hemorrhagic disease of the newborn and erythromycin eye ointment to prevent gonococcal conjunctivitis.

The Newborn Screen checks for inborn errors of metabolism like galactosemia and PKU as well as CF mutations, and Hb electrophoresis for sickle cell anemia.
Only Nurses and PCAs (i.e. staff with purple on their ID badges) are allowed to transport babies to and from mom's room and NBN! MDs and Medical Students are NOT ALLOWED to transport babies!
CDP=CBC plus manual differential with band count. Need to calculate immature to total (i:t) ratio for neutrophils (take % Bands +myelocytes and metamyelocytes divided by % Neutrophils plus % Bands +myelocytes and metamyelocytes). Anything >0.2 is considered worrisome for infection (but do not rely just on one CBC!)
For Rounds: If there are new members of the team or if the baby is new to rounds, then do a complete presentation. If they have already been discussed on rounds, it is OK to give a summary and then go to the information from the past 24hrs.
Med students should try to formulate their own plan for the day for their patients and report this on rounds. Looking up topics of interest on their patients and presenting a 60-second blurb on a topic is encouraged.
V. Resources

In the cabinets above the physician workstation are a number of newborn and pediatric textbooks and handbooks that can serve as a starting place for information, and a baby HIP(py) model for "clunks". The protocols for Hyberbilirubinemia, Hypoglycemia, Anemia, etc are posted on the board behind the computers, and in the white folder at nurses’ desk. Pager Numbers for Lactation and Social Work are posted on the board in the nursery.

Residents and students are required to read/review the following resources. This information will be discussed on daily rounds.
1. 2012 Pediatrics in Review article on “Care of the Well Newborn”
   http://pedsinreview.aappublications.org/content/33/1/4.full.pdf

2. UVA Newborn Nursery Orientation Manual (this document) – available at:
   http://www.healthsystem.virginia.edu/pub/newborn-nursery/orientation/

3. UVA Newborn Nursery Orientation Videos – available at:
   http://www.healthsystem.virginia.edu/pub/newborn-nursery/orientation/videos

4. Newborn CLIPP cases, particularly the one on jaundice. Students in the past have found these very helpful.

VI. Newborn Evaluation

History

1. Date, time and location of birth, referring MD/hospital
2. Birth weight
3. Sex, race
4. Gestational age (EGA)
   by dates (mother’s estimate)
   by pre-natal exam (obstetrician's estimate) (i.e. serial fundal heights, first fetal heart tone, sonography)
   by post-natal exam - Ballard assessment (Pediatrician's estimate)

5. Mother’s age and history of previous pregnancies (Gravid = # of pregnancies, Para = # of births, AB = # of abortions - spontaneous or therapeutic, living = # of children living - summarized, for example, as G3, P2, AB1, L2)
6. Blood types of mother and baby, Coombs test, mother’s antibody screen; ABO & Rh incompatibility
7. Maternal Labs
   VDRL
   Hepatitis B
   HIV
   GC, chlamydia
   Group B strep status
   Amniocentesis-genetic or for lung maturity

8. Complications of pregnancy, labor and delivery
   Maternal illness/infections
   Use of drugs, prescribed and non-prescribed
   Alcohol and smoking
   Duration of labor/premature labor - tocolytic drugs
   Duration of rupture of membranes - evidence of maternal infection/colonization culture results/antibiotic therapy
   Type of delivery - spontaneous vaginal (SIVA), forceps, C-section
Characteristics of amniotic fluid - oligohydramnios, polyhydramnios, meconium stained
Abnormal presentation
Fetal monitoring
Anesthesia used

9. APGAR scores at one and five minutes and every five minutes thereafter until score exceeds six
10. Neonatal course to date
11. Social history
Where mother lives
Role of father in family
Other members of the household
Financial support
Emotional support

12. Plans for feeding - breast or bottle
13. Plans for well child care and immunizations

Physical Exam
1. Vital signs, measurements
2. General appearance
level of activity
general perfusion and color
nutritional status/state of hydration
gross abnormalities

3. Skin
vernix
capillary hemangiomas (benign): most common on eyelids, forehead, back of neck - occasionally on
trunk or extremities
mongolian spots (benign)
cafe-au-lait spots: > 5 suggestive of neurofibromatosis (if all > 1.5 cm in diameter)
milia: superficial epidermal inclusion cysts - generally on face
erythema toxicum
"parchment skin": seen in post-term babies
dryness, turgor: assess hydration
petechiae
  o common, benign: usually on face and upper body - occurs 2° intra-thoracic pressure as the chest
    passes through the birth canal
  o uncommon: pathologic as a result of thrombocytopenia; important to note distribution and watch for
    progression
"sucking blisters": hands
abrasions
peeling of skin in postmature baby
jaundice

4. Head
shape
molding
asymmetry: may be normal 2° fetal posture or abnormal 2° structural defect appearance
bruising
scap: internal monitor sites, scalp blood sampling sites
torceps marks
hair distribution
palpation
caput succedaneum: diffuse, generally symmetric scalp edema 2° vertex presentation (usually resolves in first few days); edema crosses sutures
cephalohematoma: sub-periosteal hemorrhage; feels like boggy edema but is located over one particular bony area; may take months to resolve; never crosses sutures; can indicate linear skull fracture or more occult intracranial bleeding
sutures: craniotabes is a soft area in parietal bone near the sagittal suture palpable fractures

5. Fontanelles
anterior and posterior
may suggest increased intracranial pressure if bulging open wide fontanelle extending into frontal area

6. Eyes
may be hard to assess in first 24 hours due to edema of lids
reactiveness of pupils (PERRL = Pupils equal, round, reactive to light)
red reflex exam for retinoblastoma, corneal opacities
lens
test for congenital cataracts
discharge
conjunctival hemorrhage: common, may be benign; occurs 2° increase in intra-thoracic pressure when the chest passes through the birth canal
inter-canthal distance: if increased or decreased may suggest a congenital syndrome

7. Ears
external appearance: shape and position
o low set ears may suggest a congenital syndrome such as Down syndrome
external canals: check for patency, atresia
tympanic membranes: canals may be too tortuous to allow visualization
preauricular sinus and tags: may be associated with renal anomalies/hearing loss

8. Nose
external appearance
o congenital abnormalities, atresia
flaring of nostrils: may suggest respiratory distress
patency of nares: congestion/discharge

9. Mouth
external appearance: cleft lip, shape, etc
precocious dentition (supernumerary teeth)
10. Palate
structural abnormalities
- cleft: may lead to feeding problems aspiration etc. in the immediate neonatal period
- high arched: may suggest congenital syndrome lesions
- Epstein Pearls: whitish nodules on palate; benign, common; accumulation of epithelial cells

11. Neck
tone: increased may indicate neurological disease
palpitation: masses include thyroid, cystic hygroma, branchial cleft/cysts
mobility: congenital torticollis (may palpate mass as well)

12. Chest
appearance
- congenital deformities may cause asymmetry
- retraction: sub-xiphoid or intercostal suggest respiratory distress with increased effort of breathing
respiratory pattern: rate and rhythm commonly quite variable; > 60 resp/min for sustained time is abnormal

13. Lungs
auscultation
- rales, wheezes, rhonchi, grunting
- compare air movement on each side and between lung zones

14. Heart
cyanosis: central vs acrocyanosis
precardial activity
rhythm and rate
- commonly quite variable
- may range from 100-180 in various states of rest/activity
- extra systoles and sinus pauses common
S1, S2: may be grossly abnormal in valvular heart disease murmurs
- murmur = m
- grade I-VI (written e.g. II/VI)
- describe location and quality
- murmurs in first day from a closing ductus are common
- any murmur still present on third day should be evaluated
- gallops
extra heart sounds very difficult to hear at the rapid heart rate of a newborn
pulse graded 0-4+
- 0 = Absent
- 2+ = Normal
- 4+ = Bounding

15. Pulses
palpate in each extremity and compare side to side and UE to LE
decrease in LE pulse or delay in transmission to LE vs UE may indicate coarctation of the aorta
16. Abdomen
observation: distended, discolored, scaphoid
bowel sounds: may not be present early in life
palpation: for masses, distension etc.
umbilicus: number of cord vessels
liver: commonly palpable up to 1 cm below the right costal margin
spleen: may be just palpable under left costal margin
kidneys: usually palpable, at least in part, in a very relaxed infant who allows deep palpation; palpable large kidneys suggestive of hydronephrosis

17. Genitalia
inspection
  o examine all structures to ascertain if they are clearly male or female
  o particularly check for location of the urethral orifice; may be displaced (hypospadias, epispadias) in what appears to be a male infant (may be male or virilized female)
  o foreskin is often tight and appears closed
  o female genitalia may appear enlarged in proportion to the other body structures 2° the effects of maternal hormones and/or prematurity
palpation
  o palpate for testes in the scrotum or inguinal canal
  o scrotal enlargement may be 2° hydrocele which is relatively common - diagnose by transillumination as well as palpation (intermittent, recurrent hydrocele is suggestive of hernia)
  o testes may be in canal or not palpable in ELBW infant
discharge
  o females may have a clear mucous discharge or even blood ("pseudomenses") 2° hormonal stimulation in utero with sudden withdrawal in post-partum
circumcision
  o may look quite edematous and erythematous
  o watch for difficulty urinating after procedure

18. Breasts
may not be visible in ELBW
term infant may have prominent breast tissue
hormonally stimulated

19. Rectum
check for patency (evidence of stooling)
check for fissures (may see bloody stools)
check for placement (may be anterior)
20. Hernia
check inguinal regions
diastasis recti (midline weakness of the abdominal musculature) is common and may simulate a ventral hernia
21. Spine
inspect and palpate for deformity, deviation
inspect for dermal sinus tracts: may be anywhere along the midline from the nose, over the skull and down the spine to the sacrum
any dimple should be carefully examined to be sure that the bottom of the pit is visible (traction on the skin helps exam)
any discoloration or hairy lesion should be evaluated

22. Clavicles
inspect for asymmetry
palpate for fractures (common birth trauma)

23. Extremities
inspect for deformities - fetal position may cause some apparent abnormalities that are self-correcting
check joints or observe for range of motion: term infants are normally quite flexed as a general posture
check palmar creases
hips - test for congenital dysplasia by:
  o observing for differences in leg movement
  o check for differences in leg length
  o checking for asymmetry of leg skin folds (misleading)
  o manipulation of the hips (abduction) with fingers over the greater trochanter and feeling for (or hearing) clicks
  o Barlow & Ortoloni maneuvers
digits
  o count them
  o extra digit buds or skin tags are not uncommon (often familial)

24. Neuro
degree of alertness
spontaneous movement
posture
tone
grasp, suck, Moro, root
DTRs
response to light, sound
facial, brachial plexus palsies

25. Cord (Umbilicus)
check for secure clamping
count and document the arteries (2, thick-walled) and vein (single, thin walled) in the remnant

26. Voiding
95% of infants void in the first 24 hours
98% void in the first 48 hours
most common reason for "delay" in voiding is missing urination at birth

27. Stools
90% of infants pass stool in the first 24 hours
98% stool in the first 48 hours
prolonged time without stooling suggests meconium ileus (cystic fibrosis), meconium plug, or other congenital defect

Ballard Determination of Gestational Age
Newborn Nursery Psycho-Social History – For all new admissions
1. Where Mother Lives
2. Role of Biologic Father in Family
3. Other members of the household
4. Financial Support
5. Social Support
6. History of Domestic Violence
7. Any Legal Concerns (benefits, custody, criminal)
8. History of Substance Use
9. Smokers in the House?
10. City water or Well water?
NICU/ICN Schedule

1) Due to changing duty hour restrictions and loss of the anesthesia residents in the NICU, we are switching to 1 resident team starting May 24. The patient maximums are based on a 45 bed cap.

2) Resident Team Structure:
   > PGY2 and PGY1 with PGY3 on elective.
   > Responsible for a maximum of 28 patients, patients may be from either side of unit.

3) Resident Team Schedule:
   > Intake/teaching from 7:30am-8am
   > Rounds start at 8am
   > Interns will do 16h overnight shifts (6:30am - 8:30pm) for 5-6 days. They will also take day call shifts from 6a-8p.
   > PGY2 and PGY3 take day call shifts
   > Signout between Day Intern and Night Intern will take place at 6:30pm.

4) NNP Team:
   > Providers round on 8-10 patients, meaning 3 providers needed each morning.
   > Patients are a mix from both sides of the unit.

5) Night Coverage: Residents (either PGY1 or PGY2), NNP, and neonatology fellow
   > At least one member of overnight in-house team is present for attending rounds at 4:30pm.
   > Teams can signout to the overnight member of their team at any time in the afternoon.

7) Supervision (Daytime):
   > At least one senior will be present for all of rounds during the week. Some weekends they will need to leave at 10am, the fellow and attending will oversee the interns after 10am.

8) Caveats:
   > If there are more than 45 patients or if the NICU increases in size to 54 beds, the NNP Team would be responsible for the additional patients and more NNPs would need to be scheduled.
PICU Rotation

PICU Cross-Cover

During certain months with only three residents rotating in the PICU, a cross cover resident (CCR) has been added to the call rotation. This also allows the residents that are scheduled in the PICU to be the primary resident in charge of 3-4 patients. In order to make this system work, the following are expectations of the PICU CCR:

1. The CCR comes for resident sign out at 4:00 pm in the PICU conference room. The PICU resident on “day call” will sign out each patient and any follow-up that needs to be done by the CCR that night.
2. After resident sign-out, the CCR will join the attendings and fellow for attending sign-out starting at 4:30.
3. The CCR will admit new patients that come in overnight, acutely manage any issues on the current PICU patients, and follow-up on any plans made during the day on current PICU patients.
4. The CCR will report back to PICU residents any overnight events during pre-rounds.
5. The CCR will add admissions to the list for morning report.
6. The CCR will be responsible for pre-rounding on any new admission and presenting that patient to the PICU team in the morning. Rounds on new admissions will be done first to allow the post-call CCR to leave after those presentations.
7. PICU morning conference begins at 7:00 on Monday only. The CCR should attend this conference when post-call.

Responsibilities of PICU Resident to the CCR

So that the CCR is adequately prepared to take over care of the PICU patients, the PICU residents have certain responsibilities to the CCR:

1. Sign-out will occur at 4 pm the evening the CCR is on call. This sign-out process should be efficient to allow the on call resident to be available for attending rounds at 4:30. Under some circumstances, both the day call and CCR will participate in evening rounds with the attendings to provide the best care to the patients.
2. The night there is a CCR on call, there must be a “PICU day call” resident who is there until sign-out. The resident taking “PICU day call” should rotate so that the two PICU residents (who are not post-call the day the CCR is on) take approximately the same number of “PICU day calls.”

Welcome to the PICU: How the Day Works

6:00 – 7:00 – Pre-Rounds:
Each resident is responsible for the care of 3-4 PICU patients. This resident will be the primary provider for these patients. Preferably, those patients should be those admitted by that PICU resident. When there is a cross cover resident, any patients admitted overnight should be distributed among the PICU residents.

During pre-rounds, the PICU resident is responsible for getting sign out from the on-call resident, collecting vital signs, examining the patient, writing down lab work and looking at overnight x-rays. Remember that if you are on call that day and you come to pre-round early, you must leave the next day at the end of 28 hours.
8:30 - 10:30 AM – Rounds:
Our presentations are a little different from some other services. Since our patients usually have more than one problem, we think in terms of organ systems and functions or failures. The **daily presentation** on a known patient (not a new admission) should start with a sentence or two, such as “This is our 5 month old former preemie with chronic respiratory failure and nutritional compromise. Recent issues include culture-negative sepsis. Overnight there were no disasters.” Then move on to systems. Another example might be, “This is our 3 week old with HLHS POD 10 from modified Norwood. Recent issues have been fluctuating pulmonary resistance and fluid overload. Yesterday the chest was closed. Overnight we had problems with blood pressure instability and dwindling urine output.” Then move to systems. Another example might be, “This is our 16 year old with severe TBI following MVC. Yesterday he had refractory ICP and the neurosurgeons did a decompressive craniectomy. Overnight we struggled to keep the INR corrected, but the ICP stayed <10.” Then continue by systems. When presenting a **new admission** to the team, give the whole H&P that you worked so hard on. We don’t need the child’s favorite color and every uncle that died of lung cancer, but if the child doesn’t walk or talk at baseline and has recovered from status epilepticus, that information is useful. If the child was flown in at 4 am and there are no parents to interview, just write and report that your information comes from records at the outside hospital and a quick glance through the old chart if there is one.

You’ll find on the **progress note** templates that we’re using a place for the one-liner then the systems with places to record vital signs, physical exam and medications referable to each system. By collecting all that data and reporting it to the team, you will have the opportunity to reflect about that patient and make an **assessment**. This is probably the most important thing you can learn while in the PICU – how to turn gobs of data into meaningful information. You can mark your progress as you move from “I have no idea what’s going on, but he’s not right,” to “I think she’s getting a little bit better because her renal function is improving and her blood pressure is more stable,” or even, “He’s back to his baseline and ready for the floor.” Then after the assessment, you can document the detailed plans decided during rounds. Please present from copies of your notes so that the attendings can document on the bottom of your progress note, making any additions or changes as necessary.

11:00 - 12:00 pm – Work/Fun Stuff:
True, there’s a pile of orders to enter and consultants to call, but this is the fun working part of the day. Many of the orders should be entered during rounds, but it’s up to the group how to best divide the chores so that the post call person can finish notes and leave before **28 continuous hours** as well as abide by the 80-hour work week.
The swing person can assist the on call resident with work to be done, orders for the next morning, early admissions plus researching a topic from discussions on rounds.

When you’re on call, keep in mind that things can change quickly in the ICU, and the best-laid plans from rounds might be irrelevant by lunch. Some days it’s hard just to keep up. **Examine** patients you might be worried about several times during the day and night. Talk to families, call PCPs. Perform procedures as the clinical situation warrants (the fellows have the final say about who gets to do the procedure, since they have to be good enough to earn a living doing this). Ask questions. Follow up on study results. Check off your boxes. **Admit new patients. Here’s a tip:** if you make yourself dizzy checking on the patients, you’ll find things before being asked about them. Then, with a chance to think of a plan and run it past the fellow or attending, you won’t feel like you are just entering the orders people ask you to enter.

4:30 - 5:30 PM - Sign Out Rounds:
There will usually be two attendings (one for days, one for nights) plus the fellow. Fellows present in the evening. Fill in the information with any details you might have if they seem relevant. You may know the most about the new ortho patient, for example, who rolled in at 4:15, so we may ask you to give an overview. Now the patients are yours and the fellow’s. Have fun thinking and figuring out why certain things are changing and what to do about them.
If there is a cross-cover resident on that night, it is your responsibility to give this person the run-down of ALL the patient as well as provide him/her with a list of “things to do.” The cross-cover resident should then join the attending and fellows for attending sign out rounds.

Other Quirks….

- The nurses will ask you to enter “standard post op orders” for post-cardiotomy patients while they’re still in the OR. Some things will be essential, but clearly not every patient needs an epi drip from the pharmacy. Ask for guidance from the bedside nurse or the charge nurse.
- Occasionally, we have the need for verbal orders. For example, during an emergency or while you’re doing a procedure on another patient. Please sign them within 24 hours.
- You will get test code pages twice a day. Thus, you are expected to respond to pediatric codes in the hospital with the fellow and charge nurse.
- Check the white board outside the conference room for nursing assignments, posted admissions, etc.
- Please don’t eat or drink in patient rooms or at the work tables. You may use the fridge in the lounge and eat there or in the fishbowl conference room. If you’re alone at night and need to go the cafeteria, let the charge nurse or HUC know that you’re leaving.
- If you are lucky enough to get a chance to lay down at night, tell the charge nurse you’ll be in the call room (Room 7425, the code is 1-2-3).

From: Al-Shammaa, Bann *HS
Sent: Friday, April 03, 2015 5:07 PM
To: CL PEDS - Residents
Cc: Waggoner-Fountain, Linda *HS
Subject: Fw: IMCU

You're probably wondering what this means for you.

The majority of the patients in the IMU will be rounded on and cared for by the PICU attending and residents. "Step down" cardiology patients will be cared for by the cardiology attending and floor residents. It really shouldn't be too terribly different for the housestaff. The main issues will be with nursing coverage and ratios. In anticipation of that, the IMU will get ramped up very slowly, with only 1-2 patients to start.

Bann

Bann Al-Shammaa, MD
Chief Resident, Pediatrics
e-mail: ba2u@virginia.edu
PIC: 6076

From: Coleman, Maureen *HS
Sent: Friday, April 3, 2015 5:03 PM
To: CL Pediatrics Joint-Faculty; CL Pediatrics MD-Faculty; Aldayuz, Angela *HS; Alonzo, Corrie J *HS; Al-Shammaa, Bann *HS; Ballengee, Cortney Rae *HS; Black, Emily D *HS; Clark, Katherine *HS; Clark, Rachel W *HS; Coffman, Zachary J *HS; Craig, Crystal *HS; Eason, Ashley *HS; Finkler, David M *HS; Glinton, Kevin E *HS; Goodall, Catherine *HS; Hartman, Stephanie M *HS; Horner, Liana M *HS; Janovski, Alexander J *HS; Kalan, Erin S *HS; Kelly, John *HS; Lewis, Benjamin A *HS; Libby, Brock *HS; Mcgraw, Matthew *HS; Mechak, Joseph T *HS; Morrison, Adam K *HS; Onyemachi, Ufuoma *HS; Ortiz, Christina M *HS; Prasad, Shikha *HS; Proctor, Sara R *HS; Ratchford, Thomas *HS; Simson, Benjamin E *HS; Sohn, Julia K *HS; Springsteen, Caleb H *HS; Sturz, Gregory
Team,

On Monday, April 6th, Acute Care Pediatrics will be utilizing beds on 7 North to care for Intermediate Care Patients. We are responding to the increased volumes in the PICU and the increasing acuity on the Pediatric Acute Care Floors. This decision has had much consideration and effort. We are excited and pleased to provide another level of care in the Children’s Hospital. We will continue to develop the IMCU concept and gradually increase our capacity per increasing experience and evaluation of need. Multi-disciplinary team will remain the same and continue to cover these beds on 7 north. Nursing coverage will be collaborative between PICU and 7 Acute teams. Attending coverage will be accomplished by PICU and cardiology staff. More to follow as this effort grows. If there are questions, please do not hesitate to ask.

William G. Harmon, MD
Associate Professor of Pediatrics
Medical Director, Critical Care Services

Linda McGhee, RN
Acute Care Pediatrics Manager
From: McClure, Esther F *HS

The pediatric sedation service provides procedural sedation for children throughout the UVA Children’s Hospital. Our hours of operation are Monday through Friday from 0700-1700. When ordering a test or procedure that will require the sedation team, please write “Needs peds sedation” on the request so the radiology schedulers can set up a time with us.

For non-radiology cases, please continue to page #1662 - the pediatric sedation nurse - for scheduling of any urgent cases (within the next 2 weeks or so.) Otherwise please send requests to us through our e-mail pedsed@hscmail.mcc.virginia.edu. (At UVa all you need to do is type in pedsed).

Based upon recommendations from the Department of Anesthesiology and the Pediatric Sedation Service, the NPO/dietary restriction guidelines in the UVa Medical Center protocols for Moderate or Deep Sedation/Analgesia have recently been revised.

For adults, solids and milk products are to be withheld for 6 hours before the procedure (was previously 4 hours). The restriction for clear liquids remains unchanged at 2 hours.

For children, the guidelines have been streamlined to:
(1) no solids or milk/breast milk/formula for at least 6 hours before sedation, except that infants age 0 to 6 months may have breast milk up to 4 hours before sedation; and (2) oral intake of clear liquids may continue up to 2 hours before sedation. Patients known to be at risk for pulmonary aspiration of gastric contents (e.g., those with a history of gastroesophageal reflux, extreme obesity, pregnancy, a history of previous esophageal dysfunction) may benefit from appropriate pharmacologic treatment to reduce gastric volume and increase gastric pH.

Procedural sedation documents may be accessed on the intranet at:
http://www.healthsystem.virginia.edu/intranet/pi/projects/sedation/sedhome.cfm
Senior Ward Expectations

(Discussed at June 2007 Housestaff Meeting, revised 6/14)

As the Senior Resident on the Acute Care Wards, you have many responsibilities both caring for your patients and acting as the team leader. Below you will find these responsibilities outlined for you so that everyone on the team understands your role.

Patient Care

1. Work Flow
   a. At 7:00AM both you and the other Senior Resident will be here to discuss all new admission and potential discharges with the night senior and the Ward attending. Ill patients should be examined and discussed in length as well.
   b. You will be in charge of organizing “running the list” at 11:45AM, intern sign-out at 4:00PM (as the year goes on the interns can do their signout on their own, but always listen if there is time), and senior sign-out at 7:00PM.
   c. If you are going off service, you have to sign out the service to the seniors who will be starting.
   d. The day call person must follow work hour rules (must be done by 9pm in order to return at 7am). This is best accomplished by stopping all absolutely necessary work at 6:30pm and updating the list from 6:30-7pm.
   e. Discharges
      - Discuss with the subspecialty attendings which patients can be discharged the following morning and pass that information on to the night team.
      - During evening sign-out, try to identify general ward patients that can be discharged the following morning so that discharge coordination can be finished up that evening.
      - Discharge prep in Epic

2. Discharge summaries are completed by interns, but should be proof-read by senior residents.

3. PCPs
   a. Every PCP needs to be communicated with about all patients who are going home. Your role as the team leader is to make sure that a physician does this. This is the intern’s responsibility primarily.
   b. Make sure that either the Medical Student or the Intern is writing and routing a discharge summary through EPIC to the PCP.

4. Consults
   a. If another service asks for you to consult on a patient, please do the consult that day and discuss it with the attending.
   b. Make sure that you continue to follow that patient until the Pediatric team signs off on that consultation.

5. Sign Out List
   a. It is the Senior Resident’s responsibility to make sure that the Sign Out List is up to date with the appropriate information. As the year goes on encourage interns to update their patients.

Teaching

1. Radiology Rounds
   You must email a list of patients to the Pediatric Radiologist every TUESDAY to be discussed during Wednesday Radiology Rounds at 8:30-9:00AM.
2. Medical Students
   You do not have to do formal medical student teaching, but incorporate teaching into your everyday tasks (below are examples)
   a. Discuss differential diagnoses about a patient who is admitted
   b. Make sure the student is present during all procedures
   c. Give the student a reading assignment and discuss that topic with him/her
   d. Dr. Mark Mendelsohn is the supervisor for the M4AI on the wards.

3. ID Rounds
   Please make a concerted effort to attend ID rounds every Tuesday at 1pm. Please also try to identify interesting patients that should be discussed and assign that patient to a student. The ID attending or chief resident usually assigns patients to the students but feel free to give suggestions.

4. Mock Code
   During the first half of the year you should be running the codes, and then persuading the interns to run them after December.

5. Feedback
   At appropriate times during your month as Senior Resident, you should be giving feedback to both the students and residents.
July 25, 2014

From:  Lynn McDaniel, M.D.

RE:  New Medication Reconciliation Effort

To all who care for patients on 7 Acute Pediatrics

I have attached the information that is going out to the staff of the 7th Floor, Acute Pediatrics. Starting on Monday, the HUCs will be printing a medication sheet for all admissions to 7 Acute and giving the sheet to the family. The residents/LIPs will then be responsible to take this form from the parents to perform their medication reconciliation in Epic. This is a process many will be familiar with, as it is followed in many of the UVA clinics. We have significant issues with medication reconciliation across the Children’s Hospital and this is an effort to decrease medication errors on admission. Please make every effort to utilize this additional tool to improve the care and safety of our patients.

Please let me know if you have any questions or concerns about this new process.
Thanks
Lynn

Lynn M. McDaniel, MD
Director, Pediatric Hospital Medicine Service Co-Medical Director, Acute Inpatient Pediatrics
Office:  434-924-9130
Fax:  434-243-2628
Pager:  434-924-0000 PIC 2056
lmcdaniel@virginia.edu
Medication Reconciliation: Quick 4 step process to improve patient safety!

Review of Prior to Admission Medications
Quick Points:

1. Asking HUC’s to provide the medication list to each family on admission
2. In the absence of a HUC, the RN needs to provide the document to the family, just as they would care partner information
3. HUC’s—if the families attempt to ask you questions regarding any of the information on the sheet simply tell them they need to discuss any concerns with their nurse or physician.

From our Quality Officer—

- We have significant issues with medication reconciliation across the Children’s Hospital
- The pharmacy started a pilot program this past spring which has helped but is limited in its ability due to time constraints/staffing
- The HUCs will print a list of “prior to admission” medications for the family to evaluate and correct if needed. The residents/LIPs will then be responsible to take this form from the parents to perform their medication reconciliation in Epic.
- This is a pilot program (anticipate 2 months) to determine if we can decrease medication reconciliation errors on admission to 7 Acute (from outpatient clinics and/or the ER)
- If shown to be successful, we may adapt this to other areas of the Children’s Hospital (PICU, intrahospital unit transfers)

Jonathan Swanson MD, MSc
Assistant Professor of Pediatrics
Chief Quality Officer for Children’s Services
Medical Director – Neonatal Intensive Care Unit

University of Virginia Children’s Hospital

(434) 243-3995

jswanson@virginia.edu
Quick 4 step process to help rectify problems with Medication Reconciliation

1. Select unit list desired

2. Click on admission meds tab to bring up the list below

3. Right click in this area and select print

4. Hand the printed list to the family. Tell them to look it over and plan to discuss it with their doctor when they arrive.
Teach/Clinic Resident Duties

**Birdsong Pediatric Clinic**

1. Supervise patient flow (keep an eye on chart-rack and walk-ins). See patients when all clinic docs are busy and patients are waiting.

2. Answer phone/parent questions and delegate answering calls to interns and faculty.

3. Review lab results. Keep follow-up board up-to-date. ***If culture results or other important labs will be read in the evening or over the weekend, contact the Medallion resident with pertinent information and instructions.***

4. Primary care conference is most Fridays at 8 AM in the PCC. Remind clinic interns to report to PCC on those mornings, instead of AM Report. Send list of attendees to residency coordinator each week.

**Reading List – Teaching Resident**


6. A series of 13 articles published in the British Medical Journal
Dear all,

Beginning with this rotation, the “Teaching Resident” rotation will have some changes over the next five months. Your responsibilities will include the following:

1. You will work with a junior medical student in the general clinic in the mornings and teach them ambulatory pediatric topics in addition to teaching them clinically relevant topics as they related to the patients you see together.
2. In the afternoons, you will have one or two continuity clinics each week.
3. On the other three or four afternoons, you will teach the junior students on the wards and in the nurseries. I will directly observe at least two of these teaching sessions. I think bedside teaching is extremely rich (how to do a Ballard score, listening to heart murmurs, looking at birthmarks or rashes, etc.) but there could also be powerpoint talks or chalk talks or reviewing videos or audiotapes. I will not be doing the teaching, you will be and I will be observing.
4. I am creating a group of readings about clinical teaching that we will discuss
5. We will review two of your presentations (your choice of what) to review ways to improve presentations.

Your evaluation will come from the clinical faculty in general clinic and from me.

I am excited to take our student teaching skills to a new level. I am open to suggestions as well as we work through some of these modifications. Let me know if you have any questions.

Best regards,

Linda

Linda A. Waggoner-Fountain, M.D., M.Ed.
Program Director
Associate Professor of Pediatrics
Division of Infectious Diseases
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Appendix 1: Rotation Forms

Rotation Forms

Away Rotation Application
Away Rotation Evaluation
International Health Application (see additional information below)

Forms available at GME web site (bottom of page under “Documents & Forms”).

International Health Rotation

Application form available at GME web site (bottom of page under “Documents & Forms”).

To participate in an international rotation, you are required to obtain approval at three levels:

- Your residency program,
- University of Virginia’s International Studies Office,
- UVa Health System’s Graduate Medical Education (GME) Office.

It is helpful to obtain the approvals in this order, as you will need components from the first two to obtain the final approval from the GME office. Obtaining these approvals is essential to making sure that:

- You receive credit for your rotation,
- You have appropriate insurance in case of emergency,
- Your salary and benefits are uninterrupted.

Detailed directions and hints are below:

Approval from Program Director (Assures ACGME Compliance)

1. You will need to provide Linda Waggoner-Fountain with an outline of the rotation proposal, detailing the following:
   a. goals and objectives of the rotation, focusing on how these complement the 6 core ACGME competencies
   b. outline of the day to day activities of the rotation
   c. description of your supervising physician abroad (with their CV) and their role in evaluating your performance
   d. your post-trip evaluation and plans for an oral presentation about the rotation upon your return

2. Contact Dr. Waggoner-Fountain. She can assist you in developing your rotation proposal as described above. In addition, there are several countries that have long-term collaborations with UVa. Those countries have designated country directors at UVa. Drs. Linda Waggoner-Fountain or Leigh Grossman will help you identify the country director. It will be important to contact this person to let them know your plans. The directors also usually have great contacts and advice.
3. Remember that if you are planning to deliver direct patient care during a rotation abroad you may need to apply for a medical license in that country. (Uganda is one example of this.) This process usually takes several months. Check with your mentor abroad.

**UVA International Studies Office (ISO)**

1. International Studies Office
   a. Contact Stacey Hansen (srh4v@virginia.edu, 434-924-4252) who will set up an orientation session to help you navigate the ISO on-line application. Once you have completed the necessary on-line information, she will send an email to the GME office confirming that this is done
   b. The ISO is part of the University of Virginia and residents are considered “graduate students” for the purpose of the ISO – as such, you basically need to register with the ISO office on-line.

2. Health insurance (emergency coverage is usually covered by the basic health insurance plan that we automatically get as residents but you should check)

3. Evacuation insurance. MEDEX evacuation insurance is available at no cost through the University Benefits office (434-924-4392)

4. Vaccinations and other preventive medicine issues:
   a. CDC website (http://www.cdc.gov/travel/vaccinat.htm)
   b. Many African countries require proof of yellow fever vaccination (the traveler’s clinic will provide you with a yellow World Health Organization immunization card detailing your vaccinations); lasts 10 years
   c. Can be done at traveler’s clinic, a walk-in clinic like FirstMed, or the health department. The health department is usually the least expensive, but you must have a prescription for the appropriate vaccinations.
   d. Check to see if the housestaff office is willing to help with this bill as it can get fairly expensive and often it’s not covered by insurance. If you are applying for a grant to help pay your expenses, then be sure to include the cost of vaccinations in your budget.
   e. Malaria prophylaxis if appropriate
   f. Appropriate antibiotics for traveler’s diarrhea
   g. Antiretroviral therapy if you will be at risk for occupational exposure.

5. Check to make sure you are not traveling to a site that is an official “travel warning” site (website: http://travel.state.gov/). You may not travel to the country if it has a “travel warning” from the state department, even if everything has been set up.

**Approval from UVA GME**

1. This is important to maintain your salary and health benefits while you are gone. You must submit the GME paperwork at least 90 days from your departure date and the next GMEC meeting. The forms are on-line at the GME web site.

2. The contact person at the GME office is Sarah Oh at 243-7346.

3. You will need to have a mentor from both UVA and abroad.

4. The mentor from abroad will need to send a letter of intent and CV for you to submit to the GME.

5. You will need to document approval from the International Studies Office as part of your GME application.

6. You will need to confirm that you have medical evacuation insurance.
If You Will be Conducting Research Study Abroad

1. Take the IRB on-line training session (takes at least 1 hour)

2. Submit research proposal to the IRB at UVA as well as the institution where you will be working. Each country may have different requirements.

3. Keep in mind that a research project that you prepare before you go may not work because of resource restraints or other restraints that you cannot predict, so BE FLEXIBLE.

4. It is helpful to have a laptop computer that you can travel with to work on your project. You can get up to a 12% discount on Dell computers at our bookstore.

Travel and Other Hints

1. Make sure your passport is up to date (should not expire within 6 months of your return).
   a. If not, download forms for renewal or new passport at: http://travel.state.gov/passport/passport_1738.html
   b. You will need two 2” x 2” passport style pictures
   c. Takes about 10-12 weeks or longer.

2. You may also need a visa.
   a. Check the respective embassy site for requirements and possible forms
   b. You will need two passport style pictures for this as well
   c. You will need to send your up to date passport, so make sure you’ve renewed your passport before submission.

3. It is helpful to register with the US embassy in the country where you will be working so that in the case that the country becomes unstable, the embassy can help you with evacuation. This is easily done on the following website: http://travel.state.gov/travel/tips/registration/registration_1186.html

4. Talking to residents or students who have already traveled to the site can provide invaluable insight on the rotation experience and more practical aspects such as finding a place to live, or good food

5. Many residents have remarked that the medical students and colleagues whom they have met during their international rotations are very interested in learning from our residents. Please consider what topics you might like to present on while on your rotation. Commonly requested topics include: ECG interpretation, diabetes management, hypertension management, and Chest X-ray interpretation. Your presentations will probably have to be modified to fit the environment, but they are a great way to reciprocate for the great experience that you are having.

6. Remember that you will be asked to present on your rotation once you return. This requirement is a form of evaluation for you and should also provide your assessment of what the next steps are at the site. Is this the kind of site that more students/residents should travel to? Are there specific service or research projects that might be undertaken collaboratively? Having pictures (not necessarily of patients – unless, obviously, they give their permission) and case studies help make presenting a lot easier!
Appendix 2: Evaluation Forms

All forms below except those with individual hyperlinks can be found on the New Innovations web site.

Peds Evaluation of PGY-1 Resident
Peds Evaluation of PGY-2 and PGY-3 Resident
Resident Evaluation of Attending
Student Evaluation (done on Oasis program)
Continuity Clinic Resident Evaluation (Pediatric Resident Evaluation – Continuity Clinic)
Direct Observation Form: Primary Care Center (Pediatric Primary Care – Direct Observation)
MD Documentation Form: Emergency Medicine (Department of Emergency Medicine-MD Documentation Audit)
Direct Observation Form: Newborn Nursery
360º Assessment of Resident Performance Form
Morning Report Evaluation
Journal Club Evaluation
Toxicology Core Competencies Evaluation Form
PL-1 Newborn Nursery – Direct Observation
Parent Evaluation form

Pediatric Resident Evaluation for Parents

1. Did Dr. ___________________ introduce themselves to you and your child? YES or NO

2. Did they treat you and your child with respect and kindness? YES or NO

3. Did they explain information and answer your questions in a way you understand? YES or NO